BYLAWS OF

THE INDIANA HEART HOSPITAL, LLC

MEDICAL STAFF SOCIETY

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MEDICAL STAFF SOCIETY

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ARTICLE 1. NAME AND PURPOSES

Section 1.1. Name. The name of the Medical Staff organization of The Indiana Heart Hospital, LLC (hereinafter referred to as the "Hospital") shall be The Indiana Heart Hospital, LLC Medical Staff Society (hereinafter referred to as the "Medical Staff").

Section 1.2. Purposes

A. To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive, consistent with resources and equipment reasonably available, quality patient care;

B. To ensure the quality professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of clinical privileges that each Practitioner may exercise in the Hospital and through an ongoing review and evaluation of each Practitioner's performance in the Hospital;

C. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

D. To initiate and maintain the Policies and Procedures for the government of the Medical Staff upon approval by the Governing Body;

E. To provide a structure whereby issues concerning the Medical Staff and the Hospital may be discussed with the Governing Body and the Chief Executive Officer; and

F. At the request of, or upon appointment by, the Governing Body, to function solely as personnel of the peer review committees as defined by the Indiana Peer Review Act (I.C. § 34-30-15 et seq.) and as Professional Review bodies as defined by the Federal Health Care Quality Improvement Act (42 U.S.C. § 11101 et seq.) when evaluating, recommending, and/or taking action based on the competence or professional conduct of individual Practitioners, including evaluation of the qualification of professional health care providers, their character, health, ability to cooperate with others to provide patient care and perform related duties in a non-disruptive manner in a hospital setting; accuracy of diagnosis, propriety, quality, appropriateness or necessity of care and the reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients.

Such action shall be taken:

(1) in the reasonable belief that the action is in furtherance of quality healthcare;
(2) after a reasonable effort to obtain the facts of the matter;
(3) after notice and hearing procedures in accordance with the Bylaws have been afforded to the physician involved;
(4) in the reasonable belief that the action is warranted by the facts after reasonable effort to obtain the facts and notice and hearing procedures specified in the Bylaws and Policies and Procedures have taken place.

G. To provide a framework for the discharge by the Medical Staff of those duties assigned to it by the Governing Body of The Indiana Heart Hospital, LLC, consistent with the operation of its hospital and facilities in accordance with applicable Indiana laws, including, but not limited to, I.C. § 16-21-2-5 et seq.

H. To participate in measurement, assessment, and performance improvement on an organization wide basis. The Medical Staff is involved in the measurement of outcomes, processes and in the assessment of performance in relation to the design of processes and their expected or intended outcome, in order to identify opportunities for improvement. The Medical Staff is involved in the evaluation of individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities. The Medical Staff will communicate to appropriate medical staff members the findings, conclusions, recommendations, and actions taken to improve organization performance and the implementation of changes to improve performance.

ARTICLE 2. DEFINITIONS

"Active Medical Staff" means those Practitioners who are Board Certified or Board Eligible cardiologists or cardiovascular surgeons who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care, consultation and monitoring assignments. (Section 4.2)

"Adversely Affecting or Adverse Action" shall mean any action based on Professional Review Activity reducing, restricting, suspending, revoking, denying or failing to renew Clinical Privileges of a Practitioner or membership on the Medical Staff of the Hospital. A letter of reprimand or warning, requirements of proctoring or consultations, investigative suspension not in excess of fourteen (14) days, requirements of further continuing medical education or training, and imposition of terms of probation which do not prevent a Practitioner from exercising any Privileges which have been granted to him/her shall not constitute Adverse Action and shall not give rise to rights to a hearing or appeal. Further, automatic suspension for failure to complete medical records in a

timely fashion, to maintain licensure, to maintain professional liability insurance and to qualify as a health care provider under the Patients' Compensation Act, to pay Medical Staff dues or to complete any requirements of continuing medical education or to attend Medical Staff or committee meetings shall not be deemed “Adverse Action.” (Articles 9 and 10)

Automatic termination of medical staff membership and privileges for loss of licensure for twelve (12) months or more or for failure to attain Board Certification within five (5) years of Board Eligibility shall not be deemed “Adverse Action.”

“Affected Practitioner” means the Practitioner against whom an Adverse Action has been recommended or taken.

“Allied Health Professionals” means individuals other than physicians who exercise independent judgment within areas of individual professional competence and who are qualified to render patient care services in accordance with specific privileges granted and include, but shall not be limited to, dentists, psychologists, and advanced nurse practitioners.

“Appeal Board” may be comprised of the entire Governing Body or not fewer than three (3) members of the Governing Body. At least one (1) shall be a physician.

“Cardiovascular Surgeon” means an individual physician, licensed by the State of Indiana to practice cardiovascular and/or vascular surgery.

“Chief Executive Officer” means the individual appointed by the Governing Body to act on its behalf in the management of the affairs of the company.

“Clinical Privileges” or “Privileges” mean those specific procedures or categories of procedures being requested by each Practitioner for which the Practitioner is competent, skilled, trained or otherwise qualified to perform.

“Committee” means a group responsible for planning, conducting, coordinating and evaluating various Medical Staff functions as described in Articles 12 and 14.

“Consulting Medical Staff” means those Practitioners who are not members of the Active Medical Staff but who assume all the functions and responsibilities of membership on the Consulting Medical Staff. (Section 4.3)

“Governing Body” means the Board of Managers of The Indiana Heart Hospital, LLC.

“Hearing Committee” means the committee which may be convened pursuant to Article 9 of the Bylaws, and generally consists of not fewer than three (3) members of the Medical Staff who shall not have actively participated in the consideration of the matter leading up to the recommendation or action and who are not in direct economic competition with the Practitioner involved. (Article 9)

"Hearing Officer" is an individual who may be an attorney-at-law, designated to preside over any fact-finding hearing which may be convened pursuant to Article 9 of the Bylaws. (Article 9)

"Hospital" means The Indiana Heart Hospital, LLC.

"Medical Executive Council" means the six members of the Active Medical Staff elected by the Active Medical Staff members, the Medical Director of Anesthesia, the Medical Director of Emergency Medicine, the Medical Director of Radiology, the Medical Director of Vascular Medicine, the Director of Critical Care, the Hospital's Chief of Staff, the Hospital's Vice Chief of Staff (if appointed), Community Health Network, Inc.'s Vice President of Medical and Academic Affairs, and the Hospital's Chief Executive Officer or his/her designated representative. The Chairman of the Medical Executive Council shall be the Chief of Staff of the Hospital. (Article 11)

"Medical Staff Office" means the administrative office provided to the Medical Staff by the Hospital; provided that the Hospital may contract for these services with Community Hospitals of Indiana, Inc.

"Medical Staff Year" means the period between March 1st and the last day of February.

"Network" means Community Health Network, Inc.

"Physician-Employed Personnel" includes, but is not limited to, scrub nurses, surgical technicians and physician's assistants who are employed and supervised by a Medical Staff member and who perform all of their duties or a portion thereof while in the Hospital.

"Policies and Procedures" means those policies and procedures which serve to implement more specifically the general principles found within these Bylaws, subject to the approval of the Medical Executive Council and the Governing Body, and relating to the proper conduct of activities of the Medical Staff organization as well the level of practice that is to be required of each Practitioner in the Hospital. Such Policies and Procedures shall be a part of these Bylaws, and are so incorporated by reference.

"Practitioner" means an individual physician, dentist or podiatrist licensed by the State of Indiana, who has made application for membership to the Medical Staff, or is currently a member of the Medical Staff.

"Professional Review Activity" or "Professional Review Action" means those actions taken to evaluate the qualifications, clinical competence, and/or professional judgment of an applicant or a member of the Medical Staff, or to determine the merits of a complaint against any member of the Medical Staff. Such evaluation shall result in a determination and recommendation pursuant to Article 8.

"QA Council of the Medical Executive Council" means the Medical Staff members of the Medical Executive Council and the Network's Vice President for Medical and Academic Affairs.

"Regular Medical Staff" means Active Medical Staff. (Article 4)

"Temporary Clinical Privileges" means Clinical Privileges granted to a Practitioner making application to the Medical Staff for a period not to exceed ninety (90) days after a favorable recommendation by the Chief of Staff and approved by the Chief Executive Officer of the Hospital. "Temporary Clinical Privileges" may be granted to a Practitioner who may act as a consultant or perform a surgical procedure when called by a member of the Regular Medical Staff responsible for the care of the patient.

"Vice President for Medical and Academic Affairs" means the person holding the office of Network Vice President for Medical and Academic Affairs for Community Health Network, Inc.

ARTICLE 3. MEDICAL STAFF MEMBERSHIP

Section 3.1. Nature of Medical Staff Membership. Membership in the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership shall not be denied on the basis of race, sex, religion, citizenship, age or national origin.

Section 3.2. Qualifications for Membership. Only Practitioners who currently hold an unlimited license to practice in the State of Indiana, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good character, good physical, mental and emotional health and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given quality health care and their ability to make use of Hospital facilities in an efficient and effective way, shall be qualified for membership on the Medical Staff. No Practitioner shall be entitled to membership on the Medical Staff or to exercise clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice medicine in this or in any other state, or that he/she had in the past, or presently has, such privileges at another hospital; that he/she holds certification by a clinical board; or that he/she is a member of a medical school faculty. Every person appointed as a member of the Medical Staff must have professional liability insurance and a certificate of insurance qualifying him/her as a health care provider under the Indiana Patient's Compensation Act (I.C. § 34-18-6 et seq.).

Section 3.3. Conditions and Duration of Appointment

A. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on

appointments, reappointments, or revocation of appointments and the granting and revision of clinical privileges after there has been a recommendation from the Medical Staff as provided in these Bylaws.

B. Initial appointments shall be for a period of two (2) years. Reappointments shall be for a period of not more than two (2) years.

C. Appointment to the Medical Staff shall confer on the Practitioner only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

D. Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Bylaws and Policies and Procedures, and to accept assignments as directed by the Chief of Staff.

E. These Bylaws are not a contract of any kind between the Governing Body, the Medical Staff, Allied Health Care Providers, or Physician-Employees, or any individual member thereof. The continuance of a Practitioner's privileges at this Hospital is based solely on his/her continuing ability to justify the exercise of such privileges, and privileges do not obligate a Practitioner to practice at the Hospital. The Governing Body and Medical Staff are obligated by law to use fairness in dealing with persons governed by these Bylaws, but do not bind themselves to the particular means of doing so set forth in these Bylaws.

F. Resignations shall be addressed to the QA Council of the Medical Executive Council and the Governing Body.

Section 3.4. Leave of Absence – Voluntary & Involuntary.

A. Voluntary Leave of Absence.

(1) A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Staff Office stating the approximate period of the leave desired and the purpose thereof.

(2) An extension to the initial granting of a leave of absence must be requested by the physician at least 30 days prior to the expiration of the original leave of absence. Not more than one (1) extension will be granted.

(3) A request for a leave of absence to obtain further education and for healthcare issues may be requested for up to one (1) year.

(4) A request for personal reasons; i.e. vacation, pursuit of non-healthcare career business interests, or impairment shall not exceed six (6) months. Extensions will not be granted.

(5) A leave of absence requested for healthcare issues requires documentation from the treating physician as to the physician's health status and the effect of the physicians' health status with regard to his/her practice of medicine.

(6) At least thirty (30) days prior to the termination of a voluntary leave of absence, or at any earlier time, the physician may request reinstatement of privileges by submitting a written notice to that effect to the Medical Staff Office. A summary of relevant activities during the leave of absence and/or information establishing his/her current competency must accompany the request for reinstatement.

(7) During the period of a leave of absence, the physician shall not exercise clinical privileges at the Hospital, and appointment rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Chief of Staff.

(8) The process for requesting a leave of absence and for requesting reinstatement will be as follows:

a. Upon the recommendation of the Chief of Staff and the QA Council of the Medical Executive Council and with the approval of the governing body, a Medical Staff member may be granted a voluntary leave of absence or may be granted reinstatement to the Medical Staff after a leave of absence.

b. For physicians who are unable to provide documentation of competency, the Medical Staff may require that the physician contact The Center for Personalized Education for Physicians (CPEP) in Aurora, Colorado for evaluation. This evaluation will be at the physician's expense.

c. Failure to request reinstatement prior to the expiration of the physician's reappointment date or the expiration of the leave of absence, without good cause, shall be deemed a voluntary resignation from the Medical Staff

and shall result in automatic termination of appointment, privileges and prerogatives.

d. A physician whose appointment is automatically terminated shall be entitled to the procedural rights provided in Article 9 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise.

e. A request for Medical Staff appointment subsequently received from a physician so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

B. Involuntary Leave of Absence

(1) Any physician who becomes incapacitated so as to be incapable of engaging in the practice of medicine for a period of greater than 60 days shall notify the Chief of Staff of the existence of and the expected duration of the incapacity. If such notice is not given, the Chief of Staff may act on other information that establishes the existence of such incapacity. Such physician shall automatically be granted an involuntary leave of absence.

(2) During the period of any involuntary leave, the physician shall not exercise clinical privileges at the Hospital and appointment rights and responsibilities shall be inactive; but the obligation to pay dues, if any, shall continue unless waived by the Chief of Staff.

(3) At least fifteen (15) days prior to the termination of an involuntary leave of absence, or at any earlier time, the physician may request reinstatement of privileges by submitting a written notice to that effect to the Medical Staff Office. The physician shall submit a summary of relevant activities during the leave and/or information establishing his/her current capacity if so requested by the Chief of Staff. The Chief of Staff shall make a recommendation to the QA Council of the Medical Executive Council concerning the reinstatement of the physician's privileges.

(4) Failure to request reinstatement prior to the expiration of the physician's reappointment date or the expiration of the leave of absence, without good cause, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of appointment, privileges and prerogatives. A physician whose appointment is automatically terminated shall be

entitled to the procedural rights provided in Article 9 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise.

(5) A request for Medical Staff appointment subsequently received from a physician so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

ARTICLE 4. CATEGORIES OF THE MEDICAL STAFF

Section 4.1. The Medical Staff. The Medical Staff shall be divided into Active and Consulting categories. No Practitioner may be assigned to more than one membership category on the Medical Staff at any one time.

THIS SECTION SHALL ONLY APPLY FROM AND AFTER DECEMBER 31, 2003. During the first two (2) years of medical staff membership, Medical Staff members shall not be eligible to vote in any matter submitted to the Medical Staff for a vote. These Medical Staff members shall not be eligible to serve on the Hospital's Governing Body as a Medical Staff member. They shall be available for emergency care coverage at the discretion of the Medical Executive Council. They shall be eligible to serve and vote on all Medical Staff committees except they cannot serve on the Medical Executive Council, or the QA Council of the Medical Executive Council. They may not hold the chairmanship of any Standing Committee.

Section 4.2. The Active Medical Staff. The Active Medical Staff shall consist of Practitioners who are Board Certified or Board Eligible cardiologists or cardiovascular surgeons and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care, consultation and monitoring assignments. Members of the Active Medical Staff shall be eligible to admit patients to the Hospital, to vote, to serve on the Hospital's Governing Body as a medical staff member, to serve on Medical Staff committees and to hold the Chairmanship of any Medical Staff committee, and to participate in Medical Staff sponsored services. An Active member may not serve as a Chairman of more than one committee unless otherwise specifically directed by these Bylaws.

Section 4.3. The Consulting Medical Staff. The Consulting Medical Staff shall consist of any and all Practitioners who are not members of the Active Medical Staff but who assume all the functions and responsibilities of membership on the Consulting Medical Staff. Members of the Consulting Medical Staff shall not have admitting privileges at the Hospital, and shall not be eligible to vote in any Medical Staff meeting. Consulting Medical Staff members may serve on all Medical Staff Committees and may vote in committee meetings. They may not hold the chairmanship of any Standing Committee.

Consulting Medical Staff members shall be members in good standing of the Active Medical Staff or its equivalent of another Indiana licensed hospital although exceptions to this requirement may be made by the Medical Executive Council.

Section 4.4. Change of Medical Staff Category. Requests for change of Medical Staff category shall be submitted by the Medical Staff member to the QA Council of the Medical Executive Council for action and to the Governing Body for approval.

ARTICLE 5. THE RESIDENT STAFF

Section 5.1. Definition and Relationship to the Medical Staff. Physicians in training are appointed to the Residency Staff only in the following circumstances:

A. They have been accepted by the Program Director, the Faculty and the Chief of Staff for enrollment in an accredited residency at the Hospital. They must have a formal, signed, annual contract with the Hospital which defines the expectations of both parties in this educational program. Such a Resident shall be referred to as a Heart Hospital Resident or;

B. They are Residents in good standing at another institution which maintains an accredited residency program, and there is a formal agreement or letter of agreement with that institution which identifies a preceptor physician member of the Medical Staff to whom they are assigned. A rotation for a defined length of time for the sole purpose of completing requirements leading to completion of their residency program must be agreed upon. Such a Resident shall be referred to as a Rotating Resident.

Physicians appointed to the Residency Staff are not members of the Medical Staff, however, all of the clinical faculty supervising them must be members of the Medical Staff. Upon completion or termination of the residency, the physician may apply for membership.

Section 5.2. Qualifications. Both Heart Hospital Residents and Rotating Residents must be graduates of an accredited medical school, favorably recommended by their Dean and/or program directors, and have their credentials reviewed by the residency directors, appropriate faculty preceptors and the Chief of Staff of the Hospital. Residents must have a license to practice or a temporary certificate to practice from the Indiana Medical Licensing Board. They must agree to abide by the Medical Staff Bylaws and Policies and Procedures. Residents must abide by all policies set forth by the Medical Executive Council and by their respective residencies. Hospital Residents shall not be entitled to any rights of appeal and/or review other than the Residency Program Due Process outlined in the Resident Orientation Manual. Rotating Residents are subject to due process procedures of their affiliated institutions, and serve at the will of their preceptor.

Section 5.3. Supervision of Residents. Residents practicing in a Hospital residency program are subject to supervision by the clinical faculty, the director, and other Medical Staff members as defined by the policies and procedures of the residency program. Residents on official rotation from other residency programs are subject to supervision by the Resident's preceptor, who shall be an Active member of the Medical Staff. Furthermore, Residents are subject to the oversight of the Medical Executive Council, as provided in Section 11.2.K, hereof.

ARTICLE 6. PROCEDURE FOR APPOINTMENT/REAPPOINTMENT.

Section 6.1. Application for Appointment.

A. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant and shall be submitted on a form prescribed by the Medical Executive Council. The application shall require detailed information concerning the applicant's professional qualifications, shall include the name of at least two (2) persons who have observed and worked with the applicant who can provide adequate references pertaining to the applicant's professional competence and ethical character; physical, mental and emotional health; prior malpractice claims; and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily relinquished, or subjected to corrective action, or not renewed at any other hospitals or institutions, and as to whether the applicant's membership in local, state or national medical societies, or the applicant's license to practice any profession in any jurisdiction, or the applicant's Federal DEA certificate or Indiana State Controlled Substance Registration has ever been suspended, subjected to corrective action, terminated, or voluntarily relinquished; or if the applicant has ever been the subject of a criminal investigation.

B. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications

C. A criminal check will be conducted only if the applicant attests to having been the subject of a criminal investigation.

D. The completed application shall be submitted to the Medical Staff Office. The applicant may anticipate completion of the credentialing process within 120 days; provided that there may be extenuating circumstances that prevent completion of the credentialing process within the 120 day time frame.

E. By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews with regard to his/her application; authorizes the Hospital to consult with members of the Medical Staffs or with other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for Medical Staff membership; releases from any liability (to the extent permitted by law) all representatives of the Hospital and the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and releases from any liability (to the extent permitted by law) any individuals and organizations providing information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information. Furthermore, if the applicant is granted Medical Staff membership, applicant authorizes the Hospital during the time that applicant remains a member of the Medical Staff to consult with members of the Medical Staffs or with other hospitals with which the applicant has been associated (including peer review committees thereof) and with others who may have information bearing on the applicant's competence, character and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for continued Medical Staff membership and/or clinical privileges; releases from any liability (to the extent permitted by law) all representatives of the Hospital and the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and releases from any liability (to the extent permitted by law) any individuals and organizations providing information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for continued Medical Staff membership and clinical privileges, including otherwise privileged or confidential information.

F. The application form shall include a statement that the applicant has had an opportunity to read the Bylaws and the Policies and Procedures of the Medical Staff and that the applicant agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

Section 6.2. Appointment/Initial Privileges Granting Process.

A. An application will be deemed complete when all requested information has been provided as defined in the credentialing policies and procedures for processing an application and verified by the Hospital. The QA Council of the Medical Executive Council shall make a written report and recommendation to the Governing Board. Prior to making this report, the QA Council of the Medical Executive Council shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including, in its discretion, a personal interview with the applicant, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by the applicant. The QA Council of the Medical Executive Council shall determine whether to recommend to the Governing Body that the applicant be granted Provisional appointment to the Medical Staff, be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint shall also specifically recommend the clinical privileges being granted, which may be qualified by provisional conditions relating to such clinical privileges.

B. When the recommendation of the QA Council of the Medical Executive Council is to defer the application for further consideration, it must be followed up by the next regular meeting with a subsequent recommendation for either initial appointment with specified clinical Privileges or rejection of Medical Staff membership.

C. When the recommendation of the QA Council of the Medical Executive Council is favorable to the applicant, the recommendation will be submitted to the Governing Body.

D. When the recommendation of the QA Council of the Medical Executive Council is adverse to the applicant either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly notify the applicant by certified mail, return receipt requested. No such adverse recommendation shall be forwarded to the Governing Body until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article 9 of these Bylaws.

E. If, after the QA Council of the Medical Executive Council has considered the report and recommendation of the Hearing Committee and the hearing record, the QA Council of the Medical Executive Council's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with Section 6.2.C. If such

recommendation continues to be adverse, the Chief Executive Officer shall promptly notify the applicant by certified mail, return receipt requested. The Chief Executive Officer shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the applicant has exercised or has been deemed to have waived his/her rights to an appellate review as provided in Article 9 of these Bylaws.

F. At its regular meeting, after receipt of a favorable recommendation from the QA Council of the Medical Executive Council, the Governing Body shall act in the matter. If the Governing Body's decision is adverse to the applicant in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify the applicant of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his/her rights under Article 9 of these Bylaws and until there has been compliance with Section 6.2.A. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

G. At its next regular meeting, after all of the applicant's rights under Article 9 have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the QA Council of the Medical Executive Council for reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting, after receipt of such subsequent recommendation and new evidence in the matter, if any, the Governing Body shall make a decision either to grant initial appointment to the Medical Staff or to reject the applicant for Medical Staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

H. Whenever the Governing Body's decision will be contrary to the recommendation of the QA Council of the Medical Executive Council, the Governing Body shall submit the matter to the Chief of Staff for review and recommendation and shall consider such recommendation before making its decision final. The final decision regarding matters referred to the Chief of Staff shall remain solely with the Governing Body.

I. When the Governing Body's decision is final, it shall send notice of such decision to the applicant by certified mail, return receipt requested, through the Chief Executive Officer, with a copy to the Chairman of the QA Council of the Medical Executive Council.

J. All new members of the Medical Staff may request a structured orientation.

Section 6.3. Reappointment Process.

A. The Chief of Staff or his/her designee shall review all pertinent information available on each Practitioner for periodic appraisal, for the purpose of determining recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing period. The recommendations of the Chief of Staff shall be submitted to the QA Council of the Medical Executive Council. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendations shall be documented.

B. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's current professional competence and clinical judgment in the treatment of patients; ethics and conduct; compliance with Medical Staff Bylaws and Policies and Procedures; cooperation with Hospital personnel; use of the Hospital's resources for patients; relations with other Practitioners; physical, mental and emotional health status; and general attitude toward patients, the Hospital and the public, as well as upon information provided through the Quality Assurance process.

C. The QA Council of the Medical Executive Council shall make written recommendations to the Governing Body, through the Chief Executive Officer, concerning the reappointment, non-reappointment and/or clinical privileges of each Practitioner scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be documented.

ARTICLE 7. CLINICAL PRIVILEGES

Section 7.1. Clinical Privileges Restricted.

A. Every Practitioner practicing at this Hospital by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Body, except as provided in Sections 7.2 and 7.3.

B. Every initial application for Medical Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, experience, demonstrated current competence, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested.

C. Periodic review of clinical privileges shall be conducted at least every two years in connection with the reappointment process. Any increase or curtailment of clinical privileges shall be based upon the direct observation of care provided, review of all the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical, dental or other health care.

Section 7.2. Temporary Clinical Privileges.

A. Temporary Clinical Privileges may be granted by the Chief Executive Officer of the Hospital after a favorable recommendation has been made by the Chief of Staff on an application which has been completed, an initial investigation performed, and a recommendation made for the delineation of privileges requested by the applicant. Temporary Clinical Privileges may be granted for a period not to exceed ninety (90) days provided that the information available continues to support a favorable determination regarding the applicant's application for membership and privileges.

B. Temporary Clinical Privileges may be granted by the Chief Executive Officer to a Practitioner who may act as a consultant or perform a surgical procedure when called by a staff member responsible for the care of the patient. Such privileges will be granted in the same manner and upon the same conditions as set forth in subparagraph A of this Section 2. Such Temporary Privileges shall be restricted to the treatment of not more than ten (10) patients in any one year by any Practitioner, after which time such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

C. The Chief Executive Officer may permit a physician serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed ninety (90) days, providing all his/her credentials have first been approved by the Chief of Staff. If the locum tenens privileges must be extended beyond ninety (90) days, the physician must apply for staff membership.

D. The Chief Executive Officer may, at any time after consultation with the Chief of Staff, terminate a Practitioner's temporary privileges if the Practitioner's patient(s) would be endangered by continued treatment by the Practitioner. The termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 7.2.A. The Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until the patient(s) is/are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner. Any such acts referred to in this subsection shall be construed to be peer review committee actions and are protected activity under Indiana law (I.C. § 34-30-15 et seq.).

E. The Practitioner is not entitled to the procedural rights afforded by these Bylaws in Article 9 because a request for Temporary Clinical Privileges is refused or because all or any portion of the Temporary Clinical Privileges are terminated or suspended.

Section 7.3. Emergency Privileges. In the case of emergency, any Practitioner member of the Medical Staff, to the degree permitted by his/her license and regardless of service or Medical Staff status, or lack thereof, shall be permitted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff by the process identified in Section 7.2.D. For the purpose of this section an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

ARTICLE 8. CORRECTIVE ACTION

Section 8.1. Corrective Action.

A. Criteria for Initiation. Any person may provide written information about the conduct, performance, or competence of any Practitioner to the Chief of Staff. When reliable information indicates a Practitioner with clinical privileges may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital facilities; (2) unethical; (3) contrary to the Medical Staff and Hospital Bylaws or Policies and Procedures; (4) below applicable professional standards; (5) indicative of impairment; or (6) disruptive to the operations of the Hospital, any two of the following: the Chief of Staff, the Vice President for Medical

Affairs, the Chairman of any Standing Committee, a Medical Director responsible for supervising the Practitioner, and the Chief Executive Officer, may initiate action in accordance with Section 8.2, if the conditions for summary suspension are met, or may request the QA Council of the Medical Executive Council or the medical director or other physician responsible for supervising and reviewing his/her clinical care, to conduct an informal review of the Practitioner's conduct, performance, and competence.

In addition, the QA Council of the Medical Executive Council or a Medical Director responsible for supervising the Practitioner may independently initiate informal reviews of a Practitioner's conduct, performance, or competence in accordance with Medical Staff and Hospital Policies and Procedures, as may be in effect from time to time. No informal review will constitute a "hearing" as that term is used in Article 9, nor shall the procedural rules with respect to hearings or appeals apply; nor shall the Practitioner be entitled to have an attorney present.

The only actions which may result from an informal review are those listed as Section 8.1.D(1) through (3), which actions do not constitute Adverse Actions and do not give rise to a right to a hearing or appeal.

If the initial review of the Practitioner's conduct, performance and competence determines that there is no basis to consider corrective action, the persons conducting the informal review will determine, in their sole discretion, whether it is necessary to notify the Practitioner of the matter. In all other instances, the persons conducting the informal review shall notify the Practitioner and give the Practitioner an opportunity to submit comments with respect to the matter under review.

B. Initiation. Unless and until a concern about the conduct, performance, or competence of a Practitioner has been resolved by informal review, any two of the people listed in Section 8.1.A, or the Affected Practitioner may take a written request to the Chief of Staff for a formal investigation.

C. Investigation. If the QA Council of the Medical Executive Council, acting on behalf of the Medical Executive Council, determines that an investigation is warranted, the Chief of Staff shall immediately appoint an ad hoc committee comprised of no less than three (3) members of the Medical Staff, to conduct the investigation and make a recommendation to the QA Council of the Medical Executive Council. The Chief of Staff shall provide the ad hoc committee with a written statement of the allegations against the Practitioner. The Practitioner shall be notified that an investigation is being conducted. In addition, the Practitioner shall be given an opportunity to meet with the ad hoc committee and to

provide information in a manner and upon such terms as the ad hoc committee deems appropriate. The ad hoc committee may, but is not obligated to, conduct interviews with other persons involved. The ad hoc committee may, but is not obligate to, obtain an independent expert medical opinion on any issue of clinical performance or competence. The investigation conducted by the ad hoc committee shall not constitute a "hearing" as that term is used in Article 9, nor shall the procedural rules with respect to hearings or appeals apply, nor shall the Practitioner be entitled to have an attorney present or to present witnesses.

D. Ad Hoc Committee Action. Within ninety (90) days after its receipt of the written statement of allegations, or such other time period as may be established by written policies or by resolution of the QA Council of the Medical Executive Council, the ad hoc committee shall make a written report to the QA Council of the Medical Executive Council of the results of its investigation. The report shall contain three parts: (1) a statement of the facts and/or a statement of the issues regarding the facts surrounding the incident; (2) a discussion of the rationale for the recommendations made; (3) the recommendations.

The recommendation shall be one or more of the following:

(1) Determining that no corrective action be taken and, if the committee determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner's file;

(2) Issuing letters of admonition, censure, reprimand, or warning. Such a letter shall be made part of a Practitioner's peer review file for internal use only but shall not be reported as substantive corrective action to the Medical Licensing Board or to others making inquiry regarding the Practitioner. Such a letter shall be considered in the nature of instruction and guidance to the Practitioner rather than as any form of punishment. In the event such letters are issued, the Affected Practitioner may make a written response which shall be placed in the Practitioner's file;

(3) Recommending education and/or training;

(4) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff appointment or exercise of clinical privileges including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

(5) Recommending reduction, modification, suspension or revocation of clinical privileges;

(6) Recommending reductions of appointment status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;

(7) Recommending suspension, revocation or probation of Medical Staff appointment;

(8) Taking other action deemed appropriate under the circumstances.

Periods of monitoring, continuing education requirements and other remedies that require additional evaluation after time to determine compliance, competence, or improvement shall be items of continuing review by the QA Council of the Medical Executive Council regarding progress or the lack of progress of such remedies. (Exception: The Physician's Assistance Committee will be responsible for monitoring and follow-up of all impaired Practitioners.)

E. Subsequent Action.

(1) The QA Council of the Medical Executive Council may approve, amend or disapprove the recommendation of the ad hoc committee. If corrective action, as set forth in Section 9.2, is recommended by the QA Council of the Medical Executive Council, that recommendation shall be transmitted to the Governing Body, unless the Practitioner requests a hearing, in which case the final decision shall be determined as set forth in Article 9.

(2) The recommendation of the QA Council of the Medical Executive Council, with Governing Body approval, shall become final action.

Section 8.2. Summary Restriction or Suspension.

A. Criteria For Initiation. Any two of the following: the Chief of Staff, the Vice Chief of Staff (if appointed), the Vice President for Medical Affairs, the Chairman of any Standing Committee, a Medical Director responsible for supervising the Practitioner, and the Chief Executive Officer, may summarily restrict suspend the clinical privileges of a Practitioner, where the failure to take such action may result in imminent danger to the life or health of any patient, prospective patient, or other person. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person responsible shall promptly give written notice to the Practitioner, the Governing Body, the QA Council of the Medical Executive Council,

and the Chief Executive Officer. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patient(s) shall be promptly assigned to another Practitioner by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Practitioner.

B. QA Council of the Medical Executive Council Review. Within fifteen (15) calendar days after such summary restriction or suspension has been imposed, or as agreed by the Practitioner and the Chief of Staff, a meeting of the QA Council of the Medical Executive Council shall be convened to review and consider the action. If requested by the Practitioner, the Practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the QA Council of the Medical Executive Council may impose, although in no event shall any meeting of the QA Council of the Medical Executive Council with or without the Practitioner constitute a “hearing” within the meaning of Article 9, nor shall any procedural rules apply. The Practitioner may be accompanied by legal counsel but counsel may not enter into any discussion, present evidence or otherwise participate in the meeting. The QA Council of the Medical Executive Council may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the Practitioner with notice of its decision. The decision of the QA Council of the Medical Executive Council to summarily restrict or suspend clinical privileges is an administrative, interim, precautionary step in a Professional Review Activity but is not a Professional Review Action in and of itself. It does not constitute nor imply a finding of guilt, culpability or lack of clinical competence on the part of the suspended or restricted Practitioner.

C. Procedural Rights. Unless the QA Council of the Medical Executive Council terminates the summary restriction or suspension within fifteen (15) calendar days after imposed, the Practitioner shall be entitled to the procedural rights afforded by Article9.

Section 8.3. Automatic Suspension or Limitation. In the following instances, the Practitioner's privileges or appointment will be automatically suspended or limited as described, which action shall not be entitled to the procedural rights afforded by Article 9:

A. Licenses.

(1) Revocation and Suspension: Whenever a Practitioner's license or other legal credential authorizing practice in Indiana is revoked or suspended, Medical Staff appointment and clinical privileges shall

be automatically revoked as of the date such action became effective.

(2) Restriction: Whenever a Practitioner's license or other legal credential authorizing practice in Indiana is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Practitioner has been granted at the Hospital, which are within the scope of said limitation or restriction, shall be automatically limited or restricted in a similar manner as of the date such action became effective and throughout its term.

(3) Probation: Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, the Practitioner's appointment status and clinical privileges shall automatically become subject to the same terms and conditions of probation as of the date such action became effective and throughout its term.

(4) Reinstatement: If a Practitioner's license is suspended for a definite period by the applicable or certifying authority, the Practitioner's Privileges shall not be automatically reinstated upon the expiration of such period. The Practitioner shall be required to request reinstatement, which will be reviewed as if it were an application for reappointment. The Practitioner will be notified in writing of his or her duty to request reinstatement. If the Practitioner fails to request reinstatement within ninety (90) days from the time his or her suspension is lifted, the Practitioner will be deemed to have voluntarily resigned from the Medical Staff.

B. Controlled Substances.

(1) Whenever a Practitioner's Indiana Controlled Substance certificate and/or DEA certificate is revoked, limited or suspended, the Practitioner's clinical privileges shall automatically be suspended, as of the date such action became effective. Such suspension shall not lift automatically with the lifting of the revocation, limitation or suspension by those agencies but shall first be reviewed by the QA Council of the Medical Executive Council to determine if corrective action is warranted.

(2) Probation: Whenever a Practitioner's Indiana Controlled Substance certificate and/or DEA certificate is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action became effective and throughout its term.

C. Qualification as a Provider. If a Practitioner ceases to be a qualified health care provider under the terms of the Indiana Medical Malpractice Act (I.C. § 34-18-3 et seq.), the Practitioner's clinical privileges shall be automatically suspended as of the date the Practitioner becomes disqualified.

D. Medical Records. Members of the Medical Staff are required to complete medical records within such reasonable time as outlined in the Medical Record Policies and Procedures. A limited suspension in the form of withdrawal of admitting and other related Privileges, such as voluntary on-call service for the Emergency Department, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients, until medical records are completed, may be imposed by the Chief of Staff, or his designee, or the Medical Executive Council, after notice of delinquency for failure to complete medical records within such period.

Bona fide vacation, leaves for business or illness may constitute an excuse subject to approval by the Medical Executive Council. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his/her designee.

E. Any Medical Staff Member whose participation in any federally funded program; e.g. Medicare, Medicaid, CHAMPUS, etc., is terminated by any of these programs, or who is otherwise excluded or precluded from participation in any of these programs, shall automatically relinquish all clinical privileges as of the effective date of the termination, exclusion or preclusion.

Once the sanction by the federally funded program has been lifted, if within the current reappointment term, the practitioner shall be required to request reinstatement on the medical staff which will be reviewed as if it were an application for reappointment. If the practitioner fails to request reinstatement within ninety (90) days from the time his/her sanction is lifted, the practitioner will be deemed to have voluntarily resigned form the Medical Staff.

If the Medical Staff Member's participation in any federally funded program is not fully reinstated by the expiration of the Medical Staff member's then current reappointment term, the Medical Staff member will be deemed to have resigned from the Medical Staff at that time.

It shall be the duty of all Medical Staff members to promptly inform the hospital of any action taken by any federally funded program.

F. QA Council of the Medical Executive Council Deliberation. As soon as practicable after action is taken or warranted as described in Sections 8.3.A and B, the QA Council of the Medical Executive Council shall convene to review and consider the facts, and may recommend such corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 8.1.C.

Section 8.4. Disruptive Medical Staff Member. Members of the Medical Staff who engage in inappropriate or disruptive conduct are subject to collegial intervention, referral to Relationship Training, referral to the Indiana State Medical Association ("ISMA") Physician's Assistance Program, or formal disciplinary action pursuant to Articles 8 and 9 as outlined in the Disruptive Physician Policy.

ARTICLE 9. HEARINGS AND APPELLATE REVIEW

Section 9.1. General Provisions

A. Exhaustion of Remedies. If Adverse Action described in Section 2 of this Article is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

B. Application of Article.

(1) For purposes of this Article, the term "Practitioner" may include an applicant to the Medical Staff as it may be applicable under the circumstances.

(2) The Hospital may from time to time enter into exclusive contracts with Practitioners for the provision of certain services to Hospital patients. Such an exclusive contract does not constitute a reduction, suspension or termination of Clinical Privileges of any non-contracting Practitioner subject to the procedural rights specified in this Article, irrespective of whether the effect of the exclusive contract is to limit the Practitioner's exercise of his or her Clinical Privileges.

(3) Investigations concerning a Practitioner's compliance with Medical Staff and Hospital Bylaws, and Policies and Procedures will not be subject to the hearing and appeal procedures of this Article unless the investigation results in an Adverse Action described in Section 9.2.

Section 9.2. Grounds for Hearing. Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential Adverse Action and constitute grounds for a hearing:

A. denial of Medical Staff appointment

B. denial of requested advancement in Staff appointment status or category

C. denial of Medical Staff reappointment

D. involuntary change of Medical Staff category

E. suspension of Medical Staff appointment

F. revocation of Medical Staff appointment

G. denial of requested Clinical Privileges excluding Temporary Clinical Privileges

H. involuntary reduction of current Clinical Privileges

I. suspension of Clinical Privileges

J. termination of all Clinical Privileges

Section 9.3. Requests for Hearing

A. Notice of Action or Proposed Action. Within ten (10) days after a person or body has taken action or made a recommendation which constitutes grounds for a hearing under Section 9.2, said person or body shall give the Practitioner notice of the recommendation or action, and notice of the Practitioner's right to request a hearing within thirty (30) days following receipt of the notice. The notice shall set forth the reasons thereof and a summary of the Practitioner's rights at hearing. The notice shall be sent by certified mail, return receipt requested.

B. The Practitioner shall have thirty (30) calendar days following receipt of notice of action or recommendation to request a hearing. The request shall be in writing addressed to the Executive Council, with a copy to the Chief Executive Officer. In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have voluntarily waived any right to a hearing and accepted the recommendation or action involved.

C. Notice of Hearing

(1) Upon receipt of a request for hearing, the Executive Council shall schedule a hearing and, within fifteen (15) days after receipt of the request for hearing, give notice to the Practitioner of the time, place and date of the hearing. Unless extended by the Hearing

Committee, the date of the commencement of the hearing shall not be less than thirty (30) days nor more than forty-five (45) days from the date the request for hearing is received.

(2) The notice shall set forth a list of the witnesses, if any, expected to testify at the hearing on behalf of the Executive Council.

D. Notice of Charges. Together with the notice of hearing, the Executive Council shall state clearly and concisely in writing the reasons for the Adverse Action taken or recommended, including the acts or omissions with which the Practitioner is charged and a list of the medical records in question, where applicable.

E. Hearing Committee. The Hearing Committee will be established as follows: The Executive Council or, if authorized by the Executive Council, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not fewer than three (3) members of the Medical Staff who shall not have actively participated in the consideration of the matter leading up to the recommendation or action and who are not in direct economic competition with the Practitioner involved. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. Membership on a Hearing Committee shall consist of one member who shall have the same healing arts licensure as the appellant. All other members shall have M.D. or D.O. degrees.

F. Failure to Appear or Proceed. Failure without good cause of the Practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall constitute the voluntary waiver by the Practitioner of his or her right to a hearing, and the recommendations or actions shall become final.

G. Postponements and Extensions. Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Committee, or its Chairman acting on its behalf, at the discretion of the Committee or its Chairman on a showing of good cause.

Section 9.4. Hearing Procedure.

A. Prehearing Procedure.

(1) As soon as practicable prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who will give testimony or evidence in support of that party at the

hearing and a written list of documents which are reasonably known or anticipated to be offered as evidence at the hearing. While neither party shall have any right to the discovery of documents or other evidence in advance of the hearing, the Hearing Officer may confer with both parties to encourage an advance mutual exchange of documents which are relevant to the issue to be presented at the hearing.

(2) It shall be the duty of the Practitioner and the Executive Council or its designee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

B. Representation. The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on the professional conduct, professional competency, or character of the Practitioner. The Practitioner and the Executive Council have the right to be represented in any phase of the hearing by an attorney-at-law. If the Practitioner chooses not to be represented by legal counsel, the Practitioner shall be entitled to be accompanied by and represented at the hearing by any other person of the Practitioner's choosing, and the Executive Council may choose to be represented by either an attorney or a non-attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

C. Hearing Officer. The Executive Council or, if authorized by the Executive Council, the Chief of Staff shall appoint a Hearing Officer, not a member of the Hearing Committee, to preside at the hearing. The Hearing Officer may be an attorney-at-law, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as a Hearing Officer. The Hearing Officer shall not be in direct economic competition with the Practitioner involved. The Hearing Officer shall not act as a prosecuting officer nor as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a

hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. If requested by the Hearing Committee, the Hearing Officer may participate in the deliberations of such Committee and be legal advisor to it, but the Hearing Officer shall not be entitled to vote.

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

E. Rights of the Parties. Subject to reasonable limitation by the Hearing Officer, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The Practitioner may be called by the Executive Council's representative and examined as if under cross-examination.

F. Written Statements. The Practitioner and the Executive Council may be permitted to submit a written statement prior to or at the hearing, in the sole discretion of the Hearing Committee.

G. Miscellaneous Rules. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article 9. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Committee may request or permit both sides to file written arguments.

H. Burdens of Presenting Evidence and Proof. At the hearing, unless otherwise determined for good cause, the Executive Council shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Practitioner shall be obligated to present evidence in response. The Executive Council shall have the burden of establishing a prima facie case in favor of its action or recommendation, at which time the burden of proof shall shift to the Practitioner to

establish by a preponderance of the evidence that the Executive Council's action or recommendation is not warranted.

I. Presence of Hearing Committee Members and Vote. A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing of evidence, he may not participate in the deliberations or the decision unless he has the consent of each party.

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

K. Basis for Decision. The decision of the Hearing Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the Testimony. The decision of the Committee shall be final, subject to the provisions of Section 9.5.

L. Decision of the Hearing Committee. Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall render a decision which shall be accompanied by a report in writing containing a concise statement of the reasons in support of the decision and shall be delivered to the Executive Council and the Practitioner. A copy of the decision shall also be forwarded to the Chief Executive Officer and the Governing Body.

Section 9.5. Appeal

A. Time for Appeal. Within ten (10) days after receipt of the decision of the Hearing Committee, either the Practitioner or the Executive Council may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If a request for appellate review is not requested within such period the decision of the Hearing Committee shall thereupon become final.

B. Grounds For Appeal. A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for the appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has

created demonstrable prejudice; or (b) the decision was not supported by substantial evidence based upon the hearing record.

C. Time, Place and Notice. If an appellate review is to be conducted. The Appeal Board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given written notice of time, place and date of the appellate review. The date of appellate review shall be not less than thirty (30) days nor more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a Practitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangement may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.

D. Appeal Board. The Governing Body may sit as the Appeal Board, or the Chairman of the Governing Body may appoint an Appeal Board which shall be composed of not fewer than three (3) members of the Governing Body, at least one (1) of whom shall be a physician. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, as long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal and shall not be an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities.

E. Appeal Procedure. The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or challenge provided at the Hearing Committee.

Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of his position on appeal, and, in its sole discretion, the Appeal Board may allow each party or representative to personally appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their respective representatives. The Appeal Board, if less than all of the members of the Governing Body, shall present to the Governing Body and to the parties its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Hearing Committee decision. The Governing Body shall render a decision in writing and shall forward copies thereof to each side involved in the hearing.

F. Decision.

(1) Within thirty (30) days after the conclusion of the appellate review proceeding, the Governing Body shall render a decision in writing setting forth the basis for the decision and shall forward copies thereof to each side involved in the hearing.

(2) The Governing Body may affirm, modify, or reverse the decision of the Hearing Committee.

(3) The decision of the Governing Body shall be final.

G. Right to One Hearing. No Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of Adverse Action or recommendation.

Section 9.6. Exceptions to Hearing Rights. No hearing is required when a Practitioner's license or legal credentials to practice have been revoked or suspended as set forth in Section 8.3.A. In other cases described in Sections 8.3.A and 3.B, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination of the licensing or credentialing authority was unwarranted, but only whether the revocation, suspension or limitation imposed is in accordance with the Bylaws.

ARTICLE 10. OFFICERS

Section 10.1. Officers of the Medical Staff. Officers of the Medical Staff shall be an elected Chief of Staff and a Vice Chief of Staff, if one is appointed by the Chief of Staff.

Section 10.2. Qualifications of Officers. Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 10.3. Election/ Appointment of Officers

A. The Chief of Staff shall be elected at the annual meeting of the Medical Staff. Only Active members of the Medical Staff shall be eligible to vote.

B. The Nominating Committee shall offer one or more nominees for each office. Nominations of qualified candidates may also be made from the floor by members of the Active Attending Medical Staff.

C. The Chief of Staff may appoint a Vice Chief of Staff, as deemed necessary and appropriate.

Section 10.4. Term of Office. The Chief of Staff shall serve a two (2) year term or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.

Section 10.5. Vacancies in Office. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.

Section 10.6. Duties of Officers. The duties and responsibilities of the Chief of Staff and Vice Chief of Staff are as outlined in their position descriptions. The Chief of Staff and Vice Chief of Staff shall be a member of the Medical Executive Council of the Medical Staff and the Quality of Care Committee. The Chief of Staff and Vice Chief of Staff shall call Medical Staff meetings to order and shall ensure that an accurate record of all meetings and finances of the Medical Staff is maintained, and shall report on the status of the finances of the Medical Staff to the Medical Executive Council at each regularly scheduled meeting.

Section 10.7. Removal of Officers. Removal of the Chief of Staff (or Vice Chief of Staff) may be effected by a two-thirds (2/3) majority vote by secret ballot of the members in good standing of the Active Medical Staff, such vote being taken at a special meeting called for that purpose. Such a special meeting may be called by a majority vote of the Medical Executive Council or by a petition signed by at least twenty percent (20%) of the Active Medical Staff. The designation of the time and place for such a special meeting shall be governed by the procedures set forth in Section 13.1 and the quorum necessary for any vote shall be the same as the quorum necessary for a vote on any amendment to these Bylaws. Permissible basis of removal of a Medical Staff officer include:

A. failure to perform the duties of the position held in a timely and appropriate manner;

B. failure to continuously satisfy the qualifications for the position; and conflict of interest.

ARTICLE 11. MEDICAL EXECUTIVE COUNCIL

Section 11.1. Composition. The Medical Executive Council shall consist of six members of the Active Medical Staff elected by the Active Medical Staff members, the Medical Director of Anesthesia, the Medical Director of Emergency Medicine, the Medical Director of Radiology, the Medical Director of Vascular Medicine, the Director of Critical Care, the Hospital’s Chief of Staff, Network’s Vice President of Medical and Academic Affairs, and the Chief Executive Officer or his/her designated representative. The Medical Executive Council shall prepare a slate of candidates for election by the Active Medial Staff members. The elected members of the Medical

Staff Council shall serve a term of three (3) years, unless removed sooner; provided, however that the initial terms of the elected members of the Medical Executive Council shall be staggered so that one-third of the elected members are elected at each annual meeting. The Medical Executive Council shall include at least one cardiologist, one vascular surgeon and one cardiac surgeon. The Chairman of the Medical Executive Council shall be the Chief of Staff of the Hospital.

Section 11.2. Duties. The duties of the Medical Executive Council shall be:

A. to represent the Medical Staff and to act on its behalf, subject to such limitations as may be imposed by these Bylaws;

B. to receive and act upon committee reports;

C. to implement Policies and Procedures of the Medical Staff;

D. to act as a liaison between the Medical Staff and the Chief Executive Officer and the Governing Body;

E. to recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

F. to make recommendations on Hospital management matters to the Governing Body through the Chief Executive Officer;

G. to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital;

H. to ensure the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

I. to review the Bylaws of the Medical Staff no less frequently than triennially;

J. to provide for the preparation of all meetings and programs, either directly or through delegation to a program committee or to another suitable agent;

K. to provide oversight for all medical education programs conducted at the Hospital, including receiving regular reports concerning the conduct and performance of Residents from the physicians and departments responsible for such Residents.

Furthermore, the Medical Executive Council shall serve as the Infection Control Committee of the Hospital. The Infection Control Committee shall be responsible for the surveillance of potential Hospital infections, the review and

analysis of actual infections, the promotion of a preventative and corrective infection control program designed to minimize infection hazards, the supervision of infection control in all phases of the Hospital's activities and the provision of standard criteria for reporting all types of infections. The committee shall maintain Hospital compliance with all Joint Commission and other accrediting or licensing standards pertaining to infection control

Section 11.3. Meetings. The Medical Executive Council shall meet at least four (4) times per year and maintain a permanent record of its proceedings and actions.

ARTICLE 12. COMMITTEES

All meetings of committees of the Medical Staff will be considered peer review meetings to the extent that their responsibilities include the evaluation of the qualifications of, or the patient care rendered by, Practitioners (I.C. § 34-6-2-99(a)). As such, all minutes and correspondence of a peer review committee shall be confidential, and all members and personnel of the peer review committee shall enjoy all the rights, responsibilities, and protections of the Indiana Peer Review statute (I.C. § 34-30-15 et seq.).

Section 12.1. Committee Functions. Committees are divided into two (2) categories: Standing and Working. The composition, function and duties are as described in Sections 12.2 and 12.3.

Section 12.2. Standing Committees. The following shall be designated as Standing Committees: Quality Assurance Council of the Medical Executive Council. The Chairman of the QA Council of the Medical Executive Council, shall be appointed annually by the Chairman with the approval of the Chief of Staff. The Chief of Staff, or his/her delegated representative, shall be an ex-officio member of all Standing Committees. The President of the Hospital or his/her delegated representative, shall be an ex-officio member of all Standing Committees. The specific functions of each committee are outlined below. All Standing Committees shall meet as designated below. All Standing Committees shall maintain a permanent record of their proceedings and actions, and shall report to the Medical Executive Council.

A. QA Council of the Medical Executive Council

(1) Function:

a. coordinate and evaluate the Medical Staff components of the Hospital's Quality Assurance Program;

b. conduct, coordinate and evaluate the effectiveness of special studies of the inputs, processes and outcomes of care;

c. review the credentials of all applicants and make recommendations for staff membership, and delineation of clinical privileges;

d. review periodically all information available regarding the performance and clinical competence of staff members and other Practitioners with clinical privileges and, as a result of such review, make recommendations for reappointments and renewal or changes in clinical privileges;

e. take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

f. To review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles 6, 7 and 12 of these Bylaws;

g. To make a report to the Governing Board on each applicant for Medical Staff membership or clinical privileges;

h. To review, periodically, all information available regarding the competence of Medical Staff members and, as a result of such reviews, to make recommendations for the granting of privileges, and reappointments, as provided in these Bylaws; and

i. To act upon any breach of ethics that is report to it.

(2) Composition: Voting members of the Quality Assurance Council shall consist of the Medical Staff members of the Medical Executive Council and the Vice President for Medical Affairs.

(3) Duties: The duties of the QA Council of the Medical Executive Council shall be outlined in a Quality Assurance Plan which is updated and submitted for approval by the QA Council of the Medical Executive Council and Medical Executive Council annually. The current Quality Assurance Plan shall be kept on file in the Administration Office.

(4) Meeting Requirement: The QA Council of the Medical Executive Council shall meet quarterly.

Section 12.3. Working Committees. The Medical Executive Council may designate such Working Committees as are necessary or desirable for the effective operation of the Medical Staff. Functions of the Working Committees will be outlined in the Medical Staff Operating Procedures.

Section 12.4. Committees Appointed by the Chief of Staff

A. Ethics Committee

(1) Composition: The Medical Staff shall participate in the Ethics Committee of the Community Hospitals of Indiana Medical Staff. A representative of the Hospital's Medical Staff will be appointed by the Chief of Staff and will serve a two (2) year term and may be reappointed for an unlimited number of terms. The committee shall report its activities to the Medical Executive Council, as necessary.

(2) Duties: The committee will assist Practitioners and others in making ethical decisions and discussing ethical conditions and issues, not necessarily related to professional standards or quality of medical care. The consensus of the committee is not to be considered a mandate but, instead, to be utilized in an advisory manner and for information. The overall purpose of the committee is to provide education sharing and support to Practitioners and/or nursing.

(3) Meeting Requirement: The Ethics Committee shall meet on an as needed basis.

B. Physician's Assistance Committee

(1) Composition: The Physician's Assistance Committee of the Community Hospitals of Indiana Medical Staff shall also serve as the Physician's Assistance Committee for the Hospital's Medical Staff unless otherwise directed by the Chief of Staff. The Physician's Assistance Committee shall be a peer review committee. The Chairman shall be experienced in the area of addictionology, psychiatry, or issues of physician impairment. The remaining two (2) members shall be selected by the Chairman. Additional members may be added to the committee as deemed appropriate by the committee. The committee shall report its activities directly to the Chief of Staff through written reports. Members shall be appointed or reappointed each year.

(2) Duties: This committee shall be available to assist members of the Medical Staff who are referred by the Chief of Staff or who consult with it directly at their own request for issues of impairment or potential impairment in the practice of medicine due to psychiatric, substance abuse, or physical infirmity difficulties. The committee, upon referral, will immediately assess any active danger created by the physician's potential impairment to the consumers of health care from his/her practice or under his/her direction on the Medical Staff. If the committee finds such active risk to the health care consumer exists, it may recommend suspension or, in extreme cases, immediate referral to

the state licensing board. However, if the committee does not identify such immediate risk based on the physician's impairment, and as long as the physician is fully compliant with the directives of the Physician's Assistance Committee, he/she shall be exempt from mandatory reporting through the peer review structure to the Indiana State Licensing Board. If an impaired physician cooperates fully with evaluation, treatment, rehabilitation and ongoing monitoring, successfully removing his/her impairment, he/she shall be exempt from all reporting except periodic reports as requested to the Chief of Staff concerning his/her progress. Individuals being followed in any fashion by the Physician's Assistance Committee shall be identified confidentially to the Indiana State Medical Association Physician Assistance Program.

(3) Meeting Requirement: The Physician's Assistance Committee shall meet on an as needed basis.

C. Temporary Committees. Ad Hoc Committees shall be appointed by the Chief of Staff when a matter arises which cannot be properly referred to an existing committee. These committees will report their findings to the Chief of Staff and to the Medical Executive Council.

ARTICLE 13. GENERAL MEDICAL STAFF MEETINGS

Section 13.1. Special Meetings.

A. The Chief of Staff or the Medical Executive Council may call a special meeting of the Medical Staff at any time. The Chief of Staff or the Medical Executive Council shall designate the time and place of any special meeting.

B. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active and Consulting Medical Staff not less than five (5) nor more than thirty (30) days before the date of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 13.2. Voting. Any member entitled to vote under these Bylaws shall be entitled to one (1) vote, exercisable in person or by proxy, on each matter submitted to the membership for a vote at each meeting of the membership.

Section 13.3. Voting by Proxy. A member entitled to vote at any meeting of the membership may vote either in person or by proxy. A member may appoint a proxy to vote or otherwise act for the member by signing an appointment form personally or by a duly authorized attorney-in-fact of such member. For purposes of this section, a

copy of a signed proxy that has been telecopied shall be deemed "signed" by the member. An appointment of a proxy is valid for eleven (11) months, unless a longer or shorter period is specified in the appointment form. No proxy shall vote at any meeting of members unless the appointment form designating such proxy shall have been filed with the Medical Staff Office.

Section 13.4. Quorum. The presence of fifty percent (50%) of the total membership of the Active Medical Staff, represented in person or by proxy, at any regular or special General Medical Staff meeting shall constitute a quorum for purposes of amendment of these Bylaws and the presence of thirty-five (35%) of such membership quorum for all other action.

Section 13.5. Attendance Requirements. Each member of the Active Medical Staff it required to attend the annual General Medical Staff meeting and all other regular or special General Medical Staff meetings that are held in each calendar year in person or by proxy; excuses may be submitted for 50% of the meetings. A member who is compelled to be absent from any regular or special General Medical Staff meeting shall promptly submit to the Medical Staff Office, in writing, his/her reason for such absence. Unless excused for cause by the Medical Executive Council, the failure to attend at least 50% of the annual meetings may be grounds for corrective action including revocation of Medical Staff membership. Reinstatement of Medical Staff members whose membership has been revoked because of absence from Medical Staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

ARTICLE 14. COMMITTEE MEETINGS

Section 14.1. Regular Meetings. A schedule of regular meetings of a Committee may be established by resolution of the Committee.

Section 14.2. Special Meetings. A special meeting of any Committee may be called by or at the request of the Chairman, by the Chief of Staff, or by one-third (1/3) of the Committee's then members, but not less than two (2) members.

Section 14.3. Notice of Meetings. Written or oral notice stating the place, day and hour of any special meetings or of any regular meetings shall be given to each member of the Committee not less than seven (7) days before the time of such meeting, by the person or persons calling the meeting.

Section 14.4. Quorum. A quorum is defined as a simple majority of those present. At least three (3) Active members of the Medical Staff must be present at committee meetings in order to conduct business.

Section 14.5. Manner of Action. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a Committee. Proxy voting is prohibited.

Section 14.6. Right of Ex Officio Members. Persons serving under these Bylaws as ex-officio members of a Committee shall have all rights and privileges of regular members except they shall not be eligible to vote and they shall not be counted in determining the existence of a quorum.

Section 14.7. Minutes.

A. General Minutes. Minutes of each regular and special meeting of a Committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The general minutes will also indicate that quality assurance business was discussed. The minutes shall be approved and signed by the presiding officer, and after such approval is obtained, forwarded to the Medical Executive Council. Each Committee shall maintain a permanent file of the minutes of each meeting.

B. Quality Assurance Minutes. Cases discussed and actions taken by the Committee will be recorded on a separate report from the general minutes. The Committee will maintain an ongoing log of cases reviewed and problems being addressed.

Section 14.8. Attendance Requirements

A. Membership of the Medical Staff Standing Committees and Working Committees are required to attend fifty percent (50%) of the Committee meetings, with the exception of the voting members of the Medical Executive Council and the QA Council of the Medical Executive Council. Meeting attendance requirements for the Medical Executive Council and the QA Council of the Medical Executive Council shall be seventy-five percent (75%).

B. The failure to meet the foregoing annual attendance requirements, unless excused by such Chairman for good cause shown, shall be grounds for corrective action which may include revocation of Medical Staff membership. Committee Chairmen shall report all such failures to the Medical Executive Council for action.

ARTICLE 15. IMMUNITY FROM LIABILITY

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

Section 15.1. Any act, communication, report, recommendation or disclosure with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care

facility, for the purpose of achieving and maintaining quality patient care in his or any other care facility shall be privileged to the fullest extent permitted by law.

Section 15.2. Such privilege shall extend to members of the Medical Staff and to the Governing Body, its Chief Executive Officer and his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article 15, the term, "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

Section 15.3. There shall be, to the fullest extent permitted by law, an absolute immunity from civil liability arising from any such act performed for any peer review purpose, or from any communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Section 15.4. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

A. applications for appointment or clinical privileges;
B. periodic reappraisals for reappointments of clinical privileges;
C. corrective action, including summary suspension;
D. hearings and appellate reviews;
E. medical care evaluations;
F. utilization reviews; and
G. other Hospital, or Committee activities related to quality patient care and inter-professional conduct.

Section 15.5. The acts, communications, reports, recommendations and disclosures referred to in Article 15 may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Section 15.6. In furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of the Article 15 in favor of the individuals and organizations specified in Section 15.2 hereof, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

Section 15.7. The consents, authorizations, releases, rights, privileges and immunities provided by Section 6.1 of these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and the parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article 15.

Section 15.8. All acts, communications, reports, recommendations and/or disclosures as are enumerated in this Article 15 shall be held in strictest confidence by each Medical Staff member and shall not be disclosed. Disclosure of any such confidential information by any Medical Staff member to any individual, or in any proceeding, shall be the basis for limitation and/or termination of all Medical Staff Privileges.

ARTICLE 16. POLICIES AND PROCEDURES

Section 16.1. The Medical Staff shall adopt such Policies and Procedures as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organization activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital.

Section 16.2. Such Policies and Procedures shall be a part of these Bylaws, except that they may be amended or repealed at any Medical Executive Council meeting at which a quorum is present. Such changes shall become effective subject to the approval of the Governing Body.

ARTICLE 17. AMENDMENTS TO BYLAWS

Section 17.1. These Bylaws will be reviewed at least every three (3) years for currency and compliance with all relevant state and federal statutes, and for conformity with JCAHO guidelines and/or other pronouncements by professional medical organizations on issues including, but not limited to, professional responsibility and the assessment and improvement of quality patient care.

Section 17.2. A proposed amendment to these Bylaws shall be referred to the Medical Executive Council who shall then submit the proposed amendment at any special General Medical Staff meeting. If approved at the special General Medical Staff meeting by the members entitled to vote, either in person or by proxy, the Amendments so made shall be effective subject to the approval of the Governing Body.

ARTICLE 18. ADOPTION

These Bylaws shall be initially adopted and approved by the Governing Body of the Hospital.

APPROVED by the Governing Body of the Hospital on the ___ day of ____________, 2009.

____
Secretary of the Governing Body