COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY

MEDICAL STAFF BYLAWS
RULES AND REGULATIONS

February 2016

Contents

PREAMBLE

WHEREAS, Community Hospital of Anderson and Madison County, Incorporated, is a non-profit corporation organized under the laws of the State of Indiana; and

WHEREAS, its purpose is to serve as a general acute care Hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and assume this responsibility, subject to the ultimate authority of the Hospital Board of Trustees, and that the cooperative efforts of the Medical Staff, the President and the Board of Trustees are necessary to fulfill the Hospital's obligations to its patients; and

WHEREAS, the Board of Trustees and Medical Staff of Community Hospital have constituted themselves as peer review committees under all appropriate state and federal laws and regulations. It is the goal of Article VIII of these Bylaws to secure a fair hearing for any applicant for or holder of clinical privileges who has a right to a hearing or appeal under these Bylaws, conducted in an orderly fashion with adequate notice and an opportunity to be heard. The Board and Medical Staff reserve the right to afford such a fair hearing and appeal by following the procedures in these Bylaws or any other procedures, which are essentially fair and protect the interests of the affected practitioner.

WHEREAS, it is the intent of the Medical Staff that these Bylaws comply with the spirit and intent of any and all applicable state and federal laws.

THEREFORE, the practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with the Bylaws, Rules and Regulations hereinafter stated.

DEFINITIONS

1. The terms “Medical Staff” or “Staff” mean all practitioners who through formal appointment as Staff members are thereby privileged to attend patients in Community Hospital of Anderson and Madison County, Incorporated.

2. The term “Executive Committee” means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Board of Trustees.

3. The term “President” means the individual appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.

4. The term “practitioner” means an appropriately licensed medical or osteopathic physician; dentist; or podiatrist who has surgical privileges.

5. The term “Community Hospital” or “Hospital” means Community Hospital of Anderson and Madison County, Incorporated.

6. The term “patient contact” means any physical patient contact or obtaining of a patient’s history “face to face” within the Hospital setting.

ARTICLE I: Name

The name of this organization shall be the “Medical Staff of Community Hospital of Anderson and Madison County, Incorporated.”

ARTICLE II: Purposes

The purpose of this organization shall be:

1. To endeavor that all patients admitted to or treated in any of the facilities, departments or services of the Hospital shall receive appropriate quality medical care;

2. To insure a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the 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;

3. To stimulate continuing education and research;

4. To initiate and maintain Rules and Regulations for government of the Medical Staff and through its duly elected officers and thus assure self-government;

5. To provide a means whereby problems and issues the Medical Staff with the Board of Trustees and the President may discuss concerning the Medical Staff and Hospital.

ARTICLE III: Membership

Section 1 Nature of Membership

Membership on the Medical Staff of Community Hospital 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.

Section 2 Qualifications for Membership

1. To become and remain a member of the Medical Staff, a practitioner shall be a graduate of an accredited school of medicine, dentistry or podiatry and licensed to practice medicine, dentistry or podiatry in the State of Indiana.

2. Be of known professional competence and moral integrity, and shall, except in unusual cases, reside and practice within a reasonable distance from the Hospital.

3. Have completed an approved residency program.

4. Applicants who apply for membership to Community Hospital Anderson shall be Board Certified or an active candidate in the Board Certification Process in the medical specialty acceptable to the department in which the physician is applying or be eligible to take a specialty board examination necessary to achieve certification in the specialty for which the applicant has applied as a member for the Medical Staff.

5. A practitioner who has been on the Medical Staff in good standing, continuously since December 31, 1991 shall not be required to meet or comply with either.

Section 3: Conditions and Duration of Initial Appointment

1. The Board of Trustees shall make initial appointments and reappointments to the Staff. The Board of Trustees shall act on appointments, reappointments or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws. Should the Board of Trustees wish to take the initiative of approving or refusing an appointment, it shall always advise the Executive Committee of its reason and ask for recommendations. Final responsibility for all appointments or cancellations shall rest with the Board of Trustees.

2. Initial appointments shall be for a period of not more than one (1) year. Reappointments shall be for a period of not more than two (2) Medical Staff years. For the purposes of these Bylaws, the Medical Staff year commences on the first (1st) day of January, and ends on the thirty-first (31st) day of December each year.

3. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Trustees in accordance with these Bylaws.

4. Every application for 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 patient, to abide by the Medical Staff Bylaws, Rules and

Regulations, Hospital Bylaws, to accept committee assignments, to accept consultation assignments, and to provide emergency care in accordance with the Rules and Regulations.

5. The entire Medical Staff shall impose no additional requirements for Active Staff membership or individual clinical department membership without the express Voting of such requirements.

Section 4: Staff Dues

1. The Executive Committee shall establish Staff dues each year. Dues shall be payable in January and shall be delinquent the last day of March.

2. The Medical Staff shall allow the Hospital finance department to audit the expenditures of the Medical Staff at least every two (2) years.

3. If dues are not paid by March 31, the Medical Staff Office will provide direct notification to the physician, either by phone or face-to-face contact that dues are now payable as privileges will be suspended. Failure to pay dues by June 1 will be construed as termination and shall be required to reapply for Staff membership.

Article IV: Categories of the Medical Staff

Section 1: The Medical Staff

The Medical Staff shall be divided into Emeritus, Honorary, Active (Voting and Non-Voting), Provisional, Courtesy, Consulting, Telemedicine and Credentials Only groups.

Section 2: The Emeritus Medical Staff

The Emeritus Staff shall consist of practitioners who have devoted the majority of their professional careers to Community Hospital and served with excellence prior to their retirement from active practice. The members of the Emeritus Staff shall be appointed to the Board of Trustees on the recommendation of the Staff and shall have no assigned duties. Emeritus Staff members may not vote nor hold office, serve on standing medical committees, or admit, or care for patients.

Section 3: The Honorary Medical Staff

The Honorary Staff shall consist of practitioners who are not active in the Hospital and who are honored by being appointed to this category. These may be practitioners who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community. The members of the Honorary Staff may be appointed by the Board of Trustees on the recommendation of the Staff and shall have no assigned duties. Honorary Staff members may not vote nor hold office, serve on standing Medical Staff Committees or be eligible to admit patients.

Section 4: The Active Medical Staff

The Active Medical Staff shall consist of practitioners who regularly admit patients to the Hospital, who are located closely enough to the Hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency service care and consultation assignments.

There shall be two (2) levels of Active Staff membership: Voting and Non-Voting.

1. Active Voting: Voting membership shall be granted only to members of the Active Staff who regularly attend, admit, or refer for admission at least 50% of their patients in need of Hospitalization to a Madison County Hospital; or were members of the Active Medical Staff prior to January 1, 1998. This shall be determined by affidavit every two (2) years at reappointment. Members of the Active Voting Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff committees and/or Clinical Core Groups. Meeting attendance is encouraged.

2. Active Non-Voting: These members shall have the same responsibilities as listed for Active Voting Medical Staff except that they may not vote, hold office or serve in a Voting capacity on Medical Staff committees and/or Clinical Core Groups.

Section 5: The Provisional Medical Staff

The Provisional Medical Staff shall consist of those practitioners who have met all the requirements for appointment to the Medical Staff and who are awaiting appointment to the Active Medical Staff. These shall include new appointees for a period of time sufficient to permit mutual evaluation of the desirability of regular promotion to the Active Staff and previous Active Staff members placed on Provisional status as a disciplinary measure in order to allow for reevaluation of the desirability for continued Staff appointment.

Provisional Staff members shall have admitting privileges, but shall be privileged to neither vote nor hold office. They may, however, be appointed to committees and/or Clinical Core Groups to serve as members, but not as Chairmen. Meeting attendance is encouraged. They shall be required to fulfill other duties such as Emergency Room service and consultation assignments.

Provisional Staff members shall be under the professional supervision of the appropriate Department Chief and/or Chief of Staff. Provisional Staff members are placed on monitored status to allow an assessment of the practitioner's professional abilities regarding demonstrated competence, character, and quality of medical record keeping, prior to the decision to recommend advancement to full membership. Details of the monitoring process are outlined in the Focused Professional Practice Evaluation Medical Staff Policy and Procedure and the Medical Staff Peer Review Policy and Procedure.

Annually, practitioners who have not had at least five (5) patient contacts may be requested to submit in writing why utilization of Hospital services has been minimal. The practitioner may also be requested to indicate future intent of Hospital utilization. The practitioner's response will be evaluated as his/her request for advancement is processed as to whether the practitioner is a benefit to the Hospital. The practitioner will remain in Provisional Status and under a Focused Professional Practice Evaluation until completing sufficient patient care activity to allow for adequate assessment of the practitioner's professional abilities. This will include a demonstrated competence, character, and quality of medical record keeping. This assessment must be completed prior to the decision to recommend advancement to full membership and the practitioner's transition to Ongoing Professional Practice Evaluation.

Section 6: The Courtesy Medical Staff

The Courtesy Staff shall consist of those practitioners on the Active/Provisional Medical Staff at St. Vincent's Anderson Regional or Mercy Hospital in Elwood who wish to use the facilities of Community

Hospital occasionally or whose services Active Staff members may request. They are limited to less than twenty (20) patient contacts per year unless otherwise specified by the Medical Executive Committee. Their admissions shall be limited to ten (10) per year. Members of the Courtesy Staff are not eligible to neither vote, nor hold office.

Section 7: The Consulting Medical Staff

The Consulting Medical Staff shall consist of those practitioners whose services are required for application, interpretation or analysis of tests or procedures performed on patients, which are not already provided by Active Medical Staff. The Consulting Staff will not have admitting privileges and will be involved with direct patient care only by referral of the attending physician. Members of the Consulting Staff are not eligible to neither vote nor, hold office. Meeting attendance is optional but encouraged. Members of the Consulting Staff will be subject to conditions of consultation as defined in the Rules and Regulations of these Bylaws.

Section 7a: Telemedicine Consulting Medical Staff

The Telemedicine Consulting Medical Staff shall consist of those practitioners whose services are required for application, interpretation or analysis of tests or procedures performed on patients, when requested by members of the Active Voting Medical Staff in the specialty related to the telemedicine services.

This category of privileges shall include Telemedicine privileges, which is the diagnosis and/or treatment of patients employing offsite telecommunications, including, but not limited to digital imagery, telephone, fax or television.

The Telemedicine Consulting Medical Staff will not have admitting privileges and will be involved with direct patient care only by referral of the attending Active Voting Staff member. Members of the Telemedicine Consulting Medical Staff are not eligible to vote or hold office. The Telemedicine Consulting Medical Staff will be subject to the conditions of consultation as defined in the Rules and Regulations of the Medical Staff Bylaws. They will pay dues for the equivalent number of Active or Provisional Staff physician(s) they are covering.

Section 8: Dental Staff

A. General Requirements: Privileges granted to dentists shall be based upon their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other medical and surgical privileges.

B. Oral Surgical Privileges: Surgical procedures performed by oral surgeons shall be under the overall supervision of the Surgery Department. All dental patients shall receive the same basic medical appraisal on admission as patients admitted to other surgical services. Oral Surgeons who qualify for surgical privileges shall be classified as members of the Active Medical Staff after successfully completing a provisional period, in the same manner as new physician members of the Staff. The Oral Surgeon shall be responsible for recording on the patient's chart an admitting dental history and examination with a detailed description of the examination and preoperative diagnosis, the reason for admitting the patient to the Hospital, a complete

operative report describing the procedure, reason, and results of specific actions, progress notes and a discharge summary statement.

a. Oral Surgeons with history and physical examination, and Admitting Privileges: A qualified oral surgeon may seek privileges from the Surgical Department to assume responsibility for admitting and conducting a medical history and physical examination for dental patients. These privileges will only be granted to board eligible/certified oral surgeons who have been trained in physical diagnosis. If the patient exhibits medical problems, a physician consultation is required.

b. Oral Surgeons without history and physical examination and Admitting Privileges: If an Oral Surgeon is not privileged to conduct a medical history and physical examination then, a physician member of the Medical Staff shall concur with the admission and co-admit with the Oral Surgeon, and be responsible for the initial history and physical examination and assessment of the patient's medical condition at the time of admission and shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during Hospitalization.

C. General Practice Dentistry Privileges: Dentists who do not qualify for surgical privileges may be eligible for Allied Health Care Provider status, and to see patients in the Hospital at the request of the treating physician. Such dentists may not admit or co-admit patients.

Section 9: Podiatric Staff

A. General requirements: Privileges granted to podiatrists shall be based upon their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each Podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges.

B. Podiatric surgical privileges (Category II and III Privileges): Surgical procedures performed by Podiatrists shall be under the overall supervision of the Surgery Department. All podiatric patients shall receive the same basic medical appraisal on admission as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the initial history and physical examination and assessment of the patient's medical condition at the time of admission and shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during Hospitalization. Podiatrists who qualify for surgical privileges shall be classified as members of the Active Medical Staff after successfully completing a probationary term in the same manner as new physician members of the Staff. Podiatrist members of the Medical Staff may not admit patients without the concurrence and co-admission of a physician member of the Medical Staff. The Podiatrists shall be responsible for recording on the patient's chart an admitting podiatric history and examination with a detailed description of the examination and preoperative diagnosis, a statement for the reason for admitting the patient to the Hospital rather than treating as an outpatient where appropriate, a complete operative report describing the procedure, reason, and results of specific actions, progress notes, and a discharge summary statement.

C. General Practice Podiatric Privileges (Category I): Podiatrists who do not qualify for surgical privileges may be eligible for status as Allied Health Care Providers to see patients in the

Hospital at the request of the treating physician. Such Podiatrists may not admit or co-admit patients.

Section 10: Responsibility of Co-Admitting Physicians

A physician member of the Medical Staff who co-admits a patient with an oral surgeon or podiatrist does not thereby accept responsibility for the dental or podiatric care afforded to that patient. The responsibility of a co-admitting physician shall be to supervise and monitor the medical care of the patient other than the specific oral surgical or podiatric procedures, which are to be performed.

Section 11: Procedure for Change of Status

A practitioner submitting a request for change of status within the Medical Staff, shall submit a written request to the Credentials Committee. An endorsement from the Chief of the Department to which the practitioner is assigned will be obtained and of the Department to which he requests assignment, if transfer is involved. Resignations from the medical Staff shall be accepted only if the practitioner has completed his medical records and is in good standing. Thereafter, the applications for revised appointment are to be processed in the same manner as original applicants for appointment, except that there need not be the documentation outlines in Article V.

Section 12: Credentials Only Staff

Consists of those practitioners seeking to be credentialed only. The practitioners will not have privileges to admit, discharge, care for or consult on any patient who is an inpatient. They will not attend meetings or have Voting privileges with the Medical Staff. They will be required to pay annual dues. They will go through reappointment with the other Medical Staff every two (2) years.

Section 13: Hospice Staff

The Hospice Medical Staff consist of those practitioners whose services are required for the care of a Hospice Inpatient for terminal care, pain and symptom management, or caregiver breakdown. The Hospice medical Staff shall have admitting privileges for hospice inpatients only. Members of the Hospice Medical Staff are not eligible to vote, hold office or be considered Active Medical Staff. They are obligated to pay Medical Staff dues.

Section 14: Resident Staff

Medical Students/ Residents in training in an approved ACGME/AOA program and acting under the auspices of that program will not be required to request specific privileges, unless required by the Hospital's accrediting body and/or the medical student/ resident is requesting to do a specific procedure unsupervised. They must carry out all clinical care in accordance with the written educational protocols developed by their training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to such medical students/ residents. They must also describe the requirements for oversight of medical students/ residents, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how medical students'/ residents' level of responsibility and scope of practice may expand over time and how this information will be transmitted to Staff and personnel working in the Hospital. In addition, training programs will periodically communicate with the MEC regarding the performance of its medical students/ residents

and alert it to any performance concerns or matters that may threaten patient safety. The training program must work with the MEC to assure that all supervising physicians hold privileges commensurate with their oversight activities.

Medical Students/ Residents are not considered members of the medical Staff; however the clinical faculty supervising their clinical rotation at the Hospital must be members of the Hospital's Medical Staff. Medical Students/ Residents must agree to abide by the Hospital and/or Medical Staff Bylaws, rules and regulations, and policy and procedures and by their respective residencies. Medical Students/ Residents shall not be entitled to any rights of appeal and/or review through the Hospital's peer review process.

Section 15: Research Only Staff

The Research Only Staff shall consist of practitioners seeking to be credentialed for the sole purpose of conducting clinical research. The practitioners shall be regulated and privileges limited to only research related outpatient clinical care for specific protocols. The practitioners will not have privileges to admit, discharge, care for or consult on any patient who is an inpatient. Further, the practitioners may be compensated with research funds for protocol related clinical services provided and shall not bill third payers for these services. Research Only Staff may not vote, hold office, attend meetings or serve on committees. The practitioners shall maintain licensure in the State of Indiana and liability insurance. In addition, they are required to pay annual dues and complete the reappointment process every two (2) years.

Article V: Procedure for Appointment and Reappointment

Section 1: Application for Initial Appointment

A. An application form will be sent to practitioners meeting the basic criteria for appointment. If the criteria are not met, practitioners will be notified that they do not meet the requirements for Medical Staff membership and/or privileges.

B. An application fee in the amount of $225 must be received prior to the forwarding of an application. Emergency Room Courtesy Staff will be exempt. (Other questioned circumstances will be discussed with the Credentials Committee Chairman.)

C. All applications for initial appointment to the Medical Staff shall be:

    a. signed by the applicant;

    b. shall include valid identification (i.e. birth certificate/passport);

    c. shall include delineation of Staff privileges desired by the applicant;

    d. shall provide information pertaining to previous and current involvement in all professional liability actions; shall be submitted on a form agreed upon by the Medical Staff and the Board of Trustees;

    e. the applicant's professional qualifications shall include the name of at least three (3) peers who have had extensive experience in observing and working with the applicant,

and who can provide adequate references pertaining to the applicant's professional competence and ethical character;

f. the applicant shall include information as to whether his/her membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other Hospital or health care facility, and as to whether his/her membership in local, state or national medical/dental societies have ever been terminated.

D. He/She shall also provide information pertaining to whether his/her license to practice any profession in any state or his/her narcotics license has ever been suspended or terminated, or voluntarily relinquished and any previously successful or currently pending challenges.

E. The application shall be submitted to the Medical Staff Office and forwarded for review by the Chief of the Department who will forward the application when complete to the Credentials Committee with recommendation. Upon receipt of an application, the applicant's name will be posted for Medical Staff review (and Active Staff Members of the department in which the applicant is seeking privileges will be notified), to enable members to submit any written comments to the Credentials Committee or to present oral comments at the Credentials Committee meeting prior to the Committee making a recommendation to the Executive Committee. The President, via the Medical Staff Office, will be responsible for collecting references, and providing all pertinent materials such as verification of relevant training and/or experience, current competence, licensure, malpractice insurance, drug dispensing credentials, health status, etc. The application shall be considered complete when:

a. all of the above referenced materials have been received;

b. all blanks on the application form are filled in and necessary additional explanations provided;

c. verification of the information is complete;

d. a written or electronic reference which establishes current competency and information from past hospitals and other affiliations have been received;

e. any additional information necessary to fully evaluate the application has been received;

f. queries will be made to the National Practitioner Data Bank;

g. queries will be made for Criminal Background Check;

h. query will be made to the American Medical Association;

i. query will be made to the Medical Licensing Board;

j. documentation as to the applicant's health status;

k. relevant practitioner specific data as compared to aggregate data, when available

l. morbidity and mortality data, when available;

m. any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant; and

n. query will be made to the Office of Inspector General for exclusion from government programs.

F. By applying for appointment to the Medical Staff, each applicant there signifies his willingness to appear for interviews in regard to his/her application, authorizes the Hospital to consult with members of Medical Staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his 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 professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for Staff membership, releases from any liability all representatives of the Hospital and its Staff for their acts performed 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.

G. The applicant shall be allowed to have access and encouraged to review the Bylaws, Rules and Regulations of the Medical Staff and agrees to be bound by the terms thereof as presently constituted and as amended from time to time 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 application.

Section 2: Appointment Process

A. Each department shall provide the Credentials Committee with specific, written criteria for clinical privileges. The pertinent clinical Department Chief shall, within thirty (30) days of receipt of a completed application, review the applicant's training and experience and report to the Credentials Committee whether the applicant is qualified for Medical Staff membership and/or the clinical privileges requested. In instances where the applicant is not of the same subspecialty as the Department Chief, the Department Chief will consult, if necessary, with the appropriate subspecialist. However, if such consultation is not available, further attempts (with a sub specialist outside our Staff) will be performed at the Department Chief's discretion.

B. The Credentials Committee shall meet within thirty (30) days of receipt of a Department Chief's appointment report. The Committee shall review the report and supporting documentation and submit its recommendations to the Executive Committee as to approval or denial of, Staff membership and/or clinical privileges. If the Credentials Committee requires further information, its recommendation may be deferred until receipt of the additional information.

C. At its next regular meeting after receipt of the application and the report from the Clinical Department Chief and recommendation by the Credentials Committee, the Executive Committee shall determine whether to recommend to the Board of Trustees that the practitioner be provisionally appointed to the Medical Staff that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. The

Executive Committee shall also determine in regards to any clinical privileges whether to recommend to the Board of Trustees that the requested be deferred for further consideration, or qualified by probationary conditions relating to such clinical privileges.

D. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with the subsequent recommendation for provisional, appointment with specified clinical privileges, or for rejection for Staff membership and/or clinical privileges.

E. When the recommendation of the Executive Committee is adverse to the practitioner, the Medical Staff President shall promptly forward it, together with all supporting documentation, to the Board of Trustees.

F. When the recommendation of the Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the President of the Medical Staff shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Trustees until after the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article VIII of these Bylaws.

G. If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph (D) of this Section 2. If such recommendation documentation to the Board of Trustees, but the Board of Trustees shall not take any action thereon until after the practitioner has exercised or had been deemed to have waived his right to an appellate review as provided in Article VIII of these Bylaws.

H. At its next regular meeting after receipt of a favorable recommendation, the Board of Trustees or its Executive Committee shall act in the matter. If the Board of Trustees' decision is adverse to the practitioner in respect to either appointment or clinical privileges, the CEO shall promptly notify him of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his rights under Article VIII of these Bylaws and until there has been compliance with subparagraph (I) of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where not existed before.

I. At its next regular meeting after all of the practitioners rights under Article VIII have been exhausted or waived, the Board of Trustees or its duly authorized committee shall act in the matter. The Board of Trustee's decision shall be conclusive except that the Board of Trustees may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Trustees 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 Board of Trustees shall make a decision either to provisionally appoint the practitioner to the Staff or to reject him for Staff membership. All decisions to appoint shall include a delineation of the clinical privileges, which the practitioner may exercise.

J. Whenever the Board of Trustees decision will be contrary to the recommendation of the Medical Staff Executive Committee, the Executive Committee shall appoint a hearing committee, as defined in Article VIII Section 4b for review and recommendation before making its decision final.

K. When the Board of Trustees decision is final, it shall send notice of such decision through the President to the Secretary of the Medical Staff, the Chairman of the Executive Committee, the Chief of Department concerned, and by certified mail, return receipt requested, to the practitioner.

Section 3: Reappointment Process

A. Prior to the final scheduled Board of Trustees meeting in the Medical Staff year, the clinical Department Chief shall review all pertinent information available on each practitioner scheduled for periodic appraisal, for the purpose of assessing whether the practitioner is qualified for reappointment to the Medical Staff and for the granting of clinical privileges not to exceed two (2) years, and shall transmit his/her assessment in writing to the Credentials Committee. The Chief of Staff will review all pertinent information available on each Department Chief scheduling for reappointment. The Credentials Committee shall review the request and the Department Chief's assessment and shall recommend to the Executive Committee, the practitioner's reappointment or non-reappointment, or reappointment with modification of privileges.

B. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon:

    a. the member's professional competence and clinical judgment in the treatment of patients (as indicated in part by the results or quality assessment and improvement activities);

    b. ethics and conduct;

    c. physical and mental capabilities;

    d. peer recommendations;

    e. attendance at Medical Staff meetings;

    f. timeliness and accuracy in completing medical records;

    g. compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations;

    h. cooperation with Hospital personnel;

    i. use of the Hospital facilities for Staff Member's patients;

    j. relations with other practitioners;

k. general attitude toward patients, the Hospital and the public;

l. the practitioner must provide evidence of current health status and in instances of doubt the practitioner is required to submit any reasonable evidence that may be required by the Medical Executive Committee;

m. consideration will be given to information obtained from the National Practitioner Data Bank;

n. the practitioner must provide evidence of completing a minimum of 50 credits of continuing medical education every two (2) years;

o. the practitioner shall ensure that a copy of his/her current credentials (licensure, malpractice insurance, federal and state narcotics licensures) have been provided to the Medical Staff Office (verification will be obtained from the primary source); and

p. the practitioner shall also provide information pertaining to: currently pending challenges to any licensure/registration or voluntary relinquishment; involvement in a professional liability action; and voluntary or involuntary termination of membership and/or limitation, reduction, or loss of clinical privileges at another hospital since the previous reappointment.

C. At the time of reappointment, if a practitioner has not had at least five (5) patient contacts in the two (2) years under review, he will be responsible to provide affirmative information from another hospital(s) regarding a current evaluation of his practice, such that the Medical Staff may have a qualitative basis for reappointment. In addition, he may be requested to submit in writing why the utilization has been minimal and to indicate the future intent of Hospital utilization. The practitioner's response will be evaluated as his request for reappointment is processed, as to whether the practitioner is a benefit to the Hospital. Failure to submit the requested information will result in non-reappointment.

D. Prior to the final scheduled Board of Trustees meeting in the Medical Staff year, the Executive Committee shall make written recommendations to the Board of Trustees, through the President, concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner then scheduled for periodic reappraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

E. Thereafter, the procedure provided in Section 2 of this Article V relating to recommendations on applications for initial appointment shall be followed.

Section 4: Delineation of Privileges

A. Determination of initial privileges and extension of further privileges shall be based upon an applicant's training, experience and demonstrated competence. The National Practitioner Data Bank will be queried anytime a practitioner is adding or expanding his/her privileges.

B. Privileges are delineated in the categories of Psychiatry, OB/GYN, Family Practice, Anesthesiology, Emergency Medicine, Pediatrics, Medicine, Radiology, General Surgery, Plastic

Surgery, ENT, Urology, Ophthalmology, Orthopedics, Pathology, Podiatry, and Dental. The Credentials Committee as well as the Department Chief will review practitioners with current privileges whose request consists of delineation of privileges for new procedures.

Section 5: Leave of Absence

A. Leave of Absence: At the recommendation of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence for a maximum period of twelve (12) months from the Staff upon submitting a written request to the Medical Executive Committee and with approval by the Board, stating the approximate period of leave desired and the purpose thereof. During the period of the leave, the Member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Staff.

B. Termination of Leave:

   a. At least thirty (30) days prior to the termination of the leave of absence the Medical Staff member may request reinstatement of privileges by submitting written notice to the Medical Executive Committee.

   b. The Medical Staff member shall submit a summary of relevant activities during the leave to the Credentials Committee for review and recommendation to the Medical Executive Committee.

   c. The Medical Staff member shall submit a statement regarding his ability to return to medical practice including any restrictions, to the Medical Executive Committee from his treating physician and other appropriate medical care providers for leave of absence related to a medical, surgical or psychiatric condition including drug and/or alcohol addiction.

   d. If the Medical Staff member's leave of absence was related to drug and/or alcohol addiction and he had completed or is actively participating in the Indiana State Medical Association's Physicians Assistance Program, he must submit a letter to the Medical Executive Committee from the ISMA's Physicians Assistance program director or his representative stating the Medical Staff member is in compliance with the program and is medically clear to return to medical practice in lieu of statement referred in biii.

   e. The Medical Executive Committee shall make a recommendation to the Board of Trustees concerning the reinstatement of the Medical Staff member's privileges.

C. Failure to Request Reinstatement: Failure, without good cause, prior to termination of the leave, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives.

Article VI: Clinical Privileges

Section 1: Clinical Privileges Restricted

A. Every practitioner practicing at this Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Board of Trustees, except as provided in Sections 2 and 3 of this Article VI.

B. Every initial application for Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including an appraisal by the clinical Department Chief in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.

C. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided and/or review of the records of patients treated in this or other Hospitals and/or review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

D. Requests for additional clinical privileges must be in writing and the applicant's relevant recent training and/or experience must be stated. Such requests should be processed in the same manner as applications for initial appointment.

E. Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during Hospitalization.

Section 2: Temporary Privileges

A. Temporary clinical privileges may be granted by the Chief Executive Officer of the Hospital or his/her designee after a favorable recommendation has been made by the Chairman of the Credentials Committee, the President of the Medical Staff and the Chief of the Department on an application which has been completed. The applicant's Department Chairman must recommend the delineation of privileges requested by the applicant. Temporary clinical privileges may be granted for a period not to exceed one hundred twenty (120) days as long as 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 or his/her designee for the care of a specific patient to the practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph A of this Section 2,

provided that there shall first be obtained such practitioner's acknowledgment that he has had the Medical Staff Bylaws and Rules and Regulations made available to him for review and that he agrees to be bound by the terms thereof in all matters relating to his temporary clinical privileges. Such temporary privileges shall be restricted to the care/treatment of the requested patient. Such practitioner shall be required to apply for membership on the Medical Staff before being permitted 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 one hundred twenty (120) days, providing all his/her credentials have first been approved by the Department Chairman concerned and by the President of the Medical Staff. If the locum tenens privileges must be extended beyond one hundred twenty (120) days, the physician must apply for Staff membership.

D. The Department Chief concerned on any practitioner granted temporary privileges may impose special requirements of supervision and reporting. The Chief Executive Officer and Chief of Staff shall immediately terminate temporary privileges upon notice of any failure by the practitioner to comply with such special conditions.

E. The Chief Executive Officer may at any time, upon the recommendation of the President of the Medical Staff or the Department Chief concerned, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under his care in the Hospital. However, where it is determined that the life or health of such 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 2 A of Article VII of these Bylaws, and the same shall be immediately effective. The appropriate Department Chief, or in his responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

F. The practitioner is not entitled to the procedural rights afforded by these Bylaws in Article VII because a requisition for temporary clinical privileges is refused or because all or any portion of the temporary clinical privileges are terminated or suspended.

Section 3: Emergency Privileges

In the case of emergency, any practitioner, to the degree permitted by his license regardless of service or Staff status or lack of it, shall be permitted and assisted 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 does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. 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.

Section 4: Medico-Administrative Physicians

Medical Staff members who have contractual or employment relationships with the Hospital will be governed by the provisions of their contracts or terms of employment as well as by the Medical Staff Bylaws and the Hospital Bylaws. Termination of Medical Staff privileges will be subject to the same due process provisions as specifically designated in these Bylaws for any other member of the Medical Staff.

Article VII: Corrective Action

Section 1: Procedure

A. Whenever the activities or professional conduct of any practitioner with clinical privileges is considered to be lower than the standards of the Medical Staff or to be disruptive to the operations of the Hospital, or where there are questions of mental or physical competency, or where there is other improper conduct, a request for corrective action against such practitioner may be initiated by any Active Staff Member or by the President of the Hospital. All requests for corrective action shall be made to the Chief of Staff. The Chief of Staff may, at his/her sole discretion, or in his/her absence or if the complaint is about the Chief of Staff, the President, Vice President, or Secretary (in that order) may request the physician members of the Clinical Core Group, or the Department in which the practitioner is a member, to perform an informal review of the practitioner's activities or conduct, before a formal investigation is instigated. No informal review shall constitute a hearing, nor shall the procedural rules provided in these Bylaws with respect to hearings apply thereto, nor shall the practitioner or the Hospital be entitled to have an attorney present. The practitioner shall have the right to present his information to the informal review body at the appropriate time. The only actions, which may result from an informal review, are those that do not result in a reduction or suspension of clinical privileges. If the Clinical Core Group or Department determines that a reduction or suspension of clinical privileges may be appropriate or that the informal review is otherwise inadequate to resolve the matter, it shall refer the matter to the Executive Committee for formal investigation.

B. Whenever the Executive Committee determines that a formal investigation is necessary, including but not limited to situations where corrective action could be a reduction or suspension of clinical privileges, the President of the Medical Staff shall immediately appoint an Ad Hoc Committee to investigate the matter.

C. Within thirty (30) days after the Ad Hoc Committee's receipt of the request for corrective action, it shall make a report of its investigation to the Executive Committee. Prior to the making of such report the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Ad Hoc Committee. At such interview, he shall be informed of the general nature of the charges against him, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto, and neither party shall be entitled to have an attorney present. A record of such interview shall be made by the Ad Hoc Committee and included with its report to the Executive Committee.

D. Within ten (10) days following receipt of a report from the Ad Hoc Committee and following its investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto, and neither party shall be entitled to have an attorney present. A record of such appearance shall be made by the Executive Committee.

E. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended or revoked.

F. Any recommendation by the Executive Committee shall promptly notify the President of the Hospital in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the President of the Hospital fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article V, Section 2, and Article VII if applicable, of these Bylaws.

Section 2: Summary Suspension

A. The Chief of Staff and one of the other three elected officers of the Medical Staff shall have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital or when failure to take action may result in imminent danger to the life or health of any patient, prospective patient or other persons, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition. Failure to respond to an investigation as outlined in the policy and procedures from the Peer Review Committee in an appropriate time would also result in a summary suspension. In the absence of the Chief of Staff, any two of the remaining three officers may initiate the steps above. In the absence of at least three elected officers, the remaining officer and one elected Medical Staff leader on the Medical Staff Executive Committee may act. In the absence of all four of the elected Medical Staff officers, any two elected Medical Staff leaders on the Medical Staff Executive Committee may act.

B. Within fifteen (15) calendar days after such summary suspension has been imposed, a meeting of the officers of the Medical Staff shall be convened to review and consider the action. If requested by officers of the Medical Staff, the practitioner shall attend and make a statement concerning the issues under investigation, on such terms and conditions as the officers of the Medical Staff may impose, although in no event shall such meeting constitute a hearing, not shall the procedural rules provided in these Bylaws with respect to hearings apply thereto, nor shall either party be entitled to have an attorney present. The officers of the Medical Staff may modify, continue or terminate the summary suspension, but in any event it shall furnish the

practitioner with notice of their decision within the same fifteen (15) day period. The decision of the officers of the Medical Staff to summarily 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 practitioner.

C. A practitioner whose clinical privileges have been summarily suspended and such suspension has been upheld by the officers of the Medical Staff shall be entitled to request that the Executive Committee of the Medical Staff hold a hearing on the matter within such reasonable time period thereafter as the Executive Committee may be convened in accordance with Article VIII of these Bylaws.

D. The Executive Committee may recommend modifications, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article VIII, be entitled to request an appellate review by the Board of Trustees, but the terms of the summary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision thereon by the Board of Trustees.

E. Immediately upon the imposition of a summary suspension, the Chairman of the Executive Committee, Chief of Staff, or responsible Departmental Chief shall have authority to provide for alternative medical coverage for the patients of suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 3: Automatic Suspension

A. A temporary suspension in the form of withdrawal of a practitioner's admitting and consulting Staff privileges (including the writing of orders and assisting in elective surgeries), effective until medical records are completed, shall be imposed automatically after:

   a. Failure to complete medical records within ten (10) days following notification of incomplete records.

   b. Failure to complete history and physicals within twenty-four (24) hours of admission for acute care for five (5) patients in any calendar quarter.

When a practitioner has no Medical Staff privileges, his name will not appear on any patient chart.

B. Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, or placing him upon probation, shall automatically suspend all of his Hospital privileges.

C. It shall be the duty of the President of the Medical Staff and/or Chief of Staff to cooperate with the President of the Hospital in enforcing all automatic suspensions.

D. Repeated suspensions due to failure to complete medical records within the time frames specified above shall result in full complete termination of all Medical Staff privileges. Under the terms and understanding of these Bylaws, Rules and Regulations, "repeated" is interpreted

to mean four (4) or more suspensions within the calendar year of January 1 through December 31. Staff members having their privileges terminated under this Article VII, Section 3, shall be required to reapply for Staff membership and are subject to the rights and regulations contained herein.

E. A practitioner's Medical Staff privileges may be limited, up to and including full and complete termination, as determined by the Medical Executive Committee, upon the occurrence of any of the following:

   a. exclusion or suspension under a Federal or State healthcare program, including but not limited to Medicare and Medicaid (provided that a voluntary decision by the practitioner not to participate in a Federal or State healthcare program does not constitute and exclusion); or

   b. Within thirty (30) days after receipt of notice of the occurrence of any such events with respect to a practitioner, the Medical Executive Committee shall meet to consider what limitations to impose (if any) on the practitioner's Medical Staff privileges. The practitioner shall be given an opportunity to meet with the Medical Executive Committee and to provide information in a manner and upon such terms, as the Medical Executive Committee deems appropriate. The meeting of the Medical Executive Committee shall not constitute a "hearing" as that term is used in Article VIII, nor shall practitioner be entitled to have an attorney present or to present witnesses. In the event of a reduction or termination of a practitioner's privileges, the practitioner shall have the procedural rights provided in Article VIII of these Medical Staff Bylaws.

Article VIII: Hearing and Appellate Review Procedure

Section 1: Right to Hearing and Appellate Review

A. When any practitioner receives notice of a recommendation of the Medical Staff Executive Committee that, if ratified by decision of the Board of Trustees, will adversely affect his or her appointment to or status as a member of the Medical Staff or his or her exercise of clinical privileges, he or she shall be entitled to a hearing before an Ad Hoc Committee appointed by the Executive Committee of the Medical Staff, subject to veto of the President of the Hospital or Chairman of the Board. If the recommendation of the Executive Committee or Board of Trustees following such hearing is still adverse to the affected practitioner, he or she shall then be entitled to an appellate review by the Board of Trustees before the Board of Trustees makes a final decision on the matter.

B. When any practitioner receives notice of a decision by the Board of Trustees that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by a committee appointed by the Board of Trustees, and if such hearing does not result in a favorable recommendation, to an appellate review by the Board of Trustees, before the Board of Trustees makes a final decision on the matter.

C. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected practitioner is accorded all rights to which he is entitled.

D. Notice of Proposed Adverse Action:

a. In any potential adverse action, the President of the Medical Staff shall be responsible for giving prompt written notice (within ten (10) days) to the affected practitioner of the proposed adverse action and of the practitioner's rights to a hearing or an appellate review, by certified mail, return receipt requested or by personal delivery. Such notice shall contain the following information:

i. That the practitioner review action has been proposed to be taken concerning the practitioner;

ii. The reasons for the proposed action including representative records and/or incident or committee reports if known at the time;

iii. That any hearing must be requested within thirty (30) days;

iv. That an expedited hearing date may be requested by a practitioner under suspension;

v. A summary of the practitioner's rights.

Section 2: Request for Hearing

A. In all cases in which any applicant for membership has been recommended by the Medical Staff for denial, the President of the Medical Staff shall be responsible for giving prompt written notice (within ten (10) days) of an adverse recommendation to that applicant by certified mail, return receipt requested.

B. In all cases in which the practitioner has been recommended by the Medical Staff for adverse action, the applicants may, within thirty (30) days of receipt of notice of such denial, request in writing a hearing before an Ad Hoc committee.

C. The failure of a practitioner to request a hearing to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such appellate review on the matter.

D. When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing committee appointment by the Board of Trustees, the same shall thereupon become and remain effective against the practitioner pending the Board of Trustees decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Board of Trustees, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of

the Board of Trustees provided in Section 7 of this Article VIII. In either of such events, the President of the Hospital shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

Section 3: Notice of Hearing

A. Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or the Board of Trustees, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the practitioner of the time, place, and date so scheduled by certified mail, return receipt requested. The hearing date shall be not more than thirty (30) days from the date of receipt of the request for hearing provided, however, that a hearing for a practitioner which is under suspension which is then in effect shall be held as soon as arrangements may reasonably be made, but not later than fifteen (15) days from the date of receipt of such practitioner's request for hearing.

B. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision; and a list of witnesses (if any) who are expected to testify at the hearing on behalf of the Professional Review Committee or Hospital.

C. The Ad Hoc Committee shall appoint a date, time and place for the exchange of witness lists and copies of exhibits on both sides. Any witness not then listed and any exhibit not provided may in the discretion of the committee be excluded from the hearing.

D. All material contained in a practitioner's credentials and/or personal file shall be part of the hearing record, and the practitioner shall have the right to have a copy of all such material in advance of the hearing.

Section 4: Composition of Hearing Committee

A. The Ad Hoc Committee shall be appointed by the Executive Committee of the Medical Staff subject to veto by the President of the Hospital or the Chairman of the Board and shall be comprised of not less than five (5) physicians not in direct economic competition with the affected practitioner and who have had no prior involvement with the matter. The members of the Committee shall designate one of the members so appointed as Chairman. No Staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

B. When a hearing related to an adverse decision of the Board of Trustees that is contrary to the recommendation of the Executive Committee, the Executive Committee of the Medical Staff shall appoint a hearing committee to conduct such hearing and shall designate one of the members of this committee as Chairman. Four (4) representatives from the Medical Staff shall be included on this committee, as well as two (2) members of the Board of Trustees.

Section 5: Conduct of Hearing

A. There shall be at least a majority of the members of the hearing committee present when the hearing takes place and no member may vote by proxy.

B. An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Committee, and may be accomplished by use of a court reporter, electronic recording unit, and detailed transcription or by the taking of adequate minutes.

C. The personal presence of the practitioner for whom the hearing has been scheduled shall be required unless he has waived such appearance to accept the adverse recommendation/decision involved.

D. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

E. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his or her local professional society, or by an attorney at his/her own expense. +

F. The Chairman of the hearing committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

G. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely on the duct of serous affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

H. The affected practitioner shall have the following rights:

    a. Call and examine witnesses

    b. Introduce written evidence

    c. Cross-examine any witness on any matter relevant to the issue of the hearing

    d. Challenge any witness and to rebut any evidence

    e. Submit a written statement at the close of the evidence

    f. Have a copy of the record of the proceedings upon payment of any reasonable charge associated with the preparation thereof

g. To receive a copy of the written findings and recommendations of the hearing committee

If the practitioner does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

I. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, neither the affected practitioner, nor the Executive Committee of the Medical Staff or the Board of Trustees, shall be represented at any phase of the hearing procedure by an attorney at law unless the hearing committee, in its discretion, permits both sides to be represented by counsel. The foregoing shall not be deemed to deprive the practitioner, the Executive Committee of the Medical Staff, or the Board of Trustees, of the right to legal counsel in connection with preparation for the hearing or for a possible appeal; and if a hearing officer is utilized, he may be an attorney at law.

J. The hearing may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

K. Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Board of Trustees, whichever initiated the adverse recommendation of the Executive Committee or decision of the Board of Trustees. Thereafter, the procedure to be followed shall be as provided in Section 2 of article V of these Bylaws.

Section 6: Appeal to the Board of Trustees

A. Within seven (7) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he may, by written notice to the Board of Trustees delivered through the President by certified mail, return receipt requested, request an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

B. If such appellate review is not requested within seven (7) days, the affected practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this article VIII.

C. Within ten (10) days after receipt of such notice of request for appellate review, the Board of Trustees shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall through the President, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the notice of

request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may responsibly be made, but not more than fifteen (15) days from the date of receipt of such notice.

D. The appellate review shall be conducted by the Board of Trustees or by a duly appointed appellate review committee of the Board of Trustees of not less than five (5) members.

E. The affected practitioner shall have access to the report and record (and transcription, if any) of the Ad Hoc Committee and all other material, favorable or unfavorable that was considered in making the adverse recommendation or decision against him. An opportunity to submit a written statement in his own behalf, in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board of Trustees through the President by certified mail, return receipt requested, at least three (3) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the Chairman of the hearing committee appointed by the Board of Trustees, and if submitted, the President shall provide a copy thereof to the practitioner at least three (3) days prior to the date of such appellate review by certified mail, return receipt requested.

F. The Board of Trustees or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statement submitted pursuant to subparagraph (E) of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body. The Executive Committee or the Board of Trustees, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.

G. New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board of Trustees or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

H. If the appellate review is conducted by a committee of the Board of Trustees, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board of Trustees affirm, modify or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve the disputed issues. Within ten (10) days after receipt of such recommendation after referral, the committee shall make its recommendation of the Board of Trustees as above provided.

I. The appellate review shall not be deemed concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by a committee of the Board of Trustees duly authorized to act may take the Hospital Bylaws, all action required of the Board of Trustees.

Section 7: Final Decision by Board of Trustees

A. Within thirty (30) days after the conclusion of the appellate review, the Board of Trustees shall make its final decision in the matter and shall send notice thereof to the Executive Committee, and, through the President, to the affected practitioner, by certified mail, return receipt requested. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last such recommendation, the Board of Trustees shall refer the matter to the Joint Conference Committee for further review and recommendation within thirty (30) days, and shall include in such notice of its decision a statement that a final decision will not be made until the Joint Conference Committee's recommendation, the Board of Trustees shall make its final decision with like effect and notice as first above provided in this Section 7.

B. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee of the Medical Staff, or by the Board of Trustees, or by a duly authorized committee of the Board of Trustees, or by both.

C. In compliance with any and all applicable state and federal laws, the President of the Hospital shall report to the Indiana Medical Licensing Board and to the secretary of Health and Human Services or designated agency any final, substantive adverse action taken by the governing body. Such report shall also be made if the practitioner voluntarily resigns while under investigation by the Hospital relating to possible incompetence or improper professional conduct.

ARTICLE IX: OFFICERS

Section 1: Officers of the Medical Staff

A. The officers of the Medical Staff shall be:

a. President

b. Vice President

c. Secretary-Treasurer

d. Chief of Staff

e. Vice Chief of Staff (not included in "Chain of Command")

Section 2: Qualifications of Officers

Officers must be members of the Active Voting Medical Staff, in good standing, a minimum of two (2) years at the time of nomination and election, and 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 3: Election of Officers

A. Officers shall be elected bi-annually at the September meeting of the General Medical Staff. Only members of the Active Voting Medical Staff shall be eligible to vote.

B. The Vice President shall succeed to the office of President at the expiration of the President's term, providing the President does not seek re-election.

C. The Vice Chief of Staff shall succeed to the office of Chief of Staff at the expiration of the Chief of Staff's term.

D. At this meeting officers will be elected to the office of Chief of Staff at the expiration of the Chief of Staff's term.

E. Nominations from the floor from Active Voting members of the Medical Staff shall be in order.

F. Election shall be conducted by mail ballot following this annual meeting. The Medical Staff Coordinator will receive sealed ballots. They will be opened and tallied by a committee comprised of the President of the Medical Staff and the Chief of Staff. Ballots will be recast for all elections of officers which result in a tie. Should the tie continue, it shall be decided by a coin toss.

G. Results of the election will be posted.

Section 4: Term of Office

All officers and members-at-large shall serve two (2) year terms from January 1 through December 31 of the Medical Staff year or until a successor is elected. They shall not serve for more than two (2) consecutive two (2) year terms.

A. Chief of Staff: Shall be responsible for the functioning of the clinical organization of the Hospital and shall keep careful supervision over all the clinical work done in the Hospital. The Chief of Staff shall present the views, policies, needs, and grievances of the Medical Staff to the President of the Medical Staff. Shall be an ex-officio member of all committees with vote. The Department Chiefs shall be responsible to the Chief of Staff for the functioning of their departments. The Chief of Staff shall also serve as a member of the Credentials Committee.

B. Immediate Past Chief of Staff: Shall be responsible for being the Chairman of the Credentials Committee (and therefore an ex-officio member of the Executive Committee), and Chairman of the Nominating Committee, but will not be assigned to any other committees, or Medical Staff responsibilities.

C. Vice Chief of Staff: Shall be responsible for covering the duties of the Chief of Staff when the Chief of Staff is unavailable. Shall be a member of the Medical Executive Committee, the Peer Review Committee and the Quality of Care Committee. Will be nominated and elected at the September General Staff Meeting on even years. This position is not considered an Officer in the "Chain of Command".

Section 5: Vacancies in Office

The Executive Committee shall fill vacancies in office during the Medical Staff year, except for the President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President shall serve out the remaining term.

Section 6: Duties of Officers

A. President of the Medical Staff: Shall serve as the Chief Administrative Officer of the Medical Staff:

   a. Call and preside at all General Medical Staff and Executive Committee meetings;

   b. Be an ex-officio member of all committees;

   c. Appoint all standing committees and Clinical Core Groups except the Executive Committee and Quality of Care Committee;

   d. Designate the Chairman/Co-leader of the committees/Clinical Core Groups appointed;

   e. Act in coordination and cooperation with the President in all matters of mutual concern within the Hospital;

   f. Be responsible on the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

   g. Receive and interpret the policies of the Board of Trustees on the performance and maintenance of quality with respect of the Medical Staff's delegated responsibility to provide medical care;

   h. Be the spokesman for the Medical Staff in its external professional and public relations;

   i. Alternate to the Disaster Chief.

B. Vice President: In the absence of the President of the Medical Staff, he shall assume all the President's duties and have all his authority. He shall be a member of the Medical Executive Committee. He shall also be expected to perform such duties as may be assigned to him by the President of the Medical Staff. He shall also serve as Chairman of the Bylaws Committee. He shall automatically succeed the President when the latter fails to serve for any reason.

C. Treasurer: Shall balance the finances quarterly and report to the Medical Staff twice yearly at the General Medical Staff Meetings and write checks as needed.

D. Chief of Staff: Shall be responsible for the functioning of the clinical organization of the Hospital and shall keep careful supervision over all the clinical work done in the Hospital. The Chief of Staff shall present the views, policies, needs, and grievances of the Medical Staff to the Board of Trustees and President. Shall be an ex-officio member of all committees with vote. The Department chiefs shall be responsible to the Chief of Staff for the functioning of their departments. The Chief of Staff shall also serve as a member of the Credentials Committee and act as the Disaster Chief.

E. Immediate Past Chief of Staff: Shall be responsible for being the Chairman of the Credentials Committee (and therefore an ex-officio member of the Executive Committee), and Chairman of the Nominating committee, but will not be assigned to any other committees, or Medical Staff responsibilities.

Section 7: Removal from Office

Removal of a Medical Staff Officer may be effected by a two-thirds (2/3) majority vote by secret ballot of the members in good standing of the Active Voting Medical Staff, such vote being taken at a special meeting called for that purpose or at a General Medical Staff Meeting where there is a quorum present. Such a special meeting may be called by a majority vote of the Medical Staff Executive Committee or by a petition signed by at least twenty percent (20%) of the Active Voting members of the Medical Staff. The designation of the time and place for such a special meeting shall be governed by the procedures set forth in Article XII Section 3, 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, but are not limited to:

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/or

C. Conflict of interest.

Article X: Clinical Departments

Section 1: Organization

Each department shall be organized as a separate part of the Medical Staff and shall have a Department Chief who shall be responsible for overall supervision of the clinical work within his department.

Section 2: Types of Services

The number and types of services and departments may be determined and altered by the Executive Committee and shall be according to the size and needs of the Hospital and its Staff. Departments may be increased or decreased in number or subdivided into sections as the need arises, as long as the number of members in the department is three (3) or more.

The Medical Staff shall be divided into the following three (3) departments:

A. Primary Care
    a. Family Medicine
    b. General Internal Medicine
    c. Pediatrics
B. Medical Care
    a. Emergency Medicine
    b. Psychiatry
    c. Medicine
        i. Cardiology
        ii. Critical Care
        iii. Dermatology
        iv. Endocrinology
        v. Gastroenterology
        vi. Hematology/Medical Oncology
        vii. Infectious Disease
        viii. Nephrology
        ix. Neurology
        x. Pulmonology
        xi. Physical Medicine & Rehab
        xii. Rheumatology
        xiii. Radiation Oncology
        xiv. Sports Medicine
C. Surgical Care
    a. Anesthesiology
    b. OB/GYN

c. Radiology

d. Surgery

i. ENT

ii. General Surgery

iii. Ophthalmology

iv. Orthopedics

v. Oral Surgery

vi. Pathology

vii. Plastic Surgery

viii. Podiatry

ix. Urology

x. Vascular Surgery

xi. Neurosurgery

Section 3: Qualifications, Selection, & Tenure of Department Chiefs & Section Representative

A. Each Chief shall be Board Eligible/Certified by an appropriate specialty board, or affirmatively establishes, through the privilege delineation process, that the person possesses comparable competence.

B. Each Chief shall be elected by the members of the department to two (2) year terms. Term of office shall not exceed two consecutive two (2) year terms.

C. Removal of a Chief during his terms of office may be initiated by a two-third (2/3) majority vote by all Active Voting Medical Staff members of the department, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the Board of Trustees.

D. Section Representatives will be determined by the members of the section for a two (2) year term.

Section 4: Functions of Department Chiefs

Each Chief shall:

A. Be accountable for all professional and administrative activities within his department;

B. Be a member of the Executive Committee, giving guidance on the overall policies of the Hospital and making specific recommendations and suggestions regarding his own department in order to assure quality patient care;

C. Maintain continuing review of the professional performance of all practitioners with clinical privileges in his department and report regularly thereon to the Executive Committee, including supervision of members who are under temporary or provisional privileges.

D. Appoint a departmental committee, if desired, to conduct specific duties/investigations;

E. Be responsible for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within the department;

F. Be responsible for implementation within his department of actions taken by the Executive Committee of the Medical Staff;

G. Assist the Credentials Committee by submitting his assessment concerning the Staff classification, appointment, reappointment, and the delineation of clinical privileges for all practitioners in the department;

H. Be responsible for the teaching, education and research programs in his department;

I. Participate in every phase of administration of his department through cooperation with the Nursing Service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

J. Investigate complaints made by the Medical Staff and Executive Committee;

K. Investigate history and prior work performance of Medical Staff applicants;

L. Recommend to the Medical Staff the criteria for clinical privileges in the department;

M. Identify the type and scope of services required by patients of their department.

Section 5: Functions of Departments

A. Each clinical department shall establish its own criteria consistent with the policies of the Medical Staff and of the Board of Trustees, for granting of clinical privileges and for the holding of office in the department.

B. Each department shall be responsible for a review and analysis on a peer-group basis of the clinical work of the department when the Chief of the department, committees and/or Clinical Core Groups refers issues to it.

Section 6: Assignment to Departments

The Executive Committee shall, after consideration of the recommendation from the Credentials Committee, recommend initial assignment for all Medical Staff members and for all other practitioners with clinical privileges to the appropriate department.

Section 7: Clinical Privilege in Other Departments

Although practitioners may be members of only one Medical Staff department, they may have clinical privileges in one or more departments in accordance with his/her Board Eligibility/Certification, additional education/training, experience and demonstrated current competence. They shall be subject to all rules of such departments and to the jurisdiction of each Department Chief in which they have privileges.

Section 8: Meetings

A. A schedule of meeting dates shall be drawn up at the beginning of each year and printed and circulated to the entire Medical Staff.

B. Written minutes of all department meetings shall be considered peer review and maintained as a part of the records of the Medical Staff. A record of attendance shall be kept. A report of each department meeting shall be submitted to the Executive Committee.

C. Minutes are not required for section meetings unless departmental issues are being discussed (e.g. peer review).

Section 9: Continuing Education Requirements

Each member of the Medical Staff must obtain 50 credits of continuing medical education every two (2) years and provide evidence of such education at the time of reappointment. All Medical Staff members are encouraged to participate in Basic Cardiopulmonary Resuscitation training.

Article XI: Committees/Clinical Core Groups

Section 1: Executive Committee

A. Composition: The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the Chiefs of the three (3) clinical departments, the ten (10) section representatives, the Chief Pathologist, the Chairman of the Credentials Committee, the Director of Critical Care, a representative of the Infection Control/Pharmacy & Therapeutics Clinical Core Group, a Hospitalist, and two (2) members of the Active Medical Staff elected by the Active Medical Staff. Non-Voting, ex-officio members include the President of the Hospital or his representative and other administrative personnel as deemed necessary. The Chairman of the Executive Committee is the President of the Medical Staff.

B. Duties: The duties shall be:

   a. To represent and to act on behalf of the Medical Staff. Routine affairs of the Medical Staff will be handled by the Executive Committee, and each important decision communicated to the Staff for action by letter or under extreme conditions by a Special Medical Staff Meeting (Article XII, Section 3);

   b. To coordinate the activities and general policies of the various departments;

   c. To receive and act upon departmental, committee and/or Clinical Core Group reports;

d. To implement policies of the Medical Staff not otherwise the responsibility of the departments;

e. To provide liaison between Medical Staff and the President and the Board of Trustees;

f. To recommend action to the President on matters of a medico-administrative nature;

g. To make recommendations on Hospital management matters to the Board of Trustees through the President;

h. To fulfill the Medical Staff's accountability to the Board of Trustees for the medical care rendered to patients in the Hospital;

i. To ensure that the Executive Committee is kept abreast of the accreditation standards and informed of the accreditation status of the Hospital;

j. To review the credentials of all applicants and to make recommendations for Medical Staff membership, assignments to department and delineation of clinical privileges;

k. To review periodically all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations to the Board of Trustees for reappointments and renewal or changes in clinical privileges. In addition, the Committee provides oversight to the Medical Staff performance measurement, assessment and improvement activities whether accomplished through a Clinical Core Group or other avenue of improvement;

l. To 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, or recommendation to the Board of Trustees concerning termination of Medical Staff membership, when warranted;

m. The Executive Committee shall have the power to fill vacancies occurring in its membership during the period of the calendar year;

n. To meet and represent the Medical Staff as a whole in those months when the general Medical Staff does not meet;

o. To organize the Medical Staff's quality assessment and performance improvement activities by establishing mechanisms designed to conduct, evaluate, and revise such activities in accordance with the Hospital's Plan for Improving Organizational Performance (see Plan for details);

p. To develop and approve guidelines for Clinical Core Groups.

C. Meetings: The Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

Section 2: Quality of Care Committee

A. Composition: The Quality of Care Committee shall consist of the President of the Corporation, five (5) members of the Medical Staff of the Corporation, the Director of Quality Resources of the Corporation and at least five (5) members appointed by the Board of Trustees, three (3) of whom shall be members of the Board of Trustees. The Chairman of the Board shall designate the chairman of the committee from among the members appointed by the Board of Trustees. The Medical Staff members shall be designated according to the Bylaws of the said Medical Staff. Senior leaders of the Corporation may be present during the meetings of the Quality of Care Committee to provide input and a forum for the Corporation, the Medical Staff and the senior leaders.

B. Duties: The Quality of Care Committee shall:

   a. Act as a medical-administrative liaison committee;

   b. Review in-depth and oversee the Organizational Performance Improvement and Safety Plan ("PI Plan") which among other matters provides a framework for designing, measuring, assessing and continuously improving the care and services provided;

   c. Submit reports to the Board of Trustees regarding findings of the various PI reports, results of the annual PI program evaluation and any revisions to the PI Plan;

   d. Submit reports to the Board of Trustees on outcomes of safety and quality;

   e. Serve as a forum for the Board of Trustees, senior leaders, and leaders of the Medical Staff to communicate with each other on the issues of quality and safety;

   f. Make recommendations to the Board of Trustees, the Medical Staff and/or the President on matters referred to it by the Board of Trustees, the Medical Staff or the President or on matters investigated upon its own motion;

   g. Function as the means by which the Board of Trustees will be kept advised of recommendations emanating from the Medical Staff with respect to patient care evaluation activity;

   h. Receive and consider all reports on the work of the Medical Staff;

   i. Make recommendations to the Board of Trustees and the President on matters relating to maintaining accreditation from the Joint Commission on Accreditation of Healthcare Organizations and other accrediting and licensing bodies;

   j. Conduct a review of the recommendations contained in such surveys and of the progress being made in meeting such recommendations. Selected members of the Quality of Care Committee shall participate in the surveys and summation conferences, as required;

   k. Serve to review an initial decision made by the Board of Trustees concerning the approval, modification, reduction and/or termination of Medical Staff privileges which is

contrary to the recommendation made to the Board of Trustees by the Medical Staff Executive Committee and make a recommendation to the Board of Trustees on the staff privilege matter; and

l. Develop and recommend to the Board of Trustees and upon adoption by the Board of Trustees, implement a conflict management process so that conflict among leadership groups does not adversely affect patient safety or quality of care.

C. Frequency of Meetings – The Quality of Care Committee shall meet at least four (4) times annually and at such other times as may be called by the chairman of the Committee.

Section 3: Special Committees

As Hospital interests and services expand, the Medical Staff shall develop appropriate committees to direct/monitor, and review and analyze these services on a regular basis. These include, but are not limited to, committees for the following:

A. Nominating Committee

a. Composition: This committee shall consist of three (3) Active members of the Medical Staff, who shall be appointed by the President of the Medical Staff. The Chairman shall be immediate past Chief of Staff.

b. Duties of the Committee shall be:

i. To compile a slate of candidates for officers of the Medical Staff;

ii. To present such slates bi-annually to the Medical Staff at the last meeting of the year, and give an opportunity to nominate from the floor.

c. Meetings: The Nominating Committee shall meet as needed.

B. Bylaws Committee

a. Composition: The Bylaws Committee shall consist of four (4) Active Staff members. The chairman shall be the present Vice President of the Medical Staff.

b. Duties: This committee shall be responsible for making recommendations relating to revisions to and updating the Bylaws, Rules and Regulations of the Medical Staff. The Bylaws, Rules and Regulations will be reviewed annually and revised as needed.

c. Meetings: The Bylaws Committee shall meet as often as there is appropriate business, or on the call of the President of the Medical Staff, and shall maintain a permanent record of its proceedings and actions.

C. Continuing Education Committee

a. Composition: This committee shall be appointed by the Director of Continuing Education, and shall consist of three (3) members of the Medical Staff.

b. Duties: This committee shall be responsible for:

i. Preparation/presentation of the program for the General Medical Staff meetings, if any;

ii. Educational conferences and presentations;

iii. Acquisition and review of professional medical library materials and services.

c. Meetings: The committee shall meet as often as there is appropriate business and shall maintain a permanent record of its proceedings and actions.

D. Ad Hoc Committee

a. Composition: This committee shall be appointed by the President of the Medical Staff, and shall be comprised of five (5) members of the Active Staff (Article VIII, Section 4):

b. Duties: To provide a review investigation, and/or hearing for any practitioner who receives notice of a recommendation of the Executive Committee, that if ratified by decision of the Board of Trustees, would adversely affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges (Article VIII, Section 1);

c. Reports: This committee shall maintain a permanent record of its activities and submit a written report to the Executive Committee.

E. Safety Core Group: The minutes of the Safety Core Group will go to the Medical Executive Committee for review.

F. Physician Assistance Committee

a. Composition: The Physician Assistance Committee shall be composed of three (3) Active members of the Medical Staff, a majority of whom, including the chairperson, shall be physicians. The President of the Medical Staff shall appoint this committee. Except for the initial appointments, each member shall serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the President to achieve continuity. Insofar as possible, members of the committee shall not serve as active participants on other Peer Review or Quality Assurance Committees while serving on this committee. The committee shall have no disciplinary powers and will act as the practitioner's advocate. All contacts of sources of information, to include practitioner contacts, shall be confidential.

b. Duties:

i. To develop and recommend to the Medical Executive Committee policies for carrying out its duties and the assistance program;

ii. To be available to receive reports, anonymous or otherwise, from Hospital staff regarding a potentially impaired practitioner;

iii. To act as a liaison with the ISMA Physician Assistance Committee (ISMA-PAC) or comparable dental and podiatric association programs;

iv. To refer concerns/reports regarding the practitioner to the ISMA-PAC, or comparable programs with dental and podiatric associations.

v. To refer concerns/reports regarding the practitioner to the ISMA-PAC, or comparable dental and podiatric association programs or appropriate Medical Staff committee when an intervention/treatment or referral/monitoring is necessary;

vi. To be available to assist in gathering information on the potentially impaired practitioner and to assist, when needed, in the intervention;

vii. To assist, when needed, in being a practitioner monitor for the recovering practitioner.

c. Meetings: The committee shall meet when necessary. Minutes of the activities of the committee shall be recorded, but confidentiality will always be respected.

G. Peer Review Committee

a. Composition: This committee shall have five (5) members consisting of the Chief of Staff, the Department Chiefs and one Active member of the Medical Staff. Other than the mentioned members, only Medical Staff members invited to attend would be able to attend.

b. Duties: The committee's duties will be outlined in the Medical Staff Policy and Procedures.

c. Meetings: This committee shall meet once monthly unless requested to meet by the Medical Executive Committee.

Section 4: Credentials Committee

A. Composition: This committee shall consist of Active Staff members including the immediate past Chief of Staff as chairman, the current Chief of Staff, and the immediate past Chairman of the Credentials Committee, a representative from a medical discipline (Family Practice, Internal Medicine, Psychiatry, or Pediatrics), a representative from a surgical discipline (Surgery or Obstetrics), a representative from a Hospital based discipline (Emergency Medicine, Radiology, Pathology, or Anesthesia), the President of the Hospital (or his designee). The President of the Medical Staff shall appoint Medical Staff members. In addition, when applications or reappointments are being considered for privileges in a specific department, the Chief of that department shall sit as a member of the Credentials Committee and may vote on recommendations concerning privileges in that department. The Chairman shall be an ex-officio member of the Executive Committee.

B. Duties: The Credentials Committee shall be responsible for reviewing all applications and for reviewing privileges for specified professional personnel. The Committee shall receive an assessment from the Department Chief in which privileges are sought and shall report its recommendations to the Executive Committee.

C. Procedures: The basic flow of the application procedure and documentation is from the Medical Staff Office to the department, then to the Credentials Committee, the Medical Staff Executive Committee, with final approval or denial by the Board of Trustees. Denials are subject to the appeals process as spelled out in Article VIII. Detailed procedures for initial appointment and reappointment are set forth in Article V.

D. Meetings: The Credentials Committee shall meet when necessary.

Section 5: Clinical Core Groups

Clinical Core Groups (CCG) are appointed to foster a seamless organization by gathering multi-disciplinary participants from the Medical Staff and Hospital associates together for focus on:

A. Specific diagnostic categories of care;

B. Specific patient populations, and/or;

C. Clinical risk and resource management.

These collections of experts will be referred to as Clinical Core Groups, whose purpose will be to utilize quality information to examine and improve the health care delivery system at Community Hospital of Anderson & Madison County. These Clinical Core Groups will design processes of care, measure the output of these processes, assess the effectiveness of care delivery and make improvements as identified by the group. The Clinical Core Groups will function under guidelines approved by the Medical Staff Executive Committee.

Section 5a: Cancer Care Clinical Core Group/Breast Health Leadership

Composition:

A. Medical Oncologist

B. Radiation Oncologist

C. General Surgeon

D. Medical Staff from OB/GYN

E. Physician Co-Chair

F. Cancer Liaison Physician

G. Diagnostic Radiology

H. Pathology

I. Cancer Program Administrator/Director of Oncology

J. Cancer Registrar

K. Oncology Nurse

L. Case Management

M. Quality Resources

N. Administration

Responsibilities: The Cancer Committee is responsible for planning, initiating, stimulating and assessing all cancer related activities in the Hospital. The main goal of our Cancer Committee is to decrease the morbidity and mortality of cancer within our community. The Cancer Committee assures the leadership for an effective cancer program and the success is dependent on an effective Cancer Committee.

A. Monitor the multi-disciplinary membership attendance;

B. Promote team involvement and shared responsibilities through assigning designated coordinators for:

    a. Cancer Conferences/Tumor Board;

    b. Quality control of the Cancer Registry Data;

    c. Quality Improvement;

    d. Community Outreach.

C. Monitor the Cancer Committee meeting schedule and meet at least quarterly;

D. Develop and evaluate annual goals and objectives for clinical, outreach, quality improvement and programmatic endeavors related to cancer care;

E. Establish the cancer conference multi-disciplinary attendance, frequency, and program format annually;

F. Ensure that the required number of cases are discussed at Cancer Conference/Tumor Board;

G. Monitor and evaluates the Cancer Conference/Tumor Board total case presentation, and prospective case presentation annually;

H. Establish and implement a plan to evaluate the quality of cancer registry data and activity on an annual basis;

I. Annually, the Cancer Committee analyzes patient outcomes and disseminates the results;

J. Monitor the percentage of cases include AJCC Cancer Staging on all eligible cases;

K. Monitor the inclusion of CAP Protocols on all eligible pathology reports.

L. Monitors clinical trial accrual;

M. Monitors continuum of care services and patient outcomes;

N. Responsible for overseeing the subcommittee of the Breast Program Leadership as outlined in the Medical Staff Policies and Procedures.

Article XII: Medical Staff Meetings

Section 1: General Medical Staff Meetings

Meetings shall be held in the months of March and September. In those months when the General Medical Staff does not meet, the Executive Committee shall meet and represent the Medical Staff as a whole. The Executive Committee shall present a thorough review of the clinical work done in the Hospital during the preceding months. The Active Voting Medical Staff shall conduct executive business of the Staff only.

The September meeting of the General Medical Staff shall be the last regular meeting of the calendar year. The order of business shall be:

A. Report of the Secretary to include the Medical Staff financial report, Executive Committee highlights, plaque presentations;

B. Hospital statistical report for the past year;

C. Bi-annual presentations of Nominating Committee candidate slate prior to printing of ballots;

D. Special reports/recommendations;

E. Review of clinical work performed in Hospital.

Section 2: Regular Meetings

A. The clinical departments, sections, and sub-specialty groups may meet as desired.

B. Committees may, by resolution, provide the time for holding regular meetings as documented in Article XI.

C. Clinical Core Groups shall meet at least four (4) times per year to present, review, and act on Quality Management information or group activity reports.

Section 3: Special Meetings

A. A special meeting of the Medical Staff, or of any segment thereof, may be called by the President of the Medical Staff, or at the request of the President, or at the written request of

any five (5) members of the Active Staff. The Secretary-Treasurer of the Active Medical Staff shall give notice of a special meeting at least three (3) days in advance; the notice shall state the business to be considered at a special meeting.

B. A special meeting of any committee, Clinical Core Group, or department may be called by or at the request of the committee chairman, Clinical Core Group Co-Leader, Department Chief, President of the Medical Staff, or by one-third (1/3) of the group's present members, but not less than two (2) members.

Section 4: Attendance Requirements

A. Attendance at meetings is encouraged. Only Medical Executive Committee and Credentials Committee maintain mandatory attendance requirements. Members of those two committees must be physically present at 50% of the meetings held. Failure to meet the annual attendance requirement will be reported to the Executive Committee and, unless excused for good cause, may be considered as resignation from the committee. Reinstatement of suspended members shall be at the discretion of the Executive Committee.

B. A practitioner whose patient's clinical course is scheduled for discussion at a regular departmental meeting conference shall be so notified and shall be expected to attend such meeting. If such practitioner is not otherwise required to attend the regular departmental meeting, the President of the Staff, through the Administrator, give the practitioner advance written notice of the time and place of the meeting at which his attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that this attendance at the meeting which the alleged deviation is to be discussed is mandatory.

C. Failure by a practitioner to attend any meeting with respect to which he was given notice that attendance was mandatory, unless excused by the Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate presentation may be postponed by the Chief of the department, or by the Executive Committee if the Chief is the practitioner involved, until not later than the next regular department meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

Section 5: Minutes and Annual Reports

Minutes of each regular and/or special meeting of a committee, Clinical Core Group, or department shall be prepared and shall include a record of the attendance of members and the action taken on each matter. The presiding officer or secretary shall sign the minutes, and copies thereof shall be promptly forwarded to the Executive Committee. Each committee, Clinical Core Group, and department shall maintain a permanent file of the minutes of each meeting. These shall be in writing and filed in the appropriate book in the office of the Medical Staff Coordinator. Minutes are not required for section meetings unless departmental issues are being discussed (e.g. peer review).

Section 6: Quorum

A quorum shall consist of those Active and/or Voting Members present. However, not less than two (2) members shall constitute a quorum at any meeting.

Section 7: Manner of Action

The action of a majority of the members present at a meeting, which a quorum is present, shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote. Secret ballots should be available at any meeting, upon request by any member of the Medical Staff with majority approval.

Section 8: Rights of Ex-Officio Members

Persons serving under these Bylaws as ex-officio members of a committee shall have the rights and privileges of regular members except they shall not be counted in determining the existence of a quorum. Ex-officio members shall have Voting privileges.

Section 9: Agenda

A. The agenda at any regular Medical Staff meeting shall be:

   a. Call to order;

   b. Acceptance of the minutes of the last regular and of all special meetings;

   c. Unfinished business;

   d. Communications;

   e. Reports of standing committees;

   f. New business;

   g. Clinical reviews;

   h. Discussion/recommendations for improvement of the professional work of the Hospital;

   i. Administrative announcements;

   j. Adjournment.

B. The agenda at special meetings shall be:

   a. Reading of the notice calling the meeting;

   b. Transaction for business for which the meeting was called;

   c. Adjournment.

Section 10: Rules of Order

Roberts Rules of Order in Parliamentary Procedure shall govern Medical Staff Meetings

Article XIII: Conflict Resolution

In the event that there is disagreement or conflict between the Board and the MEC or the Medical Staff and MEC regarding these Bylaws, Rules and Regulations, or policies; or amendment of these Bylaws, Rules and Regulations, or policies, the process of resolving such a conflict would be as follows:

A. The conflict or unresolved issue shall be articulated in writing for consideration in the form of a petition or summary of issues from the Medical Staff to the MEC, or from the Board to the MEC.

B. At least 25% of the voting members of the Medical Staff must sign a petition stating the basis for the conflict or disagreement with the action taken of the decision made by the MEC.

C. Within 30 days of receipt of the petition from the Medical Staff, a meeting between two representatives of the MEC, as appointed by the President of the Medical Staff, and two of the Medical Staff representatives of the petitioners (as selected by the petitioners) shall be held. In the case of an issue that the Board wishes to resolve with the MEC, a meeting will be scheduled within 30 days, at a time when at least two representatives of the MEC are able to attend.

D. The representatives shall discuss the identified issues in good faith, in an attempt to resolve the conflict or disagreement in the best interests of promoting safety and high quality care.

E. If the representatives reach agreement on a proposed resolution of the conflict, the proposed resolution shall be submitted to the voting members of the Medical Staff if such action is necessary, and/or to the full Board as necessary. The decision of the Board of Trustees will be final. In the event that the proposed solution does not require a vote of the Medical Staff, the proposed solution will be forwarded to the Board for a final decision.

F. If the Board does not approve the proposed solution (after the vote of the Medical Staff, if necessary, as outlined above), the Board will have the option to request a Joint Conference of an equal number of Medical Staff and Board members in an effort to seek a final resolution. Individuals participating in a Joint Conference will be appointed by the President of the Medical Staff and Chair of the Board. The Joint Conference Committee will submit its recommendation to the Board and the party requesting the Joint Conference. The Board will then take final action on the matter. Such action will not be subject to further deliberation, review, or appeal. The MEC or the Board may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders after such a Joint Conference. The decision of the Board will be final.

G. In the event that representatives of the MEC and the petitioners cannot agree on a proposed solution, the petition will be forwarded to the Board for review and consideration. The decision of the Board will be final.

Article XIV: Immunity from Liability

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

A. First, that any act, communication, report, recommendation or disclosure by the Medical Staff, Board of Trustees, or Administration, 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, shall be immune from liability to the fullest extent permitted by law. Each applicant and practitioner acknowledges to be bound by all of the provisions of the Health Care Quality Improvement Act of 1986 and Indiana Peer Review Statute.

B. Second, that such immunity shall extend to members of the Hospital's Medical Staff and its Board of Trustees, its other practitioners, its President and his 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 XIV, the term "third parties" means both individuals and organizations from which an authorized representative of the Board of Trustees or of the Medical Staff has requested information.

C. Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

D. Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare institution's activities including, but not limited to: (1) applications for appointment or clinical privileges; (2) periodic reappraisals for reappointment for clinical privileges; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) medical care evaluations; (6) utilization reviews and; (7) other Hospital, department, service or committee activities related to quality patient care and interprofessional conduct.

E. Fifth, that the acts, communications, reports, recommendations, and disclosures referred to in Article XIV 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.

F. Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in paragraph Second, 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.

G. Seventh, that the consents, authorizations, releases, rights and immunities provided by Section 1 and 2 of Article V of these Bylaws for the protection of the Hospital's practitioner, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XIV.

Article XV: Allied Health Care Providers and Specified Professional Personnel

Section 1: Allied Health Care Providers

A. Dentists and Podiatrists who do not qualify for surgical privileges, and Psychologists, who are licensed to provide care directly to patients outside the Hospital without the necessity of a physician ordering such care and who are not the employees of the Hospital or of another healthcare provider, may be appointed as Allied Health Care Providers with appropriate privileges to provide care to patients at Community Hospital at the request of treating physicians for inpatients or to order outpatient diagnostic work for outpatients, if appropriate. Any inpatient orders written by Allied Health Care Providers must work for outpatients, if appropriate. Any inpatient orders written by Allied Health Care Providers must work for outpatients, if appropriate. Any inpatient orders written by Allied Health Care Providers must be pre-approved (i.e. routine orders, direct verbal approval, etc.) by the attending physician (or physician's appointed representative) prior to being carried out and countersigned by the attending physician (or the physician's appointed representative) within 24 hours. Such Allied Health Care Providers shall not have the right to admit or to co-admit patients to the Hospital. Such Allied Health Care Providers shall be governed by these Bylaws, but shall not be members of the Medical Staff. Appointment may be granted if:

   a. In the opinion of the Board of Trustees the Hospital has a need for the Allied Health Care Provider and can provide facilities for the conduct of such Allied Health Care Providers practice;

   b. The Board of Trustees is of the opinion that the Medical Staff has the competence to assure the Board, through its regular process of ascertaining credentials, of the competence of the Allied Health Care Provider;

   c. The Board of Trustees is of the opinion that the Medical Staff has the competence to assure the Board, through its regular processes of peer review, and of quality assurance through performance surveillance, of the continuing quality of patient care by the Allied Health Care Provider applicant;

   d. The Allied Health Care Provider holds a valid and current Indiana license or registration within his field of practice;

   e. The Allied Health Care Provider has current Malpractice Insurance coverage and qualification under the Patient's Compensation Act as described elsewhere in these Bylaws; and

   f. An Allied Health Care Provider will not be denied appointment as an Allied Health Care Provider with appropriate privileges because of possible financial competition with fully privileged members of the Medical Staff.

Section 2: Specified Professional Personnel

A. Eligibility: Specified professional personnel must be registered with the Hospital to provide specified healthcare within the Hospital for a practitioner as the employee of that sponsoring

practitioner or as the employee of another healthcare provider. Specified professional personnel may qualify for registration if they provide adequate documentation of:

a. Proof that the specified professional personnel is included in the malpractice insurance coverage and qualification under the Patient's Compensation Act of the sponsoring practitioner or other healthcare provider, as described elsewhere in these Bylaws;

b. A statement by the sponsoring practitioner that the sponsoring practitioner will at all times undertake the supervision of the specified professional personnel in the Hospital and will be responsible for the acts or omissions of the specified professional personnel within the Hospital;

c. Education, training and experience;

d. Good character, ethics and good health;

e. Specified procedures and tasks, which the specified professional personnel will be requested to perform; and

f. The individual shall also submit an application along with a copy of current licensure, if applicable.

B. Obligations:

a. All procedures performed by specified professional will be under the direction of the sponsoring practitioner who shall be responsible for the care of the patient;

b. All procedures performed must be those authorized specifically by the sponsoring practitioner who assumes responsibility for the validity of the observations and for the proper performance of the procedures;

c. Functions delegated to specified professional personnel by the sponsoring practitioner shall be based on their training, experience, competence and judgment;

d. The scope and extent of the procedures performed by specified professional personnel shall be limited to specific delegated acts, tasks or functions as they relate to the privileges of the sponsoring practitioner; and

e. Specified professional personnel will not write orders except at the specific direction of the sponsoring practitioner, in which case the specified professional personnel will sign the order with the sponsoring practitioner's name per his or her own name. The sponsoring practitioner must then countersign the order within 24 hours.

C. Registration Process:

a. Specified professional personnel shall apply for registration on forms provided by the Medical Staff Office;

b. The appropriate department and the Credentials Committee shall review each application and determine whether the Executive Committee and the approval of the Board of Trustees shall register the specified professional personnel, subject to recommendation;

c. The Medical Staff shall establish a delineation of tasks, which may be performed by physicians assistants, physician employed nurses, social workers, psychological counselors, cast technicians, physician employed operating room technicians and other specified professional personnel; and

d. Review of withdrawal of privileges will be under the jurisdiction of the appropriate department. Reappointment will coincide with the reappointment of their sponsoring practitioner.

D. Corrective Action:

a. Registration of specified professional personnel may be suspended summarily by agreement of any two of the following persons: Chief of Staff, President, Vice President, Secretary/Treasurer, Department Chief, President of the Hospital or his/her designee;

b. The specified professional personnel and the sponsoring practitioner may request an informal review of such suspension by the Executive Committee and the President of the Hospital; and

c. The Executive Committee, subject to approval by the Board of Trustees, will take final action concerning the suspension.

Article XVI: Rules and Regulations

The Medical Staff shall adopt such Rules, Regulations, Policies and Procedures as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well embody the level of practice that is to be required of each practitioner in the Hospital. Such Rules, Regulations, Policies and Procedures shall be a part of these Bylaws, except that they may be amended or repealed at any regular Medical Staff Executive Committee meeting at which a quorum is present and without previous notice or at any special meeting on notice.

Article XVII: Amendments

These Bylaws may be amended at any regular Staff meeting at which a quorum is present and without previous notice, at any special meeting on notice by a two-thirds (2/3) vote of those present of the Active Voting Medical Staff, or by mail ballot with a two-thirds (2/3) response of the Active Voting Medical Staff. Amendments so made shall be effective when approved by the Board of Trustees.

Technical Changes to the Bylaws: The MEC may adopt such amendments to the Medical Staff Bylaws, Rules, Regulations, and policies that are, in the Committee's judgment, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Every effort will be made to prevent

any of the afore-mentioned corrections from changing the original meaning of the passage. Such amendments must be ratified by the Board.

Article XVIII: Adoption

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Board of Trustees.

Accepted by the CHA Active Voting Medical Staff:	9/13/99
Approved by the CHA Board of Trustees:	9/23/99
Approved by the CHI Board of Trustees:	10/04/99
Approved by the CHI Board of Trustees:	5/13/13

Revisions:

Accepted by the CHA Active Voting Medical Staff:	3/10/03
Approved by the CHA Board of Trustees:	4/3/03
Approved by the CHI Board of Trustees:	4/14/03
Accepted by the CHA Active Voting Medical Staff:	3/8/04
Approved by the CHA Board of Trustees:	3/18/04
Approved by the CHI Board of Trustees:	4/5/04
Accepted by the CHA Active Voting Medical Staff:	9/13/04
Approved by the CHI Board of Trustees:	10/28/04
Accepted by the CHA Executive Committee:	10/21/04
Accepted by the CHA Active Voting Staff:	3/7/05
Accepted by the CHA Active Voting Staff:	4/30/07
Accepted by the CHA Active Voting Staff:	3/24/08
Accepted by the CHA Active Voting Staff:	10/1/08

Accepted by the CHA Active Voting Staff:	3/2/09
Accepted by the CHA Active Voting Staff:	10/1/08
Accepted by the CHA Active Voting Staff:	5/14/10
Accepted by the CHA Active Voting Staff:	10/4/10
Accepted by the CHA Active Voting Staff:	6/30/11
Accepted by the CHA Active Voting Staff:	3/29/12
Accepted by the CHA Active Voting Staff:	9/26/12
Accepted by the CHA Active Voting Staff:	4/18/13
Accepted by the CHA Active Voting Staff:	3/11/15
Accepted by the CHA Active Voting Staff:	11/25/15
Accepted by the CHA Executive Committee:	02/18/16

COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY

RULES AND REGULATIONS OF THE MEDICAL STAFF

RULES AND REGULATIONS

Admission and Discharge of Patients

A. Patients may be admitted to the Hospital only by a member, in good standing, of the Medical Staff. Only those practitioners with admitting privileges may admit patients to the Hospital, except in case of emergency.

B. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

C. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of a disaster, such a statement shall be recorded as soon as possible.

D. Communicable diseases that are required to be reported to duly authorized health agencies shall be so reported by the Hospital.

E. Should bed availability become limited, patients shall be admitted on the basis of the following priorities:

    a. Emergency: To be admitted immediately upon recommendation of the admitting practitioner.

    b. Urgent: To be admitted within twenty-four (24) hours upon recommendation of the admitting practitioner.

    c. Soon: Includes all elective admissions involving all services to be admitted as soon as possible upon recommendations of the admitting practitioner.

F. No patient will be transferred without such transfer being approved by the responsible practitioner.

G. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

H. Patients shall be discharged only on an order of an attending or consulting practitioner (or his authorized agent).

I. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient should sign a waiver or responsibility form, which shall be affixed to the medical record.

J. In case a patient in the Hospital wishes to change doctors, he or his family shall notify the attending physician of his dismissal from the case. Unless a friendly transfer can be arranged between the dismissed physician and the one who is to succeed him, the first physician will discharge the patient. In the event that the new physician of choice should refuse the case, it will be called to the attention of the Chief of Staff, or in his absence, his designated representative, who shall be responsible until arrangements can be completed. The chief of Staff may enlist any appropriate specialist to care for such patient if the patient's care is out of his scope of practice. The specialist must comply with the Chief of Staff.

K. In cases of transfer of a patient from the Hospital to another institution, the attending physician shall send such information with the patient as is pertinent to his condition, diagnosis, and treatment, and shall arrange for proper transportation and attendants for the patient during the transfer. The Medical Staff shall follow and or abide by the Hospital Policy and Procedure H22 pertaining to EMTALA.

Medical Records

A. The admitting practitioner shall be responsible for the preparation of a complete and legible medical record for each patient (inpatient and outpatient). Its contents shall be pertinent and current. Medical records must be accurately documented, promptly completed, properly filed and retained, and accessible. All entries in the medical record must be dated, timed and authenticated. Any entry made by a licensed non-Staff physician must be counter-signed by the attending physician. A medical record is considered complete when it contains sufficient information to identify the patient; contain information to justify admission and continued Hospitalization, support the diagnosis/condition, justify the care, treatment and services; document the course and results of care, treatment and services; describe the patient's progress and response to medications and services and promote continuity of care among practitioners. All entries must be dated, timed and authenticated in writing or electronic form by the person responsible for providing or evaluating service provided.

B. A medical history and physician examination must be completed and documented within twenty-four (24) hours following registration or admission of the patient, but prior to surgery or a procedure requiring anesthesia services (including moderate sedation).

   History and physical examinations performed within thirty (30) days prior to admission may be used if the following requirements are met:

   a. Physician writes an updated note which is written or attached to the history and physical examination

   b. The words "re-examined the patient" must be present

   c. The history and physical examination and any updates/assessments must be included in the medical record within twenty-four (24) hours of admission, but prior to surgery or other procedures whichever comes first.

   History and physical examinations performed more than thirty (30) days prior to admission, outpatient, observation or outpatient surgery does not comply with timeliness requirements and a new history and physical examination must be performed.

History and physical examination required components:

a. Identification data

b. Chief complaint

c. Details of present illness

d. Relevant past, social and family history

e. Physician examination

f. Statement of conclusions

g. Diagnosis

C. A history and physical examination for obstetrical patients must be completed within twenty-four (24) hours of admission to the Hospital, or the updated prenatal record must reflect an up to date history and physical exam within a week prior to admission, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission.

D. Delinquency on histories and physicals shall result in suspension of admitting and consulting Staff privileges (including the writing of orders and assisting in elective surgeries). Delinquency is defined as failure to complete history and physicals within twenty-four (24) hours of admission for acute care for five (5) patients in any calendar quarter. Repeated suspensions due to failure to complete medical records shall result in full and complete termination of all Medical Staff privileges as specified in Article VII, Section 3 (d).

E. The medical record shall include standard content of the record. Information must justify admission and continued Hospitalization, support the diagnosis and describe the patient's progress and response to medications and services.

a. Verify that all entries in the medical record have been authenticated by the individual designated in the hospital and medical staff policies. Authentication may include written signatures, written initials, signature stamps, codes, mechanical or computer entry in accordance with Federal guidelines, hospital and medical staff policy.

b. All records must document the following, as appropriate:

i. Identification date;

ii. Personal and family history;

iii. History of present illness;

iv. Past history;

v. Evidence of a physician examination ;

vi. Admitting diagnosis;

vii. Results of all consultative evaluation of the patient and appropriate findings by clinical and other Staff involved in the care of the patient;

viii. Documentation of complications, Hospital acquired infections and unfavorable reaction to drugs and anesthesia;

ix. Properly executed informed consent forms for procedure and treatments specified by the Medical Staff, or by Federal or State law, if applicable;

x. All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs and other information necessary to monitor the patient's condition;

xi. Provisional diagnosis;

xii. Medical or surgical treatment as applicable including operative report and pathological findings;

xiii. Progress notes;

xiv. Autopsy report when performed;

xv. Discharge summary with outcome of Hospitalization, condition on discharge, disposition of care and provisions for follow up care and final diagnosis must be completed within thirty (30) days following discharge; and

xvi. A final progress note may be substituted for the discharge summary in the care of a normal newborn infant and uncomplicated obstetric deliver. It should include any instructions given to the patient and family.

F. No record shall be considered complete until so certified by the signature of the attending physician; and no record may be filed until it is completed, except by order of the Risk Management Core Group.

G. All medical records are the property of the Hospital and may not be removed from the Hospital only in accordance with a court order, subpoena or statute. In legal cases in which medical records are summoned to court the President, the Director of medical Records Services or a designated Hospital representative shall take the records to court for use and shall return them to the Hospital. Records shall be kept in the custody of the Administration at all times. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

H. Medical records shall be completed thirty (30) days after dismissal of the patient from the Hospital. Authorized by the President of the Medical Staff, the Medical Records Department notifies practitioners by letter that has records fifteen (15) days old twice a month. A second

notice will be sent forty-eight (48) hours after the tenth (10^{th}) day to complete records. Any records not complete within fifteen (15) days of initial notification will be considered delinquent. Suspension of admitting and consulting Staff privileges (including the writing of orders and assisting in elective surgeries) will be invoked when a member of the Medical Staff has delinquent charts. Such suspension shall not prohibit the practitioner from continuing to treat patients already under his care at the time the suspension is invoked. The status of offending practitioners is on an individual basis. Repeated suspensions due to failure to complete medical records shall result in full and complete termination of all medical Staff privileges as specified in Article VII section 2 (d). In a medical emergency, admitting, consulting and delivery the President, his agent or the Chief of Staff can reinstate privileges.

I. Authentication of medical records entries must be a legible handwritten full signature, handwritten initials, electronic signature, computer key or other code. The practitioner must separately date and time his/her signature authenticating an entry. There shall be no delegation of authentication codes to another individual. Stamped signature and/or rubber stamp signatures are not acceptable on any medical records.

J. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

K. A discharge summary shall be dictated on all inpatients within seven (7) days of notification from Medical Records. A concise discharge summary provides information to other caregivers and facilities continuity of care. The discharge summary will include the reason for Hospitalization; significant findings, procedures performed; care, treatment and services provides; patient's condition at the time of discharge from the Hospital; information given to the patient/family as appropriate; and final diagnosis. A final diagnosis note may satisfy this provision in the care of normal deliveries, normal newborn infants, and patients with problems of a minor nature defined as observation, outpatient surgery, and intervention patients who require less than forty-eight (48) hour period of Hospitalization. The final progress note will serve as the discharge summary and must contain the outcome of Hospitalization. The final progress note will serve as the discharge summary and must contain the outcome of Hospitalization, case disposition, any provisions for follow up care and final diagnosis.

   When a patient is transferred to another level of care in the Hospital and the patient's caregiver's change, the transfer summary may be used in place of the discharge summary. If the caregivers remain the same a progress note may be used.

L. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission and an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings within twenty-four (24) hours of admission. When the prenatal office record is used for a history and physical, it must be updated (to within seven (7) days), or have a progress note stating the history and physical are normal within twenty-four (24) hours of admission. All C-sections should have a

written or dictated history and physical examination note available in the chart before or around the time of delivery listing the physical exam and the indications for the C-section.

M. Newborn must have a physical examination within twenty-four (24) hours after delivery and discharge summary if Hospitalized for other than routine care.

N. The mother and newborn baby shall be considered separate patients with separate records.

O. Symbols and abbreviations may be used only when the Medical Staff has approved them. An official record of approved abbreviations should be kept on file in the Medical Records Department. The Hospital list of unapproved abbreviations and acronyms are prohibited on the writing of orders.

P. All medication orders are to have diagnosis or indication written.

Q. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the resp9onsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

R. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

S. In case of readmission of a patient, all previous records shall be available for use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.

T. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the records can be studied. Subject to the discretion of the President, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

U. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

V. The practitioner assuming primary responsibility for a patient (or his/her appointed practitioner representative) must see the patient each day and write daily progress notes. Failure to meet this requirement may result in suspension of privileges.

GENERAL CONDUCT OF CARE

A. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting office should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital. If the proper consent cannot be obtained, the attending physician should consult with another physician and receive concurrence that treatment is necessary. The facts of the situation and on the basis for the medical decision should be fully documented by the physician within twenty-four (24) hours after admission. It will be the responsibility of the nursing supervisor to inform the admitting physician of the need for the consult due to lack of consent. This consent will be considered valid until legal consent can be obtained through the appropriate individuals or a court order. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure should be obtained.

B. The practitioner's orders must be clear and understandable. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.

C. All drugs and medications administered to patients shall be those listed in the latest edition of the U.S.P.N.A. or any other compendia, which is set forth by the F.D.A. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of the Federal Drug Administration.

D. Every patient admitted to the Hospital shall have appropriate laboratory studies. Clinical laboratory reports shall be signed or initialed by the responsible technician or the Pathologist. The laboratory will maintain an index according to pathologic diagnosis or body area of unusual and/or interesting cases.

E. The Radiology Service will maintain an index of X-ray reports according to radiologic diagnosis or body area of interesting or unusual cases.

F. Practitioners are urged to obtain consultations in all cases in which the diagnosis or treatment is difficult. A written or dictated consultation note shall be made and put into the record at the time of the consultation. Psychiatric consultation and treatment should be requested for and offered to all patients who have attempted suicide or have taken a chemical overdose.

G. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

H. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. This required physician to physician communication and must be done within a reasonable time frame. The nursing supervisor is to be contacted in the physician has difficulty reaching the consultant. The physician will provide written authorization to permit another attending practitioner to attend or examine the patient, except in an emergency.

I. If an employee involved in the patient's care has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, they shall consult the physician. If there is still a concern they shall call this to the attention of their superior who in turn may refer the matter to the Chief Nurse Executive. If warranted the Chief Nurse Executive may bring the matter to the attention to the chief of the appropriate department wherein the practitioner has clinical privileges. The chief of the department will attempt to make contact with the physician involved. Where circumstances are such as to justify such action, the Chief of the department may himself request a consultation.

J. Specified laboratory technical Staff have the authority to perform arterial blood punctures under the direction of the Hospital Pathologist.

K. Specified cardiopulmonary technical staff shall have the authority to perform arterial blood punctures under the direction of a qualified Medical Advisor.

L. Drugs and biologicals shall be prepared for administration and administered by appropriately qualitied, trained and supervised individuals, in accordance with current federal and state laws as well as medication administration policies and procedures. Individuals authorized to prepare and administer medications within their scope of practice include: Physicians, Registered Nurses, Student Nurses, Licensed Practical Nurses, Student Practical Nurses, Pharmacists, Physical Therapists, Physical Therapy Assistants, Occupation Therapists, Audiologists, Radiologic Technologists, Nuclear medicine Technologists, Respiratory Therapists, Cardiopulmonary Technicians, Neurodiagnostics Technicians, Specified Laboratory Technical Staff, Certified Medical Assistants and Medical Technicians.

M. Patients with the same health problems and care needs have the right to receive the same level of quality of care throughout the organization.

    a. Access and appropriateness of care and treatment is not dependent on the patient's ability to pay or source of payment;

    b. Acuity of the patient's condition determines the resources needed to meet the patient's needs.

N. Nurse Practitioners may assist with call coverage in conjunction with the on call physicians. The on call physician must remain immediately available.

O. All Allied Health Care professionals need to consult with their supervising physician on a daily basis and document in the medical record; the supervising physician must co-sign the chart.

Surgical Care Department

A. Written, signed, informed, surgical consent shall be obtained by the surgeon or anesthesia provider prior to preoperative medication, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. An individual at least eighteen (18) years of age may obtain an acknowledgement from the patient that the physician has obtained the informed consent. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents or guardian, these circumstances should be fully explained on the patient's medical record. A

consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two (2) or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form. The consent will be placed in the patient's chart.

B. All operative procedures requiring general, regional or extensive infiltration anesthesia will necessitate a history and physical examination is written or dictated prior to surgery. A medical history and physician exam that is completed thirty (30) days prior to inpatient admission or registration, an update documenting any changes in the patient's condition is completed within twenty-four (24) hours after impatient admission or registration, but prior to surgery or a procedure. If the case is an emergency surgery, the reason for taking the patient to surgery without a history and physical examination will be documented in the patient medical record.

C. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and the reports promptly signed by the surgeon and made a part of the patient's current medical record. Any practitioner with undictated operative reports forty-eight (48) hours following the day of the operation shall be automatically suspended from operative privileges, post notification, except for any inpatients that have already been scheduled for surgery or emergency surgeries. If the full report can't be entered immediately in the record, a postoperative progress note is entered with the name of the primary surgeon and assistants, procedure performed and description of procedure finding, estimated blood loss, specimen removed and postoperative diagnosis.

D. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

E. All tissues or specimens removed at the operation shall be sent to the Hospital Pathologist (except those listed below), who shall make such examination, as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

    a. Exempt specimens:

        i. It is understood that these materials may be optionally omitted from pathological examination. Failure to exert that option will permit these materials to be examined in their usual manner. When the option is exerted, it is understood that it is the responsibility of the responsible physician to order the exemption and provide adequate documentation.

        ii. The following are met for tissues listed below to be exempted:

            1. The tissue, specimen or foreign bodies are listed on the approved exemption list.

2. If not included on the exemption list, a written order from the responsible physician ordering the tissue not be sent to pathology for examination is to be written. An event report is prepared and submitted through normal channels.

3. The responsible physician provides descriptive documentation as to fully describe the removed material.

iii. Exempted tissue list:

1. Cervical cerclage material
2. Foreign body material (if no overriding medical or legal circumstances)
3. Inner occlusive devices (e.g. hemoclips and Hulka clips)
4. Intrauterine devices
5. Lenses
6. Normal vein material
7. Prostheses (plates, screws, pins, etc.)
8. Orthopedic appliances (hardware)
9. Synovial (articular, meniscus tissue that has been finely fragmented)
10. Bladder stones
11. Waste tissue (scar/fatty tissue)
12. Intervertebral disc material
13. Cataracts
14. Therapeutic radioactive sources
15. Traumatic injured members which have been amputated (e.g. fingertip if no overriding medical or legal circumstances)
16. Tissues for tissue bank
17. Toe nails or finger nails (unless examination for fungus is required)
18. Placentas that are grossly normal (unless there is some complicating disease of mother or infant)
19. Teeth (with proper documentation including the number of teeth, with fragments, must be in the medical record)

20. Foreskin of infants

General Rules Regarding Anesthesiology Care

A. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic evaluation follow up of the patient's condition.

B. The Anesthesiology Department is responsible for providing criteria for discharge from the recovery room.

C. Anesthesia care shall be regularly available for surgical patients. Individual physicians and Certified Registered Nurse Anesthetists (CRNA's) qualified by training and/or experience to administer and control all types of anesthetic agents shall provide the anesthesia service.

D. CRNA's:

   a. CRNA's performing anesthesia, always do so with the knowledge that the anesthesiologists are available for back up. The CRNA's do not take instruction from any other physician other than the anesthesiologist for the provision on anesthetic care.

      i. Labor and Delivery:

         1. The provision of acute analgesia (i.e. relief from pain via an epidural or spinal route) for labor and delivery does not require the supervision of a physician.

         2. If operating physician determines that an anesthesia effect (loss of voluntary and involuntary movement) and total relief pain is required for an operative delivery of the infant, then the operating physician supervises the CRNA.

      ii. Surgery:

         1. CRNA's practice under the supervision of an anesthesiologist while performing anesthesia in the surgery department.

E. Members of the Department are available as consultants for other patient care services when requested by other private practitioners or administrative personnel in nursing service.

F. Appropriate precautions shall be taken in ensure the safe administration of anesthetics. Practices employed in the delivery of anesthesia care shall be consistent with the policies of the Medical Staff. The anesthetist shall be responsible for:

   a. Pre-anesthetic evaluation with significant findings recorded in the progress notes or the anesthesia record in accordance with the regulatory bodies;

   b. Post-anesthetic follow up with progress notes recorded in accordance with the regulatory bodies;

c. Giving his undivided attention to the administration of anesthesia and its effect on the patient;

d. Being fully acquainted with methods of maintaining adequate ventilation, including tracheal intubation and positive pressure breathing and having equipment to provide same;

e. Entries recorded in the anesthesia record to include medication and vital signs.

G. The level of care provided to the patient who has been administered anesthesia in areas outside the operating room, is comparable to that provide din the operating room.

General Rules Regarding Obstetrical and Gynecological Service

A. "Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

a. Abortions may not be performed at Community Hospital Anderson unless the abortion is a secondary effect of a treatment necessary to prevent a substantial impairment of the life or physical health of the pregnancy woman and this treatment cannot be delayed until the fetus is viable. An obstetrical consult must be obtained and documented.

b. A physician performing an abortion at Community Hospital Anderson is responsible for assuring compliance with any and all legal requirements concerning abortions prior to performing the procedure.

B. Sterilization: Any individual eighteen (18) years of age or older, who is mentally competent or of normal intelligence, may be sterilized upon request. Written consent of the spouse on the "Sterilization Permit" is not required on any patient. Any exception because of extenuating circumstances must have a consultation from another physician who is an Active Member of the Medical Staff. Cesarean Section shall not be done only to create an opportunity for sterilization.

C. The medical record of a patient undergoing a major elective obstetrical surgical procedure must include evidence of a thorough current physical examination.

D. When the office record is used in lieu of an admitting history and physical, this should be updated to the time of delivery.

E. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission and an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. When the prenatal office record is used for a history and physical, it must be documented within seven (7) days of admission and updated within twenty-four (24) hours following registration or admission of the patient, but prior to surgery or a procedure requiring anesthesia services (including moderate sedation). The updated note is written or attached to the prenatal record and the words "re-examined the patient" must be present. Obstetrical cases going to surgery shall have a routine preoperative physical examination.

F. When there is no prenatal record available, a medical history and physical examination must be completed and documented within twenty-four (24) hours following registration or admission of the patient, but prior to surgery or a procedure requiring anesthesia services (including moderate sedation). History and physical examination performed within thirty (30) days prior to admission may be used if the following requirements are met:

   a. Physician writes an updated note which is written or attached to the history and physical examination.

   b. The words "re-examined the patient" must be present.

   c. The history and physical examination and any updates/assessments must be included in the medical record within twenty-four (24) hours of admission, but prior to surgery or other procedures whichever comes first.

G. During diagnostic or definitive gynecological surgical procedures in which a laparoscope is used, the surgeon will take photographs of the findings and/or take biopsy specimens to be sent for pathological examination.

Emergency Medicine Services

A. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Room. This shall be in accord with the Hospital's basic plan for the delivery of such services including the delineation of clinical privileges for all physicians who render emergency care.

B. Services: A medical screening examination within the capability of the Emergency Department shall be available to all regardless of ability to pay. Except in the cases where the practitioner or qualified medical personnel determine an emergency medical condition exists. No person has the absolute right to claim the services of the Hospital.

C. Patients requiring admission from the Emergency Department will be admitted to the Hospitalist Service unless their private physician wishes to assume the care of the patient in the hospital. Every specialty and subspecialty privileged in the hospital shall provide emergency on-call coverage unless too few physicians exist in a particular specialty to provide such coverage. In the event a specialty group concludes they have too few physicians to provide on-call coverage, they will submit a request to the MEC for review. Pediatric coverage will be provided for those patients who do not have a primary care physician with admitting privileges. All physicians 70 years of age have the right to voluntarily request removal from the Emergency Medicine backup roster.

D. When an emergency service patient's personal physician is not available, his alternate physician should be contacted, not the backup physician on the Emergency Medicine roster.

E. It shall be the responsibility of the physician who is temporarily suspended because of incomplete charts to have his Emergency Medicine service covered by a physician on the Active or Provisional Staff.

F. No patient shall be admitted to the care of a physician service on the backup roster until that physician has been notified of the admission and accepts responsibility for the patient admission.

G. Each Emergency Medicine patient will receive a medical screening examination to determine whether an "emergency Medical condition" exists. An emergency medical condition is a condition so severe as to reasonably be expected to result in serious physical impairment or bodily dysfunction if immediate medical attention is not received. If an emergency medical condition exists, then the individual will receive stabilizing treatment and/or appropriate transfer to another medical facility by a Staff physician of Community Hospital Anderson. Labor and delivery nurses are "qualified medical personnel" to conduct the medical screening examination on pregnant women presenting to the Hospital. Individuals presenting with psychiatric or chemical dependency symptoms may be given a medical screening examination by an Allied Mental Health Professional who services as "qualified medical personnel."

H. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:

    a. Adequate patient identification;

    b. Information concerning the time and means of the patient's arrival;

    c. Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the Hospital;

    d. Description of significant clinical, laboratory and roentgenological findings;

    e. Diagnosis;

    f. Treatment given

    g. Condition of the patient on discharge or transfer;

    h. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow up care.

I. The practitioner shall sign each patient's medical record in attendance who is responsible for its clinical accuracy.

J. There shall be a review of emergency medical records by the Emergency Medicine Department and by appropriate clinical departments to evaluate quality of Emergency Medical Care. Reports shall be submitted to the Executive Committee of the Medical Staff.

K. The Hospital's Emergency Management Plan is designed to assure appropriate and effective response to a variety of emergency situations that could affect the safety of patients, Staff, visitors or the environment, or adversely impact the Hospital's ability to provide healthcare services. The Emergency Management Plan is a combination of an all hazard Emergency Operations Plan and incident specific Emergency Response Plans.

L. In the event of a disaster or medical emergency, the Hospital will implement the Emergency Operations Plan, which includes utilization of the Hospital Incident Command System (HICS). The Incident Commander and his/her Command Staff will assume authority and management of disaster operations, in consultation with the Medical Staff's Disaster Chief. Physicians reporting to the Hospital to assist will check in with the Labor Pool and be assigned a specific post by the Disaster Chief or Operations Section Chief.

M. The Chief of the Medical Staff shall be the Disaster Chief and the President of the Medical Staff shall be the Alternate Disaster Chief. In cases of such emergencies, all physicians on the Medical Staff agree to relinquish direction of the professional care of their patients to the Disaster Chief and his associate directors. The Emergency Operations Plan must be exercised at least twice annually, and shall include members of the Medical Staff, Administration, Nursing and other Hospital Staff.

Special Care Units

A. For special care units such as recovery rooms, intensive care units of all kinds, coronary care units, newborn nurseries, etc., appropriate committees of the Medical Staff and/or clinical core groups should adopt specific regulations.

B. These regulations should be subject to approval of the Executive Committee and the Board of Trustees in the same manner as departmental rules and regulations.

C. All CCU/ICU admits require critical care consult, but patient management will be discussed with the admitting physician.

Clinical Departments

Each department will establish its own regulations and procedural rules. These will vary with the complexity of the Hospital and the degree to which each department finds it necessary to duplicate the overall organizational pattern of the Medical Staff itself.

Alternates

Each member of the Medical Staff shall record with the President the name of another member of the Medical Staff of equivalent qualifications, who may be called to attend his patients in emergencies when he is not available. In situations where there is no other practitioner on Staff with equivalent qualification, the matter will be referred to the Credentials Committee for review and recommendation to the Medical Executive Committee. The Chief of Staff or the appropriate Department Chief shall have the authority to call any appropriate member of the Staff, should he consider it necessary. Alternates shall be within a reasonable distance of the Hospital.

Autopsies

A. Autopsies shall be done by the Hospital Pathologist (or his designated agent) at the request of the attending physician after completion of proper authorization.

B. There will be no charge made for postmortem examination on patients who die while in the Hospital.

C. The Pathologist will make a complete report of the postmortem findings in written form, within thirty (30) days, which shall be a part of the medical record of the patient.

D. All members of the Medical Staff are expected to obtain permission from postmortem examinations in all cases of unusual deaths and of medical legal and educational interest. Efforts should be made to obtain an autopsy rate consistent with the needs of the Staff's ongoing education programs.

Accepted by the CHA Active Voting medical Staff: 9/9/02; 3/18/04; 3/7/05; 9/12/05; 3/30/06; 4/30/07; 6/1/07; 3/2/09; 10/1/09; 5/14/10; 1/25/11; 7/11/11; 6/7/12; 2/21/13; 3/19/15; 6/25/15