MAJOR HOSPITAL

MEDICAL STAFF BYLAWS:

Governance and Organization Manual

TABLE OF CONTENTS

DEFINITIONS

The following definitions, unless otherwise expressly indicated, apply throughout the Medical Staff Bylaws. The Medical Staff Bylaws include: (1) the Governance and Organization Manual, (2) the Credentialing Manual, and (3) the Corrective Action and Fair Hearing Manual. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms.

"Administration" or **"Hospital Administration"** means senior management at the Hospital.

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

"Applicant" means any physician, dentist, optometrist, oral surgeon, podiatrist, or NPP applying for initial appointment to the Medical Staff and/or for clinical privileges at the Hospital, as applicable.

"Chief Executive Officer" or **"CEO"** means the individual appointed by the Governing Board to act on its behalf, as its direct executive representative, in the overall management of the Hospital.

"Chief of Staff" means the chief administrative officer of the Medical Staff who is a member nominated and elected to this position pursuant to the process set forth in these Medical Staff Bylaws. The Chief of Staff may also be titled and/or referred to as the **"President of the Medical Staff."**

"Clinical Privileges" means the permission granted to a practitioner by the Governing Board to render specific patient care services within the practitioner's lawful scope of practice to patients at the Hospital, and permission to efficiently use Hospital resources necessary to exercise granted clinical privileges.

"Days" unless otherwise indicated, means "calendar days" (i.e. including Saturday, Sunday, and legal holidays) unless the due date falls on a Saturday, Sunday or legal holiday, in which case the due date shall be the first (1st) day immediately following the day that is not a Saturday, Sunday, or legal holiday.

"Dentist" means a duly licensed dentist.

"Direct Economic Competition" means those situations or circumstances when two individuals share the same clinical privileges at the Hospital and/or when their health care practices substantially overlap such that the individuals compete to provide the same type of health care services to the same population of patients.

"Economic Factors" means any information or reasons for decisions unrelated to quality of care or professional competency.

"Ex Officio" means service as a member of a body by virtue of an office or position held. Unless otherwise provided, ex officio members participate without vote.

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

"Good Standing" means a practitioner who, during the current term of appointment to the Medical Staff and/or term of clinical privileges, continues to maintain all qualifications for Medical Staff membership, clinical privileges, and assigned category, as applicable, and is in compliance with all responsibilities attendant to Medical Staff membership and clinical privileges, as applicable.

"Governing Board" or "Board" means the Board of Governors of the Hospital.

"HCQIA" means the Health Care Quality Improvement Act of 1986.

"Hospital" means Major Hospital, including any locations subject to its Indiana State-issued hospital license; Hospital is a city/county hospital organized under the laws of the State of Indiana to provide a broad range of health care services to the Shelbyville, Indiana service area, providing patient care, education and research with all of its activities subject to the ultimate authority of its Governing Board.

"Hospital Policies" refer to and include, unless otherwise specified, all Medical Staff Bylaws, Codes of Conduct, Medical Staff policies and procedures, Hospital policies and procedures, the Board Bylaws, the Hospital's Compliance Plan, all applicable accreditation standards, and all applicable federal and state laws and regulations, including but not limited to the prohibition on inappropriate fee-splitting arrangements;

"Medical Director" means a physician, dentist, optometrist, oral surgeon, or podiatrist who is responsible for monitoring the medical care provided at the Hospital, and who has general supervisory responsibility over practitioners providing medical care in a given area, section, clinical service, or department of the Hospital, or alternatively, with respect to a particular clinical service or services of the Hospital.

"Medical Executive Committee" or **"MEC"** means the Executive Committee of the Medical Staff.

"Medical Staff" means all physicians, dentists, optometrists, oral surgeons, and podiatrists who have been granted membership on the Medical Staff by the Governing Board.

"Medical Staff Bylaws" or **"Bylaws"** means the Medical Staff Bylaws of the Medical Staff, which includes the Governance and Organization Manual, the Credentialing Manual, and the Corrective Action and Fair Hearing Manual.

"Non-Physician Practitioner" or **"NPP"** means any individually licensed or certified health care provider, excluding physicians, dentists, optometrists, oral surgeons, and podiatrists, who has an independent or dependent scope of practice, and who is authorized by the Governing Board to exercise specified clinical privileges or provide direct patient care within the Hospital.

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

"Oral Surgeon" means a duly licensed dental specialist who has not only completed four (4) years of dental school but has also completed an oral and maxillofacial surgery residency approved by the Commission of Dental Accreditation of the American Dental Association.

"Peer Review" refers to any and all activities and conduct of peer review committees ultimately intended, either directly or indirectly, to further the quality of patient care provided at the Hospital. Peer Review, as defined by Indiana's Peer Review Statute, includes the evaluation of qualifications of health care providers, patient care rendered by health care providers, and complaints or concerns regarding the professional conduct or competency of health care providers, which affects or could affect adversely the health or welfare of a patient or patients. Peer Review at the Hospital includes, for example, the Credentialing

process, the Corrective Action process, OPPE, FPPE, utilization review, and all other review processes, in full or in part, that are consistent with the permissible functions of a Peer Review Committee in Indiana.

"Peer Review Committee" means a committee of the Hospital or Medical Staff that is formed in a manner consistent with Indiana and Federal law and that is responsible, in full or in part, for engaging in Peer Review. By way of example, Peer Review Committees at the Hospital include the Governing Board, the Medical Staff (as a whole), the Medical Executive Committee, and any other committee of the Medical Staff and/or Hospital that is tasked, in full or in part, with monitoring quality improvement, patient safety, or otherwise engaging in Peer Review. These Peer Review Committees include not only those serving as members of the committees, but also their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other persons or organizations, whether internal or external, who are requested to assist the committee in performing its Peer Review functions. All reports, studies, analyses, documents, materials, determinations, deliberations, recommendations, and other similar communications that are authorized, requested or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with, and to the full extent permitted by, those protections afforded under applicable Indiana law. If a Peer Review Committee or its designee deems appropriate, assistance may be obtained, in an appropriate manner, from other Peer Review Committees, other committees, individuals or organizations inside or outside the Hospital.

"Physician" means a duly licensed allopathic or osteopathic physician.

"Podiatrist" means a duly licensed podiatrist.

"Practitioner" means any physician, dentist, optometrist, oral surgeon, podiatrist, or NPP who has been granted Medical Staff membership and/or clinical privileges at the Hospital, as applicable.

"Professional Review Action" means an action or recommendation of a Peer Review Committee, taken in the course of a professional review activity, based upon a practitioner's competence or professional conduct (which conduct affects or could adversely affect the health or welfare of a patient or patients), and which adversely affects (or may adversely affect) the practitioner's Medical Staff membership and/or clinical privileges, as applicable. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence. For clarity, Professional Review Actions do not include: (a) OPPE, (b) FPPE that is performed in relation to new or additional clinical privileges, (c) FPPE that is conducted as a matter of routine process and/or that otherwise does not otherwise constitute a non-routine investigation, or (d) actions that are Administrative Actions.

"Special Notice" means any notice required to be given under the Medical Staff Bylaws, unless otherwise stated, that is designated as a "Special Notice." Such notice shall be in writing and shall be deemed given when personally delivered or sent by prepaid United States certified mail with return receipt requested, traceable courier services, or confirmed electronic communication. All Special notices shall be considered received on the date actually received if given by personal delivery or traceable courier service, or on the date shown as received on the certified mail receipt or electronic confirmation if given by such method. A refusal to accept delivery of service shall constitute effective delivery as of the date of any such refusal.

Words used in the Medical Staff Bylaws shall be read interchangeably as the masculine or feminine gender and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the Bylaws.

PURPOSES

The purposes of the Medical Staff shall be:

(a) To provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its members and other practitioners with clinical privileges, and to provide mechanisms for accountability of the Medical Staff and such practitioners to the Board.

(b) To provide an environment where patients admitted to or treated in or by any of the facilities, departments, or services of the Hospital receive appropriate, timely, quality medical care without discrimination on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status (including the ability to pay for services), sex, sexual orientation, military veteran status or any other status protected by law;

(c) To be responsible for the quality of medical care provided to patients by the Hospital, and in so doing, to promote an acceptable level of professional performance of all practitioners authorized to practice in the Hospital by the Governing Board, through the appropriate evaluation of applicants and practitioners applying or reapplying for Medical Staff membership and/or clinical privileges, and thereafter, through the ongoing review and evaluation of each practitioner's performance in the Hospital;

(d) To establish and maintain high professional and ethical standards in general conformity with the requirements for Hospital and practitioner licensure in Indiana, Medicare Conditions of Participation, and any other standards as approved by the Board to the end that the Hospital shall maintain its status as an exemplary hospital;

(e) To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed among the Medical Staff, Governing Board, and CEO;

(f) To initiate and maintain Medical Staff Bylaws for the self-governance of the Medical Staff, which shall be reviewed periodically and revised as necessary, minimally every three (3) years, subject to final review and approval by the Governing Board;

(g) To carry out peer review activities, both alone and in conjunction with Hospital administrative personnel, as agents of the Board, in making recommendations for the credentialing/recredentialing of applicants and practitioners, in setting standards for and reviewing the efficient and effective use of hospital resources, in investigating professional conduct or clinical concerns, and in carrying out other peer review functions in the furtherance of quality of care;

(h) To provide an appropriate educational setting that will lead to continuous advancement in professional knowledge and skill; and

(i) To render such other services as are reasonably necessary to carry out the foregoing purposes.

ARTICLE 1. ELIGIBILITY FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Section 1.1. Nature of Medical Staff Membership and Clinical Privileges

Membership on the Medical Staff is a privilege, which shall be extended only to those physicians, dentists, optometrists, oral surgeons, and podiatrists who have demonstrated a high level of professional competence and have met, and continue to meet, the qualifications, standards and requirements set forth in the Medical Staff Bylaws. NPPs are not eligible for membership on the Medical Staff, but may apply for and receive clinical privileges, and may participate in Medical Staff functions and activities as set forth herein. No physician, dentist, optometrist, oral surgeon, podiatrist, or NPP shall provide services to patients in the Hospital unless he or she has been appropriately granted clinical privileges to do so. A doctor of medicine (MD) or osteopathy (DO) shall be responsible for the care of each patient with respect to any medical or psychiatric condition that is not within the scope of practice and clinical privileges of a non-physician. Further, there shall be one designated attending physician at all times. The Hospital and Medical Staff shall not discriminate on the basis of race, national origin, religion, color, creed, sex, sexual orientation, or on the basis of any handicap, age, or other legally protected status that does not affect a practitioner's ability to safely and reasonably provide care to patients with or without reasonable accommodation.

Any practitioner who renders professional services at the Hospital, either as an employee or independent contractor, or as an employee or independent contractor of an entity with whom the Hospital contracts, must possess Medical Staff membership and/or clinical privileges, as applicable, as recommended by the Medical Staff and granted by the Governing Board. The membership and/or clinical privileges of such practitioners, as applicable, shall otherwise remain subject to the terms and conditions of employment and/or the contract (as applicable), which shall take priority over these Bylaws.

Section 1.2. Qualifications for Medical Staff Membership and Clinical Privileges

1.2.1. General Standards

Only those physicians, dentists, optometrists, oral surgeons, podiatrists, and NPPs who can document their licensure, certification, background, education, training, experience, professional competence, health status, adherence to the ethics of their professions and Hospital and Medical Staff policies, good reputation, character, judgment, and ability to work with others shall be qualified for Medical Staff membership and/or clinical privileges, as applicable. Additionally, to be considered for, to obtain and to maintain membership, all applicants must meet the requirements of any Medical Staff Development Plan (if any) that is adopted by the Governing Board and in effect at the time of application and as may be amended from time to time.

1.2.2. Basic Qualifications

With the exception of Honorary Staff, only those applicants and practitioners who can continuously demonstrate or provide evidence of the following qualifications

to the satisfaction of the MEC and Governing Board will be eligible for appointment or reappointment to the Medical Staff and/or the granting of clinical privileges, as applicable:

(a) Current and valid, non-probationary and unrestricted Indiana license applicable to his or her profession;

(b) Current, valid, and unrestricted Drug Enforcement Administration ("DEA") registration (with appropriate Indiana registration) and Indiana Controlled Substances registration, unless such registrations, in the discretion of the Governing Board following recommendation by the MEC, are not in any fashion required by, or attendant to, the clinical privileges sought or maintained by the applicant or practitioner, as applicable;

(c) Eligibility to participate in Federal and Indiana governmental health care programs, including Medicare and Medicaid;

(d) Absence of any felony criminal conviction, and absence of any misdemeanor criminal conviction that would violate the pertinent requirements for participation in the Medicare or Medicaid programs;

(e) Professional liability insurance in the coverage, scope, amounts and/or limits established by the Governing Board; unless the Governing Board or CEO make an exception for good cause (as may be the case, for example, with telemedicine providers), all applicants and practitioners are additionally required to maintain professional liability insurance sufficient to qualify (and must qualify) as a Qualified Provider, with participation in the Indiana Patient's Compensation Fund, consistent with the language and intent of Indiana's Medical Malpractice Act;

(f) Acceptable character, competence, training, medical education and post graduate training, experience, background, and judgment;

(g) Satisfactory clinical performance within the preceding twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought and which is adequate to meet the Hospital's current criteria for clinical competence;

(h) Acceptable professional liability case frequency, judgment or settlement history (no less than five (5) years);

(i) Physical and mental ability and health status necessary to perform the obligations of Medical Staff membership and the requested clinical privileges, as applicable, to the satisfaction of the Hospital and Medical Staff;

(j) Appropriate written and verbal communication skills;

(k) Willingness and ability to properly discharge the responsibilities established by the Governing Board and Medical Staff; and

(l) Board certification, as required by Section 1.2.3 of these Bylaws

No applicant or practitioner shall be entitled to membership on the Medical Staff and/or clinical privileges in the Hospital, as applicable, merely by virtue of licensure in Indiana or in any other state; board certification, fellowship, or membership in any professional organization, specialty body or society; or by virtue of holding similar clinical privileges at any other health care organization.

1.2.3. Board Certification

(a) All applicants for Medical Staff membership and clinical privileges must be board certified in a specialty that is reasonably related, in the discretion of the Governing Board (upon recommendation from the MEC), to the clinical privileges they seek.

(b) As an exception to subsection (a), above, applicants to the Medical Staff may be board eligible, when they apply for Medical Staff membership and clinical privileges, in a specialty that is reasonably related, in the discretion of the Governing Board (upon recommendation from the MEC), to the clinical privileges they seek. Such applicants, however, must become board certified in such specialty as soon as reasonably possible, but in all instances, within the time period required by the applicant's applicable specialty board for certification following eligibility. If the specialty board does not identify a maximum period of time for certification following eligibility, then the applicant is hereby required to achieve certification within five (5) years of initial appointment. A failure to timely achieve board certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff membership and clinical privileges. Such termination shall constitute an administrative action.

(c) As an additional exception to subsection (a), above, if an applicant has completed his/her residency or fellowship training in the twelve (12) month period prior to applying to the Medical Staff, and the pertinent specialty board expressly requires a defined period of clinical practice prior to board eligibility, then such applicants may apply for Medical Staff membership and clinical privileges, but must then achieve board eligibility within two (2) years of initial appointment to the Medical Staff. Thereafter, the applicant must achieve board certification within the time requirements set forth in the preceding subsection (b). A failure to timely achieve board eligibility or certification, as required by this subsection, shall result in the immediate and automatic termination of Medical Staff membership and clinical privileges. Such termination shall constitute an administrative action.

(d) Acceptable specialty boards include those boards recognized by the American Board of Medical Specialties and the American Osteopathic Association, as well as the American Board of Podiatric Medicine, American Board of Foot and Ankle Surgery, the American Board of Multiple Specialties in Podiatry, or any other specialty board approved by the MEC and Governing Board. Board certification must be in a specialty that is reasonably related to the clinical privileges sought by or granted to the applicant or member.

(e) Members who were appointed to the Medical Staff as of January 1, 2007, and who are not board certified shall not be required to become board certified as a condition of continued Medical Staff membership and clinical privileges, provided that these members otherwise meet the established competency requirements and other relevant criteria established by the Medical Staff and Governing Board. All other applicants and members must meet the board certification requirements set forth in this Section 1.2.3.

(f) In the event a member appointed to the Medical Staff as of January 1, 2007, and who is otherwise exempt from the board certification requirement pursuant to the preceding subsection (e), applies for new or additional clinical privileges that (in the discretion of the Governing Board, upon recommendation from the MEC) relate to a clinical specialty that is different than the member's current specialty, or are otherwise inconsistent with or beyond the scope of the member's current clinical practice, then the member shall be required to satisfy the board certification requirements set forth in this Section 1.2.3.

(g) In exceptional circumstances, the Governing Board may accept alternative information to the board certification requirement upon recommendation of the MEC, but only when the Governing Board determines that there is good cause to make an exception and only if the applicant or member demonstrates that he or she has completed the training necessary to obtain board certification in the area of proposed practice, and provides sufficient proof, in the Governing Board's sole discretion (upon recommendation from the MEC), of equivalent training, education, experience, and ability to perform the clinical privileges requested. The MEC shall document the exceptional circumstances supporting any such recommendation and include such information with its recommendation. An exceptional circumstances decision based on alternative information shall not be considered a waiver of any other criteria for Medical Staff membership or privileges. Furthermore, the determination to make an exception pursuant to this subsection (g) shall relate only to the particular clinical privileges sought and granted (or their future equivalent). Such an exception shall not constitute an exception as to any new or additional clinical privileges that are thereafter sought.

(h) All determinations made by the MEC and Governing Board with respect to application or waiver of the board certification requirements, as set forth in and contemplated this Section 1.2.3, shall constitute administrative actions, and as such, shall not entitle the applicant or member subject of the request to any fair hearing or other rights to due process.

Section 1.3. Responsibilities of Medical Staff/NPPs

As initial and ongoing conditions for appointment/reappointment to the Medical Staff and for clinical privileges at the Hospital, as applicable, each practitioner shall:

(a) Provide appropriate, timely, quality medical, dental or podiatric care without discrimination on the basis of race, national origin, handicap,

religion, color, creed, sex, age, financial status, sexual orientation, or other legally protected status;

(b) A M.D./D.O. (or Medical Staff member designee) shall make rounds on all attended inpatients at least once every day (only one M.D. or D.O. may be designated as the attending physician);

(c) Notify patients as to the reasons for any proposed change in the physician responsible for their care;

(d) Call for or respond to consultations when required by patient condition or Hospital Policy.

(e) Shall refrain from delegating the responsibility for diagnosis and/or care of hospitalized patients to a Medical Staff member, non-physician practitioner, or any other paramedical person who is not qualified for any reason to undertake this responsibility and/or who is not adequately supervised;

(f) Submit to and meaningfully participate in focused, ongoing, and periodic peer review of professional competence and skill, as well as quality assurance and improvement activities, functions, and responsibilities, as may be reasonably requested or otherwise required by the Bylaws or other Hospital or Medical Staff policy or procedure, whether undertaken by the Hospital internally or externally;

(g) Accept committee assignments, as applicable, on a reasonable basis and make a good faith effort to attend Clinical Service and Committee meetings;

(h) Comply with all current and applicable Hospital Policies;

(i) Meaningfully participate in Hospital accreditation, licensing, and compliance education activities;

(j) Consistent with Hospital Policy applicable to CME, and in addition to completing any CME required to maintain licensure, DEA registration, and/or CSR (as applicable), successfully complete the minimum number/type of CME hours required by the practitioner's applicable board(s) to participate in Maintenance of Certification (MOC); if the practitioner is not board certified and participating in MOC, then the practitioner must successfully complete a minimum of 25 hours of Category 1 CME per year that directly relates to the Clinical Privileges held by the practitioner;

(k) Except for those practitioners that are exempt pursuant to Hospital Policy, serve on the Hospital's Emergency Service call roster, as established by the applicable Clinical Service and/or MEC (with the MEC maintaining final authority over such rosters), and fulfill such obligations in a manner that is consistent with Hospital Policies, including but not limited to the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and related provisions, as implemented by the Hospital and the Medical Staff;

(l) Comply with the Hospital's communicable disease surveillance and prevention program pursuant to Hospital Policies;

(m) Participate in and successfully complete in a timely manner any Hospital sponsored or required training programs, including but not limited to those related to electronic medical record (EMR) and related clinical system implementation, pass any related program examination or opt-out examination, and submit required program documentation; applicants and members shall comply with all applicable Hospital Policies related to such training programs, including but not limited to implementation and use of EMR systems; members shall utilize the EMR (to the fullest extent the EMR is available) rather than hard-copy documentation/charting; and

(n) Report to the Chief of Staff and CEO within five (5) business days of receiving notice of any of the following:

(i) The initiation of any challenge or investigation by any state's Medical Licensing Board or other governmental agency of any professional license or certification and the scope and nature of any charges related to the challenge or investigation;

(ii) The initiation of any investigation by the Office of the Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS) or any other state or federal agency, including the scope and nature of any charges relating to the investigation, including any change in eligibility with third-party payers or participation in governmental health care programs, including Medicare and Medicaid, and any sanctions imposed or recommended by the OIG or CMS, and/or the receipt of a professional review organization citation and/or quality denial letter concerning alleged quality problems in patient care;

(iii) The initiation of any challenge or investigation by the DEA or the voluntary or involuntary relinquishment of any state-controlled substance license or DEA registration;

(iv) The voluntary or involuntary termination of medical staff membership or clinical privileges at another hospital or ambulatory surgery center (this requirement does not apply to locum tenens clinical privileges that naturally lapse/expire);

(v) The voluntary or involuntary limitation, reduction or loss of medical staff membership or clinical privileges at another hospital or ambulatory surgery center;

(vi) Receiving an adverse judgment, or upon the monetary settlement of, a professional liability action, including the parties thereto and related allegations;

(vii) The investigation, arrest, indictment or conviction with regard to any felony or criminal misdemeanor, except for misdemeanors involving minor traffic violations (note: traffic violations involving,

or alleging to have involved, drugs, alcohol, or operating a vehicle while intoxicated are not considered "minor traffic violations" for purposes of these Bylaws and must be reported); or

(viii) The suspension or lack of professional liability insurance at the scope, level or amount as determined by the Governing Board.

(o) Agree to accept all meeting notices and other Hospital and Medical Staff related communications via Major Hospital(@majorhospital.org) email; all applicants and practitioners may additionally provide the Hospital's Medical Staff Office with (and update as may become necessary) a secondary email address that is accurate, current, private, and secure for other Medical Staff communication.

Section 1.4. Conditions and Duration of Membership/Clinical Privileges

(a) Initial appointments and reappointments to the Medical Staff and the granting of clinical privileges shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, restrictions or revocations of membership or clinical privileges, and requests for clinical privileges after there has been a recommendation from the Medical Staff pursuant to the processes set forth in the Medical Staff Credentialing Manual, except as otherwise provided for in the Bylaws with regard to corrective action pursuant to the Corrective Action and Fair Hearing Manual.

(b) Medical Staff appointments, reappointments, and clinical privileges shall be for a period established by the Governing Board up to a maximum of three (3) years. Determinations to appoint or reappoint members, or to extend clinical privileges, for a period of less than three (3) years constitute administrative actions, and therefore, do not constitute adverse actions as defined within the Corrective Action and Fair Hearing Plan.

(c) Appointments and reappointments to the Medical Staff shall confer on the applicant/reapplicant only such clinical privileges as have been granted by the Governing Board in accordance with the Medical Staff Bylaws.

(d) Every application for appointment and reappointment to the Medical Staff and/or for clinical privileges at the Hospital shall be signed by the applicant/reapplicant. By submitting an application, each applicant/reapplicant acknowledges his or her obligation to provide continuous care and supervision of his or her patients.

Section 1.5. Ethics and Ethical Relationships

Acceptance of Medical Staff membership and/or clinical privileges shall constitute the practitioner's agreement to strictly abide by all applicable guidelines and opinions set forth in the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, the Principles of Ethics and Code of Professional Conduct of the American Dental Association, the Principles of Ethics of the American Podiatric Association and all other applicable ethical guidelines of the practitioner's licensing body.

Section 1.6. Conflict of Interest

A conflict of interest arises when there is a divergence between a practitioner's private interests and his/her professional obligations pursuant to the Medical Staff Bylaws and/or other Hospital Policies. No practitioner shall participate in a Medical Staff Committee deliberation or vote, nor take any action in his or her capacity as a Medical Staff Officer, Chairperson, Clinical Service Chief, or in any other Medical Staff leadership capacity, if the practitioner has (a) an actual conflict of interest or (b) a potential conflict of interest sufficient to render the practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, and the Hospital.

(a) An actual conflict of interest exists if a practitioner: (a) is the practitioner under review (or is a first degree relative or spouse of such practitioner), (b) authored the complaint giving rise to the review, or (c) has an admitted and material bias in the matter. All actual conflicts of interest shall be disclosed to the applicable Committee, Committee Chairperson, Chief of Staff, and/or CMO.

(b) Potential conflicts of interest may be personal or financial in nature. The following are representative, but not all inclusive, of circumstances that may give rise, upon further review, to a potential conflict of interest sufficient to preclude a practitioner's participation pursuant to this section:

(i) A practitioner was directly involved in rendering clinical care to the patient subject of review, even though the practitioner is not the practitioner subject of the review;

(ii) A practitioner previously voted on the same issue/matter in connection with another Medical Staff Committee;

(iii) A practitioner is a business partner of the practitioner subject of the review, regularly receives referrals from the practitioner under review, or otherwise has a direct financial interest in the outcome of the review;

(iv) A practitioner is in direct economic competition with the practitioner under review such that adverse action taken against the practitioner (if adverse action is a potential result of the review) will result in direct financial gain to the Member;

(v) A practitioner is involved in a real or perceived personal conflict with the practitioner under review.

(c) Potential conflicts of interest shall be disclosed or reported to the applicable Committee, Committee Chairperson, Chief of Staff, and/or CMO. Any person may raise the possibility of a potential conflict of interest. When a potential conflict of interest is raised, it is the responsibility of the applicable Committee (with whom the practitioner is participating) to consider the matter and determine whether a potential conflict of interest exists sufficient to render the practitioner incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, and the Hospital. If a potential conflict of

interest is raised with respect to a Medical Staff Officer, Chairperson, Clinical Service Chief, or other Medical Staff leader in connection with a function unrelated to a particular Committee, the concern should be communicated to and addressed by the MEC.

(d) Nothing in this Section, without more, is intended to preclude a Member from participating in a review or other matter solely because the Member practices within the same medical specialty as the practitioner under review or subject of the matter. Similarly, nothing in this Section, without more, is intended to preclude a Member from participating in a review or other matter solely because the Member is employed by the Hospital or is employed by an affiliated Major Health Partners entity.

(e) Notwithstanding the foregoing, as set forth in the Corrective Action and Fair Hearing Manual, no member that is in direct economic competition with an affected practitioner may serve on a Hearing Committee, even if such circumstance would not require removal pursuant to this Section.

(f) Nothing herein precludes a practitioner from recusing himself/herself from participating in a deliberation or vote even though a potential conflict of interest sufficient to strictly require removal pursuant to this Section has not been identified.

Section 1.7. Leave of Absence

(a) A practitioner requesting a leave of absence must submit a written request to the CEO and Chief of Staff. During a leave of absence, the practitioner is not permitted to exercise clinical privileges at the Hospital but retains his or her membership on the Medical Staff, if applicable.

(b) A request for a leave of absence must state the reasons for, and the approximate duration of, the leave of absence. A leave of absence may be granted for an interval between sixty (60) days and one (1) year, and at the expiration of the first year, an additional (up to) one (1) year leave of absence may be sought; provided however, that if the requesting practitioner's appointment to the Medical Staff or clinical privileges are due to expire during the course of any requested leave of absence, a leave of absence extending beyond the term of appointment shall not be granted. To extend a leave of absence beyond an existing appointment, a practitioner on leave of absence must seek and obtain reappointment to the Medical Staff, pursuant to Section 1.5 of the Medical Staff Credentialing Manual, in conjunction with a request for an extension of the leave of absence. Failure to seek reappointment to the Medical Staff or renewal of clinical privileges shall result in the practitioner's voluntary resignation from the Medical Staff and/or relinquishment of clinical privileges. A practitioner may not be granted a leave of absence beyond a total of two (2) successive years in leaves of absence.

(c) Except as expressly provided elsewhere in this Section, the Governing Board delegates to the CEO the authority to make final determinations in connection with requests for leaves of absence and reinstatement. In determining whether to grant a request, the CEO shall consult with the Chief of Staff, and use his or her best efforts to make a determination within thirty (30) days of the receipt of the written request based on reason(s) for request and any clarifying information requested from the practitioner.

(d) No later than thirty (30) days prior to the termination of a leave of absence, the practitioner may submit to the MEC a request for reinstatement of clinical privileges. The practitioner must submit a written summary of relevant activities during the leave if the MEC so requests, as well as all other information reasonably requested by the MEC. The MEC shall make a recommendation to the CEO concerning the reinstatement. The recommendation should include a plan for FPPE if the practitioner's leave of absence was for a period greater than six (6) months or if otherwise determined by the MEC to be reasonably appropriate. A practitioner shall not be reinstated, and therefore shall not be able to exercise clinical privileges, until the CEO has approved the request, even if this approval process results in a delay of reinstatement. A practitioner who fails to submit a timely request for reinstatement shall be deemed to have voluntarily withdrawn his or her Medical Staff membership and/or clinical privileges (as applicable). In such event, the practitioner may thereafter apply as an initial applicant.

(e) In the event the MEC's recommendation constitutes an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Thereafter, the Governing Board shall make a final determination regarding reinstatement.

(f) In the event the MEC's recommendation does not constitute an "Adverse Action," the recommendation shall be transmitted to the CEO. If the CEO concludes that reinstatement is appropriate, then the CEO (or designee) will advise the practitioner of this final determination and the effective date of the reinstatement. The CEO (or designee) will also advise the practitioner of any limitations, changes in staff category, requirements, or other actions that are attendant to, or being taken with respect to, the reinstatement.

(g) In the event the CEO concludes, as part of his/her evaluation, that a limitation, change in staff category, requirement, or other action should be taken that would constitute an "Adverse Action," as defined in the Corrective Action and Fair Hearing Manual, then the CEO's determination shall be transmitted to the Governing Board in the form of a recommendation. Thereafter, the Governing Board shall evaluate the matter and make a determination regarding the reinstatement and any associated actions.

(h) If the Governing Board concludes that "Adverse Action" is appropriate, then the practitioner shall be notified of his/her hearing rights (as applicable) pursuant to the Corrective Action and Fair Hearing Manual. Following this process, the Governing Board shall take final action.

(i) If the practitioner's leave of absence was for health reasons, or if health concerns are reasonably suspected or identified at the time of the requested reinstatement, the practitioner's request for reinstatement must be accompanied by a report from the practitioner's pertinent physician(s) or other health care provider(s) indicating that the practitioner is physically and/or mentally capable of resuming a Hospital practice and safely executing the membership and clinical privileges requested. The MEC, CEO, and/or Governing Board may additionally request that the practitioner undergo physical and/or mental evaluation (at the practitioner's cost), with the complete results of such evaluation made available to the MEC, CEO, and Governing Board as part of the evaluation for reinstatement.

(j) A practitioner on a leave of absence is required to maintain sufficient professional liability insurance pursuant to Section 1.2.2 herein.

(k) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that a practitioner has not demonstrated good cause for a leave of absence or where a request for extension is otherwise not granted, the determination shall constitute an Administrative Action. A determination made regarding reinstatement, unless constituting an "Adverse Action" pursuant to the Corrective Action and Fair Hearing Plan, shall also constitute an Administrative Action.

Section 1.8. Medical Staff Year

The Medical Staff Year is from January 1 to December 31.

ARTICLE 2. CATEGORIES OF THE MEDICAL STAFF

Section 2.1. The Medical Staff

The Medical Staff shall be organized into the categories set forth below. All members of the Medical Staff, except for members of the Honorary Staff, must satisfy the basic qualifications and responsibilities set forth in Sections 1.2 and 1.3 of this Manual. Members must also satisfy such other qualifications that are specific to each category. Based upon the qualifications for each category, members may be administratively reclassified to the category for which they are eligible should the member's status or eligibility change during an appointment period.

Section 2.2. The Active Staff

The Active Staff is generally responsible to the Governing Board for the quality of medical care and treatment of inpatients and outpatients in the Hospital and the overall organization of the Medical Staff. Members of the Active Staff are expected to contribute to the organizational and administrative affairs of the Medical Staff.

2.2.1. Qualifications

The Active Staff shall consist of physicians, dentists, optometrists, oral surgeons, and podiatrists who meet the following requirements:

(a) Are professionally based in, or otherwise regularly available to, the community served by the Hospital;

(b) In the MEC's sole discretion, regularly admit, attend to, or treat patients at the Hospital within their scope of practice and granted clinical privileges, or alternatively, are not clinically active in the inpatient setting, but maintain an active ambulatory practice in the community and are actively involved with the Hospital and Medical Staff;

(c) As an alternative to the preceding subsections (a) through (b), Active Staff status may also be extended to those physicians, dentists, optometrists, oral surgeons, and podiatrists who hold a Medical-Administrative position at the Hospital, whether or not such individuals also maintain clinical privileges while holding such position

2.2.2. Responsibilities

Members of the Active Staff shall:

(a) Regularly attend and participate in meetings of the Medical Staff and any Medical Staff Committees to which the member is appointed;

(b) Actively participate in quality assessment and improvement activities of the Medical Staff, and participate on Medical Staff Committees when requested;

(c) Except for those practitioners that are exempt pursuant to Hospital Policy, provide emergency service call coverage, as well as call coverage for unattached patients, in a manner consistent with their clinical privileges;

(d) Maintain accurate, legible, timely and complete medical records; and

(e) Demonstrate the capability to provide continuous and timely patient care to the satisfaction of the MEC and Governing Board.

2.2.3. Prerogatives

Members of the Active Staff may:

(a) Exercise such clinical privileges as are granted by the Governing Board; these clinical privileges may include permission to admit patients to the Hospital;

(b) Participate in Hospital and Medical Staff educational opportunities;

(c) Serve on Medical Staff Committees;

(d) Vote on all matters presented at general and special meetings of the Medical Staff and the Medical Staff Committees of which they are a member; and

(e) Hold Office at any level of the Medical Staff organization.

Section 2.3. The Affiliate Staff

The Affiliate Staff shall consist of physicians, dentists, optometrists, oral surgeons, and podiatrists who intend to maintain clinical privileges at the Hospital, but who do not meet the qualifications for the Active Staff category or the Auxiliary Category.

2.3.1. Qualifications

The Affiliate Staff shall meet the qualifications and responsibilities set forth in Sections 1.2 and 1.3 herein, but do not meet the requirements for Active Staff contained in 2.2.1(b) or (c), above. Members who qualify for the Active Staff, but who maintain only "refer and follow" clinical privileges at the Hospital, may opt to be part of the Affiliate Staff.

2.3.2. Responsibilities

Members of the Affiliate Staff shall:

(a) Make reasonable attempts to attend and participate in meetings of the Medical Staff;

(b) Actively participate in quality assessment and improvement activities of the Medical Staff;

(c) If requested by the MEC or Governing Board, actively participate on Medical Staff Committees;

(d) If requested by the MEC or Governing Board, provide emergency service call coverage, as well as call coverage for unattached patients in a manner consistent with their clinical privileges;

(e) Maintain accurate, timely and complete medical records; and

(f) Demonstrate the capability to provide the continuous and timely patient care to the satisfaction of the MEC and Governing Board.

2.3.3. Prerogatives

Members of the Affiliate Staff have the same prerogatives as members of the Active Staff, except that members of the Affiliate Staff may not serve as a Medical Staff Committee Chairperson, may not hold Office at any level of the Medical Staff organization, and may attend, but not vote at, general or special meetings of the Medical Staff or its Clinical Services unless the MEC determines for good cause to permit an Affiliate Staff member such voting rights.

Section 2.4. The Auxiliary Staff

The Auxiliary Staff shall consist of those physicians, dentists, optometrists, oral surgeons, and podiatrists who either: (a) intend to exercise all clinical privileges (i.e. – their entire clinical practice at the Hospital) remotely via telemedicine link, or (b) are Doctors of Medicine or Doctors of Osteopathic Medicine who are currently in (and have not yet completed) a residency training program, but have received their Indiana medical license.

2.4.1. Qualifications

The Auxiliary Staff shall satisfy the qualifications set forth in Sections 1.2 and 1.3, and meet the requirements set forth immediately above.

2.4.2. Responsibilities

Members of the Auxiliary Staff shall, as applicable:

(a) Actively participate in quality assessment and improvement activities of the Medical Staff;

(b) Attend Medical Staff and/or Committee meetings if expressly requested by the MEC, Chief of Staff, or Committee Chairperson; and

(c) Maintain accurate, timely and complete medical records.

2.4.3. Prerogatives

Members of the Auxiliary Staff may (even if not requested) attend Medical Staff regular and special meetings and may exercise such clinical privileges as are granted by the Governing Board, provided however that Auxiliary Staff are not eligible for admitting privileges and may not serve as the primary or attending physician. Auxiliary Staff members shall not be eligible to serve on Medical Staff Committees, vote or hold elected Office in the Medical Staff.

Section 2.5. The Honorary Medical Staff

2.5.1. Qualifications

The Honorary Staff are those individuals that are recognized for their noteworthy contributions to the community, Medical Staff, and Hospital. Honorary Staff members must have served on the Medical Staff no fewer than ten (10) years and must be retired from the active practice of their health care profession. The Honorary Staff is restricted to those members recommended by the MEC and approved by the Governing Board. Honorary Staff are not required to satisfy the qualifications or responsibilities set forth in Sections 1.2 and 1.3 herein. Notwithstanding the foregoing, any member appropriately appointed to the Honorary Medical Staff prior to December 31, 2018 shall be exempt from the qualifications set forth above and shall be entitled remain a member of the Honorary Medical Staff.

2.5.2. Responsibilities

Members of the Honorary Staff have no responsibilities to the Medical Staff, provided however, that Honorary Staff participating in Medical Staff activities must

do so in a constructive manner and not otherwise violate applicable codes of conduct or related policies.

2.5.3. Prerogatives

(a) Members of the Honorary Staff may attend any meeting of the Medical Staff, unless otherwise excluded for good cause by the MEC. Honorary Staff may also participate in Hospital and Medical Staff educational opportunities;

(b) Honorary Staff members shall not be eligible to vote at general or special Medical Staff or Committee meetings, or hold elected Office in the Medical Staff, and may not serve on Medical Staff Committees, unless by special invitation of the MEC; and

(c) Honorary Medical Staff members are not eligible for clinical privileges.

ARTICLE 3. NON-PHYSICIAN PRACTITIONERS

Section 3.1. Description

Non-Physician Practitioners are those licensed or certified individuals who the Governing Board has determined to be eligible to apply for clinical privileges consistent with the minimum eligibility and qualification requirements established by the Governing Board as described in Section 1.2 herein and Section 2.5 of Medical Staff Credentialing Manual, which will include their recognized scope of practice, licensure, certification, education, and demonstrated competency.

Section 3.2. Credentialing and Privileging of NPPs

NPPs are credentialed and privileged in the manner described in the Medical Staff Credentialing Manual.

ARTICLE 4. OFFICERS

Section 4.1. Medical Staff Officers

The following Medical Staff Officers shall be members of the Active Staff who fulfill necessary governance functions of the Medical Staff and who represent the needs and interests of the entire Medical Staff:

(a) Chief of Staff;

(b) Vice Chief of Staff; and

(c) Secretary.

Section 4.2. Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members of the Active Staff in good standing during their term of office. No member under consideration by the MEC for an officer position may be under current investigation by the Medical Staff or have had significant or repeated quality of care or

professional conduct issues. Nominees should have a reputation for leadership and excellent patient care services and be willing to serve in a leadership position. Failure to maintain such status shall immediately result in the member's disqualification to hold office. The MEC will have the discretion to determine if a member desiring to run for office meets these qualifying criteria. Any member who is nominated must disclose to the MEC his or her ineligibility to hold office when considering the qualifications in this Section 4.2.

Officers may not simultaneously serve as an Officer of the Medical Staff and as a Clinical Service Chief, unless the MEC determines that good cause exists to make an exception. Further, Officers may not simultaneously serve as an officer on the medical staff of another, unaffiliated hospital that is located in the Hospital's service area. Noncompliance with this requirement will result in the Officer being automatically removed from office unless the Governing Board determines in consultation with the MEC that allowing the Officer to maintain his/her position is in the best interest of the Hospital. The Governing Board in consultation with the MEC shall have discretion to determine what constitutes a "leadership position" at another hospital or facility.

Medical Staff Officers are not prohibited from serving multiple or successive terms.

Section 4.3. Nominations

4.3.1. **By MEC**. In the last year of each Officer's term of office, the MEC shall submit one (1) or more nominees for each such office and will make such list of nominees available to the Medical Staff, either by posting the list of nominees within the Hospital or by written or electronic notice, in advance of the Annual Meeting.

4.3.2. **Nominations from the Floor**. Nominations of candidates for any office may also be made from the floor at the time of the Annual Meeting of the Medical Staff prior to voting on the office. A nomination from the floor must be seconded and supported by at least five (5) additional members of the Active Staff in order to be eligible.

Section 4.4. Election of Officers

The Officers shall each be elected at the annual meeting of the Medical Staff, biannually, unless an earlier election is required to fill a vacancy, by members of the Active Staff. Voting shall be by secret written ballot. If any candidate is unopposed, the current Chief of Staff may call for a voice vote, unless any member objects, in which case the vote shall be by secret ballot.

A member of the Active Staff who is eligible to vote, but who cannot be present at the annual meeting, may cast an absentee ballot by designated electronic ballot or by leaving his or her ballot in a sealed envelope with Hospital Administration and/or the Hospital's Medical Staff Office before the annual meeting. Absentee votes will be considered whether the vote is taken by secret ballot or by voice vote, and irrespective of whether additional nominations are made from the floor as set forth in Section 4.3.2, above.

The current Secretary (or designee) shall be responsible for the final collection and counting of all ballots.

Section 4.5. Terms

Each Officer shall serve a two-year (2) term, commencing on the first day of the Medical Staff year following his/her election or appointment (as applicable). Each Officer shall serve until the end of term and/or until a successor is elected, unless he/she shall sooner resign or be removed from office.

Section 4.6. Removal

Except as otherwise provided, removal of an Officer may be accomplished by a two-thirds (2/3) vote of a quorum of the Active Staff at any special or regular meeting of the Medical Staff. Voting may be in person or by designated electronic or hard copy absentee ballot. Removal may be based upon either the failure to perform any of the duties of that position held as described in these Bylaws or the failure to maintain Medical Staff membership.

Section 4.7. Vacancies

If there is a vacancy in the Office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. All other vacancies shall be filled by the MEC if the remaining term is less than six (6) months and by a special election of the Active Staff at its next scheduled quarterly meeting if the remaining term is greater than six (6) months.

Section 4.8. Duties

4.8.1. Chief of Staff

(a) The Chief of Staff shall serve as the chief administrative officer of the Medical Staff, and therefore, shall have the responsibility for the organization and conduct of the Medical Staff. In fulfilling this responsibility, the Chief of Staff shall:

(i) Represent the views, policies, needs and grievances of the entire Medical Staff to the CEO and Governing Board;

(ii) Consult directly with the Board (personally or by way of an appointed designee) at least twice in a calendar year to discuss matters related to the quality of medical care in the Hospital, such consultations should occur face-to-face (or via telecommunication system permitting immediate, synchronous communication) with the Board or a designated subcommittee of the Board.

(iii) Work with the CEO and Governing Board in all matters of mutual concern within the Hospital;

(iv) Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff, except with respect to special meetings described in Section 4.6 herein, as applied to the Chief of Staff;

(v) Serve as Chairperson of the MEC;

(vi) Serve as an *ex officio* member of all other Medical Staff Committees;

(vii) Be responsible for the enforcement of the Medical Staff Bylaws, for implementation of corrective action activities and sanctions where indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a practitioner;

(viii) Appoint members and Chairpersons of each standing, special, and multidisciplinary Medical Staff Committee, except the MEC, as provided in Article 6 herein;

(ix) Be responsible, as Chairperson of the MEC, for carrying out quality assessment and performance improvement functions of the Medical Staff;

(x) Be the spokesperson for the Medical Staff in its external professional and public relations; and

(xi) Perform such other functions as may be assigned to him/her by these Bylaws, by the members, by the MEC or by the Governing Board.

(b) When undertaking the foregoing duties and responsibilities, the Chief of Staff is acting at all times on behalf of the MEC and subject to the MEC's authority.

4.8.2. Vice Chief of Staff

In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The Vice Chief of Staff shall additionally serve as a member of the MEC and a member of such other Committees, and shall have such other duties and responsibilities, as are assigned to him/her by these Bylaws, by the Chief of Staff, MEC, or the Governing Board.

4.8.3. Secretary

The Secretary shall serve as the secretary of the Medical Staff and shall fulfill those duties that are regularly associated with such roles. The Secretary shall additionally serve as a member of the MEC, and a member of such other Committees, and shall have such other duties and responsibilities as are assigned to him/her by these Bylaws, by the Chief of Staff, MEC, or the Governing Board. In the absence of the Vice Chief of Staff, the Secretary shall assume all the duties and have the authority of the Vice Chief of Staff.

Section 4.9. Use of Designees

Any Medical Staff Officer may delegate certain tasks and activities to various designees, including but not limited to the CEO and Medical Staff Office, to assist the Officer in fulfilling his or her duties and responsibilities, which may include activities related to credentialing, privileging, and other peer review.

ARTICLE 5. CLINICAL SERVICES

Section 5.1. Organization of Clinical Services

The Medical Staff shall function as one body and shall not be divided into departments or sections. Rather, the Medical Staff shall be organized into Clinical Services. Except with respect to the Pathology Service and the Radiology Service (where a Medical Director is appointed, as set for below), each Clinical Service shall have a Clinical Service Chief who shall be responsible for the overall supervision and administrative work within that Service. Each Clinical Service Chief shall report (in part) to the Chief of Staff, who (on behalf of MEC) shall be responsible for the supervision of all Clinical Services within the Medical Staff organizational structure.

5.1.1. Current Clinical Services. The current Clinical Services are as follows:

(a) Medicine (Internal Medicine);

(b) Family Medicine;

(c) Outpatient Medicine Service;

(d) Surgery;

(e) Obstetrics;

(f) Pediatrics;

(g) Emergency;

(h) Radiology;

(i) Pathology; and

(j) Anesthesiology.

5.1.2. Future Clinical Services. The MEC shall periodically restudy the Medical Staff Clinical Service structure set forth in these Bylaws and recommend to the Governing Board what action is desirable with respect to changing, adding and/or deleting a Clinical Service for better organizational efficiency and improved patient care.

Section 5.2. Qualifications, Election, and Tenure of Clinical Service Chiefs and Vice Chiefs

5.2.1. Qualifications. Each Clinical Service Chief and Clinical Service Vice Chief shall be a member in good standing of the Active Staff, and shall be qualified by training, experience, administrative ability, and clinical and professional leadership qualities necessary for the position.

5.2.2. Election and Tenure. The members appointed by the Hospital to serve as the Service Director of the Radiology Service and the Service Director of the Pathology Service, respectfully, shall also serve as and fulfill the duties of the Clinical Service Chief over those Clinical Services, as set forth herein. With respect to the remaining Clinical Services, each Clinical Service Chief shall be nominated and elected in the same manner, at the same time, and pursuant to the same processes as set forth above Sections 4.3 and 4.4 for Medical Staff Officers. Each Clinical Service Chief may also, in his/her discretion, appoint a Vice Clinical Service Chief subject to MEC's approval to assist the Clinical Service Chief with respect to those

duties set forth below, including but not limited to serving as the Clinical Service Chief's authorized designee. Clinical Service Chiefs and Clinical Service Vice Chiefs are not prohibited from serving multiple or successive terms.

In the event of a tie vote in relation to Clinical Service Chiefs, the two candidates receiving the tie vote shall serve as Co-Chiefs of the Clinical Service. In such event, there shall not be a Vice Chief of the Clinical Service. The Co-Chiefs shall jointly carry out the functions of Chief. However, only one of the Co-Chiefs shall sit as a member of the MEC. Promptly following their appointment, the Co-Chiefs shall jointly determine which of the Co-Chiefs shall serve in this capacity over the course of their term. In the event the Co-Chiefs are unable to agree, or otherwise fail to agree, on this matter, the MEC shall determine which of the two Co-Chiefs shall serve in this capacity.

If there is a tie vote that involves more than two individuals, the MEC shall appoint one of the candidates to serve as the Clinical Service Chief.

Section 5.3. Terms

Each Clinical Service Chief and Clinical Service Vice Chief shall serve a two-year (2) term, commencing on the first day of the Medical Staff year following his/her election or appointment (as applicable). Each Clinical Service Chief and Clinical Service Vice Chief shall serve until the end of term and/or until a successor is elected, unless he/she shall sooner resign or be removed from office. There shall be no term limits. Notwithstanding the foregoing, those members serving as Clinical Service Chiefs by virtue of their position as a Service Director shall serve as a Clinical Service Chief for the duration of their appointment as a Service Director unless earlier removed as provided herein.

Section 5.4. Removal

The MEC or Governing Board may remove any Clinical Service Chief or Vice-Chief for good cause.

Section 5.5. Vacancies

If there is a vacancy in the position of Clinical Service Chief, then the Vice Clinical Service Chief shall serve out the remaining term. The vacancy left in the position of Vice Clinical Service Chief shall be filled by the MEC if the remaining term is less than six (6) months and by a special election of the Active Staff at its next scheduled meeting if the remaining term is greater than six (6) months

Section 5.6. Duties of Clinical Service Chiefs and Clinical Service Vice Chiefs

Each Clinical Service Chief shall serve as a member of the MEC, unless already serving on the MEC as an Officer of the Medical Staff, and in this capacity, shall fulfill (individually or

through the Vice Clinical Service Chief or through another designee approved by the Chief of Staff) the following functions on behalf of the MEC:

(a) Be accountable for all professional, clinical, and administrative activities within his or her Clinical Service;

(b) Maintain continuing review of the professional performance of all practitioners with clinical privileges assigned to his or her Clinical Service, and report regularly thereon to the Chief of Staff and MEC;

(c) Implement within his or her Clinical Service quality related or peer review activities, including but not limited to OPPE and FPPE processes, as delegated by the Governing Board, MEC or Chief of Staff;

(d) Assist in enforcement of the Hospital Policies, as they pertain to his or her Clinical Service and the practitioners assigned to it;

(e) Be responsible for implementation of Clinical Service-related actions taken by the MEC or Governing Board;

(f) Delineate and recommend to the MEC clinical privileges for applicants/practitioners applying or reapplying for (as applicable) clinical privileges within the Clinical Service, including a review of each applicant's/practitioner's quality or peer review record;

(g) Be responsible for recommending to the Medical Staff the criteria for clinical privileges that are relevant to the patient care provided within the Clinical Service;

(h) Be responsible for the teaching, education and research programs in his or her Clinical Service;

(i) Develop, propose, and implement policies and procedures that guide and support the provision of care, treatment and services;

(j) Assist in the determination of the qualifications, competence, and number of personnel assigned to the Clinical Service;

(k) Assess and recommend resources for needed patient care services; and

(l) Assist in the budgetary planning pertaining to his or her Clinical Service as requested by the Chief of Staff, MEC, CEO, CMO, or Governing Board.

The Clinical Service Vice Chief shall perform the duties of the Clinical Service Chief in the Chief's absence. The Vice Chief shall also perform such duties listed in these Bylaws, as well as other applicable duties as may be assigned to him/her to assist the Chief with his/her responsibilities set forth in this Section. Any Clinical Service Chief or Clinical Service Vice Chief may additionally delegate certain tasks and activities to various designees, including but not limited to the Medical Staff Office, to assist the Officer in fulfilling his or

her duties and responsibilities, which may include activities related to credentialing, privileging, and other peer review activities.

Section 5.7. Clinical Service Committees

Each Clinical Service, by and through the practitioners clinically privileged in and assigned to that Clinical Service, is hereby constituted as a Peer Review Committee pursuant to Indiana law in order to assist the Clinical Service Chief, Clinical Service Vice Chief, Clinical Service Director, and MEC in fulfilling their credentialing, quality, and other peer review obligations. As such, these "Clinical Service Committees" shall be entitled to all peer review protections, privileges, and immunities afforded by State and Federal law. The Clinical Service Chief or Director (as applicable) shall convene the Clinical Service Committee in his/her discretion and shall serve as the Chairperson of the Clinical Service Committee. All Active Staff members (in good standing) assigned to the Clinical Service shall serve as voting members. All Affiliate Staff members assigned to the Clinical Service shall be permitted to attend Clinical Service Committee meetings, without vote. All other Medical Staff members, NPPs, and other individuals may be invited, in the discretion of the Clinical Service Chief, to attend Clinical Service Committee meetings, without vote. The Clinical Service Committees shall meet pursuant to a schedule established by the Clinical Service Chief, but in any event, shall meet with sufficient frequency to carry out their functions and responsibilities. The quorum, voting, and other general procedures of the Clinical Service Committees (not already addressed above) shall be the same as those set forth below in Article 7 for other Medical Staff Standing Committees.

In addition to the Clinical Service Committees, each Clinical Service Chief or Clinical Service Director (as applicable), in his/her discretion, may establish other standing or ad hoc committees within the Clinical Service to assist the Clinical Service Chief/Director in fulfilling his or her functions hereunder. Whenever engaged in any legitimate peer review function, such committees shall be constituted as peer review committees pursuant to Indiana law. As such, these committees shall be entitled to all peer review protections, privileges, and immunities afforded by State and Federal law. The quorum, voting, and other general procedures of any such Clinical Service ad hoc committees shall be the same as those set forth below in Article 7 for other Medical Staff Ad Hoc Committees.

Section 5.8. Directors.

The Pathology and Radiology Services, as well as the Cardiopulmonary/Sleep Center, Hospitalist, and Physical Therapy sections, shall each have a Director who maintains privileges in their respective service, is a member of the Active Medical Staff and is qualified by training, experience and demonstrated ability for the position. The Directors are appointed annually, and may serve unlimited number of terms, by the President/CEO in collaboration with the Chief of Staff. The Directors perform the same functions as the Service Chiefs, as listed above and as otherwise provided in the Medical Staff Bylaws, except that the Service Directors do not sit as members of the MEC. The Directors are accountable for planning, directing and supervising all activities within the service/section throughout the hospital. Upon appointment and/or reappointment, Directors will be notified in writing of their appointment and responsibilities. A copy of the correspondence will be placed in their credentialing file. Resignations and vacancies are addressed by the President/CEO in collaboration with the Chief of Staff.

ARTICLE 6. MEDICAL EXECUTIVE COMMITTEE

The MEC shall serve as the executive committee of the Medical Staff, and in so doing, shall represent and act on behalf of the Medical Staff to the fullest extent contemplated by these Bylaws.

Section 6.1. Composition

The voting members of MEC shall consist of the three (3) Medical Staff Officers and each Clinical Service Chief (unless a Clinical Service Chief is already serving as a voting member of the MEC in his/her capacity as a Medical Staff Officer, in which case the member will serve on the MEC in both capacities but will have a single vote). The immediate past Chief of Staff shall also serve as a voting member. If the immediate past Chief of Staff is unavailable to serve, refuses or serve, or is already serving as a member of the MEC by virtue of a different position, then an at-large member of the Active Staff will be elected to serve in place of the Immediate Past Chief of Staff. The at-large member will be nominated and elected, and is subject to the same provisions for qualifications, tenure/term, removal, vacancy and other related processes, as set forth in Sections 5.2 through 5.5, above, for Clinical Service Chiefs. In the event a Clinical Service Chief is not available to attend a MEC meeting, the Clinical Service Chief may request that the Clinical Service Vice Chief attend and participate (with vote) as the Clinical Service Chief's proxy. The CEO and CMO will serve as ex officio members of the MEC and shall attend MEC meetings (subject to below), without vote. A majority of voting MEC members must at all times be Doctors of Medicine or Doctors of Osteopathic Medicine. Any member of MEC may call for an Executive Session, at which time only voting members and those ex officio members invited, may attend. All peer review matters/proceedings should be conducted in executive session.

Section 6.2. Duties and Authority

The duties of the MEC shall be to:

(a) Function as the Medical Staff's **Credentials Committee**, and in so doing, investigate, review, evaluate, report on, and make recommendations to the Governing Board regarding the qualifications of each applicant for initial appointment and/or clinical privileges and each practitioner for reappointment or modification of appointment and/or for clinical privileges and, in connection therewith, obtain and consider the recommendations of the appropriate Medical Director;

(b) Unless delegated to one or more other Medical Staff Committees or unless fulfilled by a qualified group outside of the Hospital as permitted by pertinent law and accreditation standard, the MEC shall assist the Medical Staff **Utilization Review Committee** in fulfilling its obligations pursuant to the Hospital's Utilization Review Plan and as may otherwise be required fulfill all legal obligations and accreditation requirements to perform meaningful utilization review (subject to the Hospital's Utilization Review processes and procedures);

(c) Unless delegated to another Medical Staff Committee, serve as the Medical Staff's **Wellness/Impairment Committee**, and in so doing, address concerns regarding practitioner impairment;

(d) Unless expressly delegated to one or more other Medical Staff Committees (or designees), fulfill the Medical Staff's obligation (either by way of the MEC itself, or by appointing eligible practitioners to serve on appropriate Hospital, Medical Staff, or Multi-Disciplinary Committees) to conduct, or otherwise participate in, infection control, pharmacy and therapeutics evaluation, medical records review, mortality review, transfusion review, and such other areas where Medical Staff participation and/or oversight is required or determined to be best practice (as further set forth in the Medical Staff Committee Plan, which is attached hereto);

(e) Recommend to the Governing Board all matters relating to Medical Staff category, Clinical Service assignments, and clinical privileges;

(f) Develop and recommend to the Governing Board processes for conducting corrective action, OPPE, FPPE, and any other processes deemed necessary and appropriate to address concerns related to clinical competency, professional conduct, patient safety, and the quality of patient care;

(g) Implement, oversee, make recommendations, and take action pursuant to the processes established for corrective action, OPPE, FPPE, or that are otherwise established to address concerns related to clinical competency, professional conduct, patient safety, and the quality of patient care;

(h) Assign, when deemed necessary, responsibility for monitoring and evaluating the quality of patient care to Clinical Service Chiefs and Medical Staff Committees, including OPPE, FPPE, investigation of concerns, implementation of actions, monitoring of results and recommending approval and revision of policies related to patient care;

(i) Coordinate the activities of and policies adopted by the Medical Staff and any Medical Staff Committees;

(j) Consider, adopt, and implement various policies and procedures as may be necessary to fulfill and enforce the general provisions of the Medical Staff Bylaws and the Medical Staff's overall obligations;

(k) Account to the Governing Board and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital;

(l) Take reasonable steps to ensure professional and ethical conduct and competent clinical performance on the part of Medical Staff members and practitioners with clinical privileges at the Hospital, including initiating and pursuing investigations and corrective action, when warranted;

(m) Inform the Medical Staff on the accreditation program and the accreditation status of the Hospital;

(n) Take responsibility for the participation of the Medical Staff in performance improvement activities;

(o) Review and recommend changes to the Medical Staff Bylaws, policies, and other organizational documents or proposals as may be required;

(p) Call special meetings of the Medical Staff at any time, as needed;

(q) Review and approve Clinical Service and Medical Staff Committee reports;

(r) Account to the Governing Board regarding organizational proposals, including but not limited to, the various organizational documents of the Medical Staff and the role of Medical Staff leaders;

(s) Act on behalf of the Medical Staff when the Medical Staff cannot be assembled, or between regular meetings of the Medical Staff;

(t) Act as a liaison in conjunction with the Medical Staff and the Governing Board, and in so doing, make recommendations to the CEO and Governing Board on medical-administrative and Hospital management matters including institutional planning, budgeting and appropriate utilization of resources; Act upon the recommendations of the Governing Board, as well as any other Medical Staff Standing or Ad Hoc Committees.

Notwithstanding the establishment of peer review policies for implementation of various quality assurance and performance improvement activities within the Hospital, the MEC and Governing Board retain the authority at all times to undertake such peer review activities that they deem appropriate under the circumstances.

Section 6.3. Regular Meetings

The MEC shall generally meet on a monthly basis, but at all times will meet as frequently as necessary to fulfill its duties. The Chief of Staff, or designee, shall provide written or electronic notice (stating the date, time, and place of any regular meeting) to each member of the MEC. The MEC may meet in person, or when necessary may meet by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting.

Section 6.4. Special Meetings

The Chief of Staff may call a special meeting of the MEC. In such event, the Chief of Staff, or designee, shall provide each member with written, oral or electronic notice stating the date, time and place of any special meeting as soon as practicable before the time of such meeting, unless waiver of notice is agreed to by all voting members of the MEC. The MEC may meet in person, or when necessary may meet by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting.

Section 6.5. Quorum

The presence of at least fifty percent (50%) of the voting members of the MEC shall constitute a quorum.

Section 6.6. Manner of Action

An action by MEC will be approved if a majority of those members eligible to vote at a meeting (at which a quorum exists) vote to support the action. MEC action may occur by e-mail correspondence or other reliable electronic means provided there is a voting record of all eligible members.

Section 6.7. Rights of Ex Officio Members

Except as otherwise provided in these Bylaws, ex officio members of the MEC shall have all rights and privileges of regular members, except that ex officio members shall not have the right to vote, nor will be counted in determining the existence of a quorum.

Section 6.8. Minutes

Minutes of each regular and special meeting of the MEC shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the Chief of Staff (or designee) as soon as practicable after they are prepared. MEC shall maintain a permanent file of the minutes of each meeting.

Section 6.9. Removal

Voting Members of MEC may only be removed/replaced pursuant to the processes set forth in these Bylaws for removal of Officers, Clinical Service Chiefs, or at-large MEC members, as applicable.

Section 6.10. Use of Designees

MEC may delegate certain tasks and activities to designees and other personnel in order to assist the MEC in fulfilling its duties and responsibilities (including but not limited to those activities involving credentialing, privileging, and peer review). These designees and other personnel may include, but are not necessarily limited to, other Medical Staff Committees, any single voting or nonvoting member of the MEC, any member of the Medical Staff, the Medical Staff Coordinator, or other Hospital or Medical Staff personnel.

ARTICLE 7. STANDING AND AD HOC MEDICAL STAFF COMMITTEES

In addition to the Clinical Service Committees, the MEC has established, and may establish additional, Standing and/or Ad Hoc Committees of the Medical Staff (other than the MEC) to assist with and/or carry out the functions of the Medical Staff. All Medical Staff Standing and Ad Hoc Committees, including the Clinical Service Committees, shall be subject to oversight by, and report to, the MEC. All Standing Committees of the Medical Staff shall be subject to the approval of the Governing Board.

Section 7.1. General Requirements Applicable to Standing and Ad Hoc Medical Staff Committees

7.1.1. <u>Appointment/Composition and Duties of Standing Committees</u>. The members and chairpersons of any Standing Medical Staff Committees will be appointed by the Chief of Staff, in collaboration with the CEO, for a term of two (2) years, unless otherwise specified in these Medical Staff Bylaws. The MEC shall

establish the duties and functions of any such Standing Committee, unless otherwise specified in these Medical Staff Bylaws.

7.1.2. **Regular Meetings of Standing Committees**. Except as otherwise provided for in these Bylaws, Standing Medical Staff Committees shall meet as often as necessary to fulfill their responsibilities and at such dates, times, and places as are designated by the Chairperson. Written or electronic notice stating the date, time, and place of any regular meeting shall be given to each member of the Medical Staff Committee. Standing Committees may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting.

7.1.3. **Special Meetings of Standing Committees.** A special meeting of any Standing Committee may be called by the Chairperson, the Chief of Staff, or at least one-third (1/3) of the Committee's then members, but not fewer than two (2) members. Written, oral or electronic notice stating the date, time and place of any special meeting shall be given to each member of the Medical Staff Committee as soon as practicable before the time of such meeting, unless waiver of notice is agreed to by all members of the Committee. Standing Committees may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting.

7.1.4. **Ad Hoc Committee Appointment and Duties**. Ad Hoc Committees, as may be required to carry out activities of the Medical Staff, may be appointed by the Chief of Staff. Such Ad Hoc Committees shall be limited to a term as established by the Chief of Staff and shall confine their activities and duration to the purpose for which they were appointed. The members, chairperson, composition and duties of any Ad Hoc Committee, unless otherwise specified in these Bylaws, shall be specified by the Chief of Staff. Ad Hoc Committees may meet, or may permit any of their members to participate, in person, or by video or telephonic means such that the committee members may simultaneously interact and participate in the meeting.

7.1.5. **Standing Committee and Ad Hoc Committee Quorum Requirements**. Unless otherwise provided in these Bylaws or by the MEC, the participation (in person and/or by way of permissible electronic/telephonic means) of a majority of the voting members of any Standing or Ad Hoc Committee shall constitute a quorum.

7.1.6. **Manner of Action for Standing and Ad Hoc Committees.** Except as otherwise provided by these Bylaws, an action by a Standing or Ad Hoc Committee will be approved if a majority of those present and eligible at a meeting at which a quorum exists votes to support the action. Committee action may also occur by e-mail correspondence or other reliable electronic means provided there is a voting record of all eligible members. All Committee actions and recommendations are subject to review and approval by the MEC.

7.1.7. **Rights of Ex Officio Members on Standing and Ad Hoc Committees**. Unless otherwise provided in the Medical Staff Bylaws, practitioners serving as ex officio members of a Standing or Ad Hoc Committee shall have all rights and privileges of regular members, except that ex officio members shall not have the right to vote nor be counted in determining the existence of a quorum.

7.1.8. **Attendance Requirements for Standing and Ad Hoc Committees**. Attendance by members at Standing and Ad Hoc Committee meetings is expected and required.

7.1.9. **Minutes For Standing and Ad Hoc Committee Meetings**. Minutes of each regular and special meeting (as applicable) of a Standing or Ad Hoc Committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding Chairperson as soon as practicable after they are prepared and shall be forwarded to the Chief of Staff. Each Standing and Ad Hoc Committee shall maintain a permanent file of the minutes of each meeting.

7.1.10. **Executive Session**. An executive session is a meeting of a Standing or Ad Hoc Committee, which only Medical Staff members who are voting members of the Committee may attend, unless others are expressly requested by the Committee to attend. Executive sessions may be called by the Committee's Chairperson at the request of any Committee member and shall be called by the Chairperson by duly adopted motion. An executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality. The CEO and CMO shall be an invited guest at all executive sessions.

7.1.11. **Removal and Vacancies**. The Chief of Staff, upon good cause, may remove any member or Chairperson of a Standing or Ad Hoc Committee, and fill such vacancy by appointment. The Chief of Staff will promptly notify the MEC of any appointments and removals. If a majority of the MEC disagrees with one or more appointments or removals, the MEC shall modify the appointment or removal, as applicable.

7.1.12. **Use of Designees**. Any Medical Staff Standing or Ad Hoc Committee may delegate certain tasks and activities to various designees, whether a Committee or individuals, including the Chief of Staff, CEO and CMO, to assist the Committee in fulfilling its duties and responsibilities, which may include activities related to credentialing, privileging, and peer review.

Section 7.2. Inpatient Service Committee

The Inpatient Care Committee shall consist of at least three (3) members of the Active Staff in addition to the Emergency Services Director. The Inpatient Care Director from the Nursing Service Division and a representative from Hospital Administration (as designated by the CEO) shall be ex-officio members with vote. The Health Information Manager, Case Manager, and the Nursing Division Emergency Services Director shall be ex-officio members without vote. A majority of the eligible voting members of the Inpatient Care Committee must be members of the Active Staff.

7.2.1. The duties of the Inpatient Care Committee shall be to:

(a) Review and evaluate the quality, safety, and appropriateness of patient care services provided within the Inpatient Care Unit, including critical, medical and surgical patients; initiate appropriate actions based upon findings of the review activities. The Inpatient Care Committee shall also serve as a forum to resolve problems and discuss policy issues related to the Inpatient Unit;

(b) Work with the Health Information Department to assure that all medical records meet acceptable standards and criteria and are reviewed for timely completion, clinical pertinence and overall adequacy;

(c) Conduct utilization management studies designed to assess the appropriateness of allocation of Hospital and physician services; the Inpatient Care Committee shall have the authority to review all medical records of any hospitalization during the patient stay or after discharge; and

(d) Review all cases reasonably assumed by the Hospital to be outlier cases because of the extended length of stay exceeding the threshold criteria for diagnosis.

7.2.2. The Inpatient Care Committee shall meet at least quarterly.

7.2.3. The committee members from the Active/Medical Administrative Staff or their alternate are expected to attend at least fifty percent (50%) of the meetings in any Medical Staff year.

Section 7.3. Infection Control Committee

7.3.1. The Infection Control Committee shall consist of at least three (3) members of the Active Staff in addition to the Pathology Service Director. The Infection Preventionist, a representative of Nursing Administration (as appointed by the CEO), and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. A Laboratory Representative (as appointed by the CEO) shall be an ex-officio member without vote. A majority of the eligible voting members of the Infection Control Committee must be members of the Active Staff.

7.3.2. The duties of the Infection Control Committee shall be to:

(a) Develop, review and enforce policies and procedures regarding employee health and a Hospital infection control program, including an infection surveillance and reporting program and standard criteria for reporting infection cases;

(b) Function as a forum to resolve problems, initiate and discuss policy issues, and establish and review rules and regulations for the Laboratory;

(c) Establish policies and procedures governing all transfusions of blood of blood derivatives, systems for reporting transfusion reactions, and monitoring of appropriateness of blood transfusions; and

(d) Develop policies and procedures regarding transfusions of potentially HIV/HCV infectious blood and blood products.

7.3.3. The Infection Control Committee shall meet at least quarterly.

7.3.4. The voting members of the Infection Control Committee, or their designated alternate, are expected to attend at least fifty percent (50%) of the meetings in any Medical Staff year.

Section 7.4. Pharmacy and Therapeutics Committee

7.4.1. The Pharmacy and Therapeutics Committee shall consist of at least four (4) members of the Active Staff. The Pharmacy Director, a representative of Nursing Administration (as appointed by the CEO), and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. A majority of the eligible voting members of the Infection Control Committee must be members of the Active Staff.

7.4.2. The duties of the Pharmacy and Therapeutics Committee shall be to examine and survey all drug utilization policies and practices within the Hospital. The Pharmacy and Therapeutics Committee shall assist in the development of professional policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, handling and safe administration of drugs, as well as all other matters relating to drugs within the Hospital. The Committee also has the responsibility to:

(a) Develop a drug formulary and review it and update it regularly;

(b) Advise the Medical Staff and the pharmacist on matters pertaining to the choice of available drugs and the addition or deletion of drugs from the Hospital formulary or drug list;

(c) Establish, maintain and support a mechanism for effective communication to the Medical Staff, Hospital personnel and patients as it pertains to general drug usage;

(d) Establish, maintain and support a mechanism for safe-guarding the rights and welfare of human subjects involved in clinical investigations;

(e) Establish standards for the use and control of investigational drugs;

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

(g) Evaluate drug usage; and

(h) Formulate procedures for reporting adverse drug reactions and medication errors/near misses in administration of drugs; participate in the investigation, evaluation and implementation of the appropriate actions to correct identified problems, minimize medication errors and improve medication administration safety.

7.4.3. The Pharmacy and Therapeutics Committee shall meet at least quarterly.

7.4.4. The voting members of the Pharmacy and Therapeutics Committee are expected to attend at least fifty percent (50%) of the meetings in any calendar year

Section 7.5. Emergency Services and Ambulatory Care Committee

7.5.1. The Emergency Services and Ambulatory Care Committee shall consist of at least three (3) members of the Active Staff, in addition to the Chief of Emergency Medicine. The Emergency Services Director from the Nursing Service Division and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. The Director of Inpatient Care shall be an ex-officio member without vote. A majority of the eligible voting members of the Infection Control Committee must be members of the Active Staff.

7.5.2. The duties of the Emergency Services and Ambulatory Care Committee shall be to:

(a) Review and evaluate the quality, safety and appropriateness of patient care services provided within the Emergency Department and Ambulatory Care Center; initiate appropriate actions based upon findings of the review activities; the Emergency Services and Ambulatory Care Committee shall also function as a forum to resolve problems and initiate and discuss policy issues related to the Emergency Room Department and the Ambulatory Care Center;

(b) Conduct utilization management studies designed to assess the appropriateness of placement of patients in the Ambulatory Care Center; the Emergency Services and Ambulatory Care Committee shall have the authority to review all medical records and hospitalization during the patient stay or after discharge, including length of stay;

(c) Develop and maintain current standardized policies and procedures for medical control and direction of an Advanced Life Support emergency ambulance service; the Emergency Services and Ambulatory Care Committee will also focus on Code Blue and Rapid response evaluations house wide; and

7.5.3. The Emergency Services and Ambulatory Care Committee shall meet at least quarterly.

7.5.4. The voting members of the Emergency Services and Ambulatory Care Committee, or their designated alternate, are expected to attend at least fifty percent (50%) of the Emergency Services and Ambulatory Care Committee meetings in any Medical Staff year.

Section 7.6. Radiation Safety

7.6.1. The Radiation Safety Committee shall consist of at least three (3) members of the Active Staff. The Radiology Service Director and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. A Radiology Department Nurse (as appointed by the CEO) shall be an ex-officio member without vote. A majority of the eligible voting members of Radiation Safety Committee must be members of the Active Staff.

7.6.2. The Radiation Safety Committee shall function as a forum to resolve problems, initiate and discuss policy issues and establish and review rules and regulations for Radiology services.

7.6.3. The Radiation Safety Committee shall meet at least annually.

Section 7.7. Pediatric Committee

7.7.1. Pediatric Committee shall be comprised of at least two (2) members of the Active Staff whose practice includes the care of infants and children. The Chief of Pediatrics, the Director of Maternal/Child, and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. A majority of the eligible voting members of Pediatric Committee must be members of the Active Staff.

7.7.2. The duties of the Pediatric Committee shall be to:

(a) Review and evaluate the quality, safety and appropriateness of patient care services provided to infants and children at the Hospital;

(b) Initiate appropriate actions based upon findings of the review activities; the Pediatric Committee shall also function as a forum to resolve problems, initiate and discuss policy issues related to the care of infants and children throughout the Hospital; and

(c) Develop and maintain current standardized policies and procedures for medical control and direction of Pediatric and Neonatal Advanced Life Support / Neonatal Resuscitation Program; and

7.7.3. The Pediatric Committee shall meet at least quarterly.

7.7.4. The voting members of the Pediatric Committee, or their designated alternate, are expected to attend at least 50% of the Pediatric Committee meetings in any Medical Staff year.

Section 7.8. OB Service Committee

7.8.1. OB Section Committee shall be composed of at least two (2) members of the Active Staff, including one member from Anesthesia services. The Chief of Obstetrics and a representative of Hospital Nursing Administration (as appointed by the CEO) shall be ex-officio members with vote. The Director of Maternal/Child shall be an ex-officio member without vote. A majority of the eligible voting members of OB Section Committee must be members of the Active Staff.

7.8.2. The duties of the OB Section Committee shall be to:

(a) Review and evaluate the quality, safety and appropriateness of patient care services provided to OB patients at Major Hospital; and

(b) Initiate appropriate actions based upon findings of the review activities; the OB Section Committee shall also function as a forum to resolve problems, initiate and discuss policy issues related to the care of OB patients.

7.8.3. The OB Section Committee shall meet at least quarterly.

7.8.4. The voting members of the OB Section Committee, or their designated alternate, are expected to attend at least fifty percent (50%) of the meetings in any Medical Staff year.

Section 7.9. Surgical Service Committee

7.9.1. The Surgical Section Committee shall consist of at least two (2) members of the Active Staff, including one member from Anesthesia services. The Chief of Surgery and a representative of Hospital Nursing Administration (as appointed by the CEO) shall be ex-officio members with vote. The Surgical Services Director shall be an ex-officio member without vote. A majority of the eligible voting members of Surgical Section Committee must be members of the Active Staff.

7.9.2. The duties of the Surgical Section Committee shall be to:

(a) Review and evaluate the quality, safety and appropriateness of patient care services provided within the Surgery Department; and

(b) Initiate appropriate actions based upon findings of the review activities; the Surgical Section Committee shall also function as a forum to resolve problems and initiate and discuss policy issues related to the Surgery Department.

7.9.3. The Surgical Section Committee shall meet at least quarterly.

7.9.4. The voting members of the Surgical Section Committee, or their designated alternate, are expected to attend at least fifty percent (50%) of the Surgical Section Committee meetings in any Medical Staff year.

Section 7.10. Outpatient Adult Care Committee

7.10.1. The Outpatient Adult Care Committee shall consist of at least four (4) members of the Active Staff and the Cardiopulmonary Director for the Nursing Services Division. The Business Development Director and a representative of Hospital Administration (as appointed by the CEO) shall be ex-officio members with vote. The Emergency and Outpatient Ambulatory Services Director and the Disease Management Nurse Director shall be ex-officio members without a vote. A majority of the eligible voting members of Surgical Section Committee must be members of the Active Staff.

7.10.2. The duties of the Outpatient Adult Care Committee shall be to:

(a) Review and evaluate the quality, safety and appropriateness of patient care services provided within the Chronic Disease Management Department, Clinical Nutrition, Outpatient Cardiopulmonary Departments, and the Outpatient Adult Physician Practices;

(b) Initiate appropriate actions based upon findings of the review activities;

(c) Function as a forum to resolve problems and initiate and discuss policy issues related to the Chronic Disease Management Department,

Clinical Nutrition, Outpatient Cardiopulmonary Departments, and the Outpatient Adult Physician Practices;

(d) Conduct utilization management studies designed to assess the appropriateness of care provided in the outpatient settings and utilization of ancillary services; the Committee shall have the authority to review all medical records of any hospitalization during the patient stay or after discharge as well as the outpatient medical record from the physician practice excluding mental health records; and

(e) Develop and maintain standardized policies for the Chronic Disease Management Department, Clinical Nutrition, Outpatient Cardiopulmonary Departments, and the Outpatient Adult Physician Practices.

7.10.3. The Outpatient Adult Care Committee shall meet at least quarterly.

7.10.4. The voting members of the Outpatient Adult Care Committee, or their designated alternate, are expected to attend at least fifty percent (50%) of the Outpatient Adult Care Committee meetings in any Medical Staff year.

Section 7.11. Cancer Committee

7.11.1. The Multidisciplinary Cancer Committee shall be composed of the following required Medical Staff members: a Diagnostic Radiologist, a Pathologist, a Surgeon, a Medical Oncologist, and a Radiation Oncologist. A Cancer Liaison Physician is also required and can fulfill a leadership position within the Cancer Committee such as Chair, or Quality Improvement Coordinator or represent one of the required physician specialties. Other required members include a Cancer Program Administrator, an Oncology nurse, a Social Worker or Case Manager, a Performance Improvement or Quality Management Representative, a Certified Tumor Registrar, and a Palliative Care team member when these services are provided on site.

7.11.2. The duties of the Cancer Committee shall be to:

(a) Assess the scope of services offered and determine the need for additional non-required Cancer Committee members based on the major cancer sites seen by the program. These additional non-required Cancer Committee members are designated in the Cancer Committee policy.

(b) Appoint individual members of the committee as coordinators of important aspects of the cancer program. An individual cannot fulfill more than one coordinator role. These coordinator roles are: Cancer Conference Coordinator, Quality Improvement Coordinator, Cancer Registry Quality Coordinator, Community Outreach Coordinator, Clinical Research Representative or Coordinator, and Psychosocial Services Coordinator. The Benesse Oncology policies delineate the roles and responsibilities of each of the coordinators.

(c) Goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the program.

(d) The Cancer Committee shall meet at least quarterly and maintain a permanent record of its findings, proceedings, and actions and shall submit a report thereof to the Executive Committee.

7.11.3. Required Active/Medical Administrative Staff members or their designated alternate are expected to attend at least seventy-five percent (75%) of the meetings in a calendar year. All members of the Cancer Committee may vote.

ARTICLE 8. MEDICAL STAFF MEETINGS

Section 8.1. Regular Meeting

The Medical Staff shall generally meet on a bi-monthly basis. The Medical Staff's final meeting during the Medical Staff Year, which will generally be held in November, shall constitute the Medical Staff's "Annual Meeting." The Medical Staff shall utilize its Annual Meeting to: conduct any routine Medical Staff elections, and to address any other matters established by the Chief of Staff or otherwise made a part of the agenda. The date, time, and place of the Medical Staff's regular meetings, including the Annual Meeting, shall be designated by the Chief of Staff and posted in an appropriate location in the Hospital, or otherwise provided to the Medical Staff, not less than thirty (30) days prior to the meetings.

Section 8.2. Special Meetings

8.2.1. The Chief of Staff or the MEC may call a special meeting of the Medical Staff at any time. The Chief of Staff shall additionally be required to call a special meeting of the Medical Staff within fourteen (14) days of receiving a written request signed by not less than twenty-five percent (25%) of the Active Staff and stating the purpose of such meeting. The MEC shall designate the date, time and place of any special meeting.

8.2.2. Written or electronic notice stating the date, time, and place of any special meeting of the Medical Staff shall be given to each member of the Active Staff. Such notice shall also be posted or otherwise made reasonably available for the benefit of any other categories of the Medical Staff entitled to attend the Medical Staff meeting.

Section 8.3. Quorum

A quorum at any duly convened regular or special meeting of the Medical Staff shall consist of a majority of those eligible to vote present in person and/or by way of permissible electronic/telephonic means. Communication, including the means to vote electronically or by returning a ballot, sent to the Active Medical Staff member via either the Major Hospital assigned email account ending in @majorhospital.org or the email account on file with the Medical Staff Office (see Section 1.3), shall include the Active Medical Staff member in the quorum.

Section 8.4. Action

Except as otherwise provided by these Bylaws, an action will be approved if a majority of those present and eligible at a meeting (or by absentee ballot) in which a quorum exists votes to support the action. A member who is eligible to vote, but who cannot be present at any Medical Staff meeting, may cast an absentee ballot by designated electronic ballot or by leaving his or her ballot in a sealed envelope with Hospital Administration or Medical Staff Affairs before the meeting.

Section 8.5. Minutes

Minutes of all Medical Staff meetings shall be taken and prepared by the Secretary, or his/her designee, and shall include a record of attendance and/or the presence of quorum and the vote taken on each matter. Copies of such minutes shall be signed by the Secretary as soon as practicable after they are prepared and shall be forwarded to the MEC and Governing Board. These minutes shall be deemed final when transmitted to the Governing Board, subject however, to such corrections as may be made at the next regular or special meeting of the Medical Staff. A permanent file of the minutes of all Medical Staff meetings shall be maintained by the Medical Staff Office.

ARTICLE 9. CONFIDENTIALITY, IMMUNITY, AND RELEASES

Section 9.1. Authorizations and Conditions

By applying for or exercising Medical Staff membership and/or clinical privileges or by providing specified patient care services at this Hospital, each applicant and practitioner specifically authorizes the Hospital and Medical Staff, and their authorized peer review committees and representatives, to consult with any third party who may have information bearing on the applicant's or practitioner's professional qualifications, credentials, clinical competence, character, mental and physical condition, ethics, behavior, or any other matter related to the delivery of quality patient care.

This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of all third parties that may be relevant to the Medical Staff and Governing Board's review and each applicant and practitioner specifically authorizes all third parties to release and provide such information to the Hospital, Medical Staff, and their authorized representatives upon request, and further:

9.1.1. Authorizes the Medical Staff and Hospital, including but not limited to their respective peer review committees and representatives, in their discretion, to share, exchange, release, provide, and disclose information bearing on his or her competence, conduct, qualifications, patient care, and quality outcomes, including but not limited to peer review information, with/to: the Hospital, any other hospital, ambulatory surgery center, physician group, practice, or other entity employing any applicant or practitioner at the Hospital, any other hospital or health care entity, and any resources and entities used by the Hospital for internal quality control, reducing morbidity and mortality, and improving patient care, as well as any representative, employee and/or agent of each;

9.1.2. Authorizes the Medical Staff and Hospital to act upon any information received by the Medical Staff and/or Hospital, including but not limited to their respective peer review committees and representatives, from any third party that bears on the applicant's or practitioner's competence, professional conduct, qualifications, patient care, and/or quality outcomes;

9.1.3. Agrees to be bound by the provisions of this Article 9 and to absolutely waive all legal claims against the Hospital, Medical Staff and any Medical Staff or Hospital

peer review committee, agent, employee, or other representative who acts in substantial compliance with these Bylaws;

9.1.4. Acknowledges that the provisions of this Article 9 are express conditions to his or her application for or acceptance of Medical Staff membership and/or the continuation of such membership or to his or her exercise of clinical privileges at the Hospital; and

9.1.5. Acknowledges and consents to the Hospital and Medical Staff providing any communications required or contemplated by the Medical Staff Bylaws, or otherwise deemed reasonably necessary by the Hospital or Medical Staff, by way of the email address provided by the applicant or practitioner to the Hospital's Medical Staff Office. Each applicant and practitioner represents, warrants and agrees that the email address they provide to Hospital, by way of the Medical Staff Coordinator, is accurate, current, private, and secure.

Section 9.2. Confidentiality of Information

Information with respect to any applicant or practitioner that is submitted, collected, obtained or prepared by any Medical Staff or Hospital Peer Review Committee or designee of such Committee, or any other health care facility or organization or Medical Staff for the purpose of achieving, maintaining and improving quality patient care, reducing morbidity and mortality, contributing to clinical research or performing any Peer Review or Peer Review Committee activity, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Hospital representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to similar information that may be obtained from or provided by third parties. This confidentiality of information, however, shall not be construed to limit the authorizations set forth in Section 9.1 above.

Section 9.3. Immunity From Liability

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure contemplated by these Bylaws, even where the information involved would otherwise be deemed privileged. To the fullest extent permitted by law, all individuals requesting an application, and applicants for or practitioners having appointment, reappointment or clinical privileges, or any individual seeking to provide or providing patient care services in the Hospital releases from any and all liability, extends absolute immunity and agrees not to sue, to the Hospital, the Medical Staff, and any Medical Staff or Hospital peer review committee, agent, employee, or other representative, and any other third party for any acts, communications, requests, reports, records, statements, documents, recommendations, or disclosures involving the individual, requested, sent or received by this Hospital or the Medical Staff, and their authorized representatives from or to any third party in furtherance of quality health care.

The acts, communications, reports, recommendations and disclosures referred to in this Article 9 may relate to an individual's professional qualifications, clinical competency, professional conduct, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Section 9.4. Activities and Information Covered

The confidentiality and immunity provided by this Article 9 shall apply to all actions, information, communications, reports, recommendations or disclosures performed or made in connection with activities of the Hospital and Medical Staff concerning, but not limited to:

(a) Applications for appointment, clinical privileges or specified services;

(b) Periodic reappraisals for reappointment, clinical privileges or specified services;

(c) Patient care audits;

(d) Utilization reviews;

(e) FPPE and OPPE;

(f) Corrective action;

(g) Hearings and appellate procedures;

(h) Any Peer Review or Peer Review Committee activity;

(i) Reports or disclosures to the National Practitioner Data Bank, other hospitals, medical staffs, medical associations, and licensing boards;

(j) Hospital-wide quality improvement activities; or

(k) Any information collected and/or reported to a Patient Safety Organization in which the Hospital participates.

Section 9.5. Releases

Each applicant and practitioner shall, upon request, execute any general or specific release as part and a condition of the appointment, reappointment, and/or privileging process. Failure to execute such releases, however, shall in no way affect the immunity release and consents made by the applicant or practitioner as described above.

Section 9.6. Indemnification

All Medical Staff Officers, Chairpersons, Committee members, practitioners and other individuals who are appropriately authorized by the Governing Board to act for and on behalf of the Hospital in performing functions pursuant to these Bylaws shall be indemnified when acting in those capacities to the fullest extent permitted by law and Hospital policy, provided that such individuals have acted in good faith, without malice, and in the best interest of the Hospital.

Section 9.7. HIPAA Compliance/Organized Health Care Arrangement

As applicable, and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Medical Staff and Hospital may agree to operate as an Organized Health Care Arrangement (OHCA) under which a joint notice of privacy practices would be issued, and the participating entities in the OHCA would share protected health information with each other, as necessary to carry out treatment, payment, and health care operations

related to activities of OHCA, such as quality assurance activities. In such case, the entities participating in the OHCA agree to abide by the terms of the joint notice with respect to protected health information created or received by a covered entity as part of its participation in the OHCA. The joint notice would be written, disseminated and maintained in compliance with all applicable regulatory requirements, as outlined in the HIPAA implementing regulations.

Under the OHCA, the Medical Staff and Hospital, as participants in the OHCA, would separately retain all other obligations and responsibilities under the HIPAA regulations, including, but not limited to, the uses and disclosures of protected health information, fulfilling the patient rights provisions and appointment of a privacy officer. Additionally, individual members of the Medical Staff and Hospital will retain individual liability for instances of non-compliance with the HIPAA regulations.

Section 9.8. Reporting to Authorities

Any actions that occur as a result of applicant, practitioner, Medical Staff or Governing Board action that are reportable to the National Practitioner Data Bank and Indiana State Medical Licensing Board as required by applicable Indiana state and federal law shall be reported in the manner and time period required by such authorities.

Section 9.9. Cumulative Effect

Provisions in these Medical Staff Bylaws and in application forms relating to authorizations, confidentiality of information and immunity from liability shall be in addition to other protections afforded by applicable Indiana state and federal laws and not in limitation thereof, and in the event of conflict, applicable law shall be controlling.

ARTICLE 10. EXCLUSIVE CONTRACTS

Section 10.1. Exclusive Contracts

The Governing Board, in its sole discretion, may enter into exclusive agreements for certain services for the purpose of securing the continued availability of a given service line, and/or to ensure that care provided at the Hospital is efficient, effective, consistent, and of appropriate quality. Prior to making such a determination, the Governing Board will notify and consult with the Medical Staff, by way of the MEC, of its intentions.

ARTICLE 11. RELATED MEDICAL STAFF DOCUMENTS

Section 11.1. Adoption of Related Documents

In addition to this Governance and Organization Manual, the Medical Staff and Governing Board have adopted the following documents that shall, collectively, make up the Medical Staff Bylaws, which exist to support the Medical Staff:

(a) The Medical Staff Credentialing Manual, which shall specify procedures for Medical Staff appointment and reappointment, and determination of clinical privileges; and

(b) The Medical Staff Corrective Action and Fair Hearing Manual, which shall specify categories of corrective action and hearing and appeal procedures.

Section 11.2. Medical Staff Bylaws are NOT a Contract

The Medical Staff Bylaws are intended to create a framework to ensure compliance with pertinent State and Federal law, and accreditation requirements, and to ensure entitlement to all immunities and protections set forth in the pertinent State peer review statutes and the Federal Health Care Quality Improvement Act. These Bylaws are not intended in any fashion to create a legal contract. Accordingly, these Bylaws shall not be interpreted as, nor construed to be, a contract of any kind between the Hospital and the Medical Staff as a whole, or any individual member, applicant, or practitioner individually, and shall not in any fashion give rise to any type of legal action, claim or proceeding for breach of contract.

Section 11.3. Medical Staff Policies

The MEC, subject to Governing Board approval, may adopt and amend various policies and procedures to fulfill its obligations and functions as described herein, provided such policies are supportive and congruent with, and do not conflict with, these Bylaws, the Hospital Bylaws, applicable Federal or State law, or accreditation standards. Any Medical Staff policy or procedure (or portion thereof) that is inadvertently inconsistent with these documents, or pertinent law or accreditation standards, shall be considered void and without effect. All policies and policy amendments adopted by the MEC and approved by the Governing Board shall be communicated to the Medical Staff in a timely manner.

Policies may also be proposed directly to the Governing Board by a majority of the Active Staff who are eligible to vote. Before submitting to the Governing Board, proposed policies must be brought before the Active Staff by a petition signed by twenty-five percent (25%) of the members of the Active Staff. Any proposed policies must be presented to the MEC for review and comment before such policy is voted by the Active Staff. All proposed policies and related amendments become effective only after approval by the Governing Board.

ARTICLE 12. POWERS AND RESPONSIBILITIES OF THE GOVERNING BOARD

As established by Indiana State and Federal law, the Governing Board is the supreme authority in the Hospital. As such, the Governing Board is responsible for the management, operation, and control of the Hospital. In all matters, unless inconsistent with or contradictory to applicable State or Federal law, the Governing Board's Bylaws will take precedence over these Medical Staff Bylaws. The Governing Board, if necessary to ensure prompt legal compliance or in the event of other circumstances that dictate immediate/urgent action, may unilaterally/provisionally amend these Medical Staff Bylaws. However, any such provisional amendments shall thereafter be promptly published to the Medical Staff and shall be considered at any regular or special meeting of the Medical Staff for affirmation as set forth in Article 14, below. The procedures and processes set forth in these Bylaws shall not otherwise preclude the Governing Board from taking any direct or independent action otherwise authorized under the Governing Board's Bylaws, policies, and procedures, or applicable State and Federal law.

ARTICLE 13. AMENDMENTS TO MEDICAL STAFF BYLAWS

All proposed amendments and restatements to the Medical Staff Bylaws should first be reviewed and recommended by the MEC. Requests for amendment or restatement may also be recommended by the Active Staff following timely receipt by the Chief of Staff of a written petition signed by at least twenty percent (20%) of the Active Staff who are in good standing. Such proposed amendments or restatements may be considered at any regular or special meeting of the Medical Staff after the proposed amendments have been distributed to the Medical Staff via either the Major Hospital assigned email account ending in @majorhospital.org or the email account on file with the Medical Staff Office. To be adopted, any such

amendments shall require an affirmative vote of those members of the Active Staff as more fully described in Sections 8.3 and 8.4. Any proposed revisions made to these amendments or restatements adopted at a regular or special meeting of the Medical Staff, and any technical corrections made by the MEC related to reorganization, renumbering, punctuation, spelling or grammar related changes or necessary to comply with law or regulation, may be provisionally adopted without distribution as is otherwise required under this Article 13. Such proposed amendments or restatements shall thereafter be promptly published to the Medical Staff and shall be considered at any regular or special meeting of the Medical Staff. Except as otherwise provided above (or elsewhere in these Medical Staff Bylaws), neither the Medical Staff nor the Governing Board may unilaterally amend these Bylaws. The Medical Staff Bylaws shall be reviewed periodically and revised as necessary, minimally every three (3) years, subject to final review and approval by the Governing Board.

ARTICLE 14. PARLIAMENTARY PROCEDURE

Any procedural matter not clarified in the Medical Staff Bylaws shall be evaluated and acted upon by the Medical Staff Officers or Chairperson, as appropriate, in conjunction with Robert's Rules of Order.,

ARTICLE 15. ADOPTION

The Medical Staff Bylaws shall be adopted at any regular or special meeting of the Active Staff, and shall replace any previous Medical Staff Bylaws, and shall become effective immediately upon approval by the Governing Board.

This Governance and Organization Manual, along with the remainder of the Medical Staff Bylaws/Manuals, was approved and adopted, as an amendment/restatement of the then-current Medical Staff Bylaws, by resolution and approval of the Medical Staff and Governing Board, in accordance with and subject to the then-current Medical Staff Bylaws and Hospital's Bylaws, respectively, as of the dates set forth below.

By:_____
Chief of the Medical Staff

Date: _____

By:_____
Chairperson Governing Board

Date:_____

ARTICLE 16. RECORD OF DOCUMENT REVISIONS

Date(s) approved by Medical Staff and Governing Board	**Article/Section Modified**