Parkview Ortho Hospital

MEDICAL STAFF BYLAWS

October 19, 2022

ORTHOPAEDIC HOSPITAL
AT PARKVIEW NORTH, LLC

MEDICAL STAFF BYLAWS

Table of Contents

PREAMBLE

These Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff at the Parkview Ortho Hospital. They provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving quality medical care. They provide the professional and legal structure for Medical Staff operations as well as organized Medical Staff relations with the Board of Managers. They also provide for Medical Staff relations with applicants to, as well as members of, the Medical Staff. These Bylaws, when approved by the Board of Managers, create a system of mutual rights and responsibilities between members of the Medical Staff and the Parkview Ortho Hospital.

DEFINITIONS

"**Active Staff**" or "**Active Medical Staff**" means those Medical Staff Members who are orthopaedic surgeons, physiatrists, podiatrists, physicians specializing in pain management, who provide continuous care and call coverage and services to patients of the physicians and Hospital. The Active Staff shall discharge all functions and responsibilities of appointment on the Active Medical staff including but not limited to service on committees, as needed, and attending Medical Staff meetings.

"**Ad Hoc Hearing Committee**" means the committee appointed by the Board of Managers of the Hospital or the Medical Executive Committee, to review and make judgment regarding any Adverse Recommendation that has been proposed regarding any Practitioner with regard to his/her application to the Medical Staff and or his/her Clinical Privileges.

"**Adverse Recommendation**" or "**Adverse Action**" means any recommendation or action that would restrict or deny the privileges of a Practitioner. Such terms also include any recommendation or action that grants or recommends the granting of privileges to a Practitioner that are less than the privileges or membership sought by such Practitioner. An Adverse Recommendation and/or Adverse Action shall entitle the affected Practitioner to the due process procedures provided in these Bylaws, unless otherwise stated.

"Advisory Board" means the Board consisting of Practitioners which will provide clinical and operational input to the Active Medical Staff.

"**Affiliate Medical Staff**" means those Medical Staff members who are otherwise qualified, but do not utilize the Hospital as their primary facility for medical practice. Unless otherwise stated, "Affiliate Medical Staff" members must maintain Active Staff Privileges at another facility that requires participation in quality management activities consistent with those of the Orthopaedic Hospital at Parkview North.

"**Allied Health Practitioners**" means individuals who are not otherwise eligible for membership on the Medical Staff, but who, by documented experience and/or training, applicable licensure or certification, and demonstrated competence, are qualified to provide services needed or desired by the Hospital and the Medical Staff. Allied Health Practitioners may be either Dependent, (e.g. RNs), Semi-Independent, (e.g. NPs or PAs), or Independent, (e.g. Optometrists). For Individuals performing services as Allied Health Practitioners, the Medical Executive Committee must approve their scope of practice (for Dependent AHPs) or recommend them for Clinical Privileges to the Hospital Board of Managers (for Semi-Independent or Independent AHPs)

"**Board**" or "**Board of Managers**" means the legally constituted governing body of the Orthopaedic Hospital at Parkview North, LLC.

"**Contract Practitioners**" means those Medical Staff members who provide specialty services as contracted with the Hospital including Orthopaedics, Physiatry, Podiatry, Pain Management, Pathology, Radiology and Anesthesia.

"**Hospital**" means Parkview Ortho Hospital.

"Inquiry Body" means the committee appointed by the Medical Executive Committee to investigate a request for disciplinary action against a Practitioner.

"**Medical Executive Committee**" means the committee with voting members consisting of the entire Active Medical Staff. This committee serves as the governing body of the Medical Staff as described in these Bylaws unless stated otherwise herein.

"**Medical Record**" means the documentation of a patient's care that serves as a communication tool for clinical information, support for financial claims, legal evidence, resource for research and statistical quality review, and an educational tool for clinicians.

"**Medical Staff**" means collectively those licensed Practitioners holding Doctor of Medicine, Doctor of Osteopathy, or Doctor of Podiatric Medicine degrees, who have been granted staff appointment by the Board of Managers of the Hospital.

"**Peer Review Committee**" means any committee of the governing body, Hospital or Medical Staff that conducts professional review activity.

"**Personnel of a Peer Review Committee**" means not only the members of such committee but also all of the committee's representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves on a peer review committee in any capacity whether such person is acting as a member or is under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to its actions.

"**Policies**" or "**Policies and Procedures**" means documents describing a definite course or method of action to guide and determine future decisions. Medical Staff "Policies" must be approved by the Medical Executive Committee and are attendant to the Bylaws of the Medical Staff, as are the Rules and Regulations. All Medical Staff Policies approved by the Medical Executive Committee must be communicated to the entirety of the Medical Staff in a timely fashion.

"**Practitioner**" unless otherwise specified, means a member of the Medical Staff holding Doctor of Medicine, Doctor of Osteopathy or Doctor of Podiatric Medicine degrees.

"**Precautionary**" means action done without delay or formality as an interim step and does not imply any final finding.

"**President of the Hospital**" means the individual, or his designee, appointed by the Board of Managers to act in its behalf in the overall management of the Hospital.

"**Privileges**" or "**Clinical Privileges**" means the permission granted to a Practitioner to provide specific services to patients, and to perform specific clinical functions in the Hospital. The Practitioner shall be granted reasonable access to Hospital equipment, facilities, and personnel necessary to effectively exercise such privileges in accordance with these Bylaws.

"Reconciliation Committee" means a committee comprised of two (2) members of the Board of Managers, two (2) members of the Medical Staff, and two (2) members of Hospital Administration, for the purpose of reviewing an Adverse Recommendation against a Practitioner made by the Medical Executive Committee but not upheld on appeal by the Board of Managers.

"**Rules and Regulations**" means statements that exert control and direction. "Rules and Regulations" must be approved by the Medical Executive Committee**;** who are the Active Medical Staff and are attendant to the Bylaws of the Medical Staff as are the Medical Staff Policies**.** Any amendments to the Rules & Regulations passed by the Medical Executive Committee must be communicated to the entire Medical Staff in a timely fashion.

"**Telemedicine**" means the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care.

ARTICLE I: NAME

The name of this organization shall be the Parkview Ortho Hospital North Medical Staff.

ARTICLE II: MEMBERSHIP

Section 1. Medical Staff Membership

Membership on the Medical Staff at the Parkview Ortho Hospital ("Hospital") is an authorization to exercise only such clinical privileges at the facility as are specifically granted, if any, and shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated Rules, Regulations, and Policies of the Medical Staff and Hospital.

Section 2. Qualifications for Medical Staff Membership

Membership on the Medical Staff at the Hospital is extended only to Practitioners holding Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (D.P.M.). These Practitioners must be licensed to practice in the State of Indiana. They must be "qualified" as a health care provider as defined in the Indiana Malpractice Act. They must be able to document their background, experience, education, training, current competence, good judgment, and ability to safely perform any privileges requested. They must adhere to the ethics of their profession, have a good reputation, and be able to work with others. The foregoing must be present with sufficient adequacy to assure the Medical Staff and the Board of Managers that any patient treated by them in the Hospital will be given quality medical care.

No Practitioner shall be entitled to appointment on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that the Practitioner is duly licensed to practice medicine or podiatry in this state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at this Hospital or another hospital.

Section 3. Responsibilities of all Medical Staff Members

The responsibilities of all members of the Medical Staff are to:

A. Abide by the Bylaws, Regulations, and Policies of the Medical Staff and the Hospital.

B. Abide by the Principles of Medical Ethics as defined by their applicable professional association including the American Medical Association, American Osteopathic Association or American Board of Podiatric Surgery.

C. Agree to and recognize the Hospital's obligation to query and report Adverse Actions to the National Practitioner Data Bank as established by federal statute. Information

obtained by query of the Data Bank will be used in evaluating the Practitioner's qualifications for initial or continued membership and if applicable, privileges granted.

D. Maintain personal medical malpractice insurance coverage as required by the Indiana Medical Malpractice Law (IC 34-18).

E. Exercise only those privileges granted by the Board of Managers.

F. . Any member with delineated clinical privileges may provide any type of emergency care in a life-threatening situation or a situation that threatens serious harm, as long as the care provided is within the scope of the individual's license.

G. Provide appropriate care to those patients for whom they are assigned as attending or consulting physician, or to ensure that care is provided by an appropriate level of physician coverage.

H. Complete in an appropriate fashion all medical records for the patients to whom care is provided in the Hospital.

I. Inform the Medical Staff in an appropriate manner of any changes made or formal actions initiated that could result in a change to their license, state or federal controlled substance registration, professional liability insurance coverage, and voluntary or involuntary reduction of clinical privileges at other health care institutions. Final judgments or settlements for any malpractice activity must be reported as well as the filing of any felony charge.

J. Ensure appropriate authorization is obtained, and assume medical and legal responsibility for Complementary and Allied Health Practitioners performing duties on behalf of the Practitioner, as described in associated policies.

K. Ensure appropriate authorization is obtained, and appropriately supervise students, interns, medical residents, and other non-M.D./D.O. Practitioners who have not been granted Clinical Privileges.

L. Cooperate with and participate in performance improvement and peer review activities. -

M. Hold harmless those participants performing peer review activities related to self, such peer review to be performed without malice and in good faith.

N. Maintain the confidentiality of the peer review process recognizing no right to discovery of the peer review of other Medical Staff members.

O. Work with other Medical Staff members, nurses, ancillary staff, support staff, Hospital Administration, Hospital Board of Managers, and other individuals and organizations in a cooperative, professional, and civil manner .

P. Refuse to engage in improper inducements for patient referral or any other unethical behavior

Q. Meet the Continuing Medical Education requirements as required by Medical Staff CME policy.

R. Report any health condition that may adversely affect the ability to provide quality care for patients.

S. Pay medical staff dues and assessments, asrequired.

T. Uphold the privacy rights of the patients.

U. Make appropriate arrangements for coverage to ensure patients receive continuous care.

Compliance with the above is necessary to apply for and/or maintain membership, and privilegesif applicable.

Section 4. Rights of all Medical Staff Members

A. To exercise those privileges granted by the Board of Managers.

B. To have reasonable access to Hospital equipment, facilities, and personnel to effectively exercise such privileges in accordance with these Bylaws.

C. Unless otherwise stated, in the event of an Adverse Recommendation regarding appointment or reappointment to the Medical Staff or any recommendation to restrict or deny Clinical Privileges, applicants to the Medical Staff as well as Medical Staff members have the right to due process as provided in these Bylaws.

Section 5. Non-discrimination

Medical Staff membership and/or Clinical Privileges shall not be based on any legally protected class, including: gender (pregnancy, sexual orientation, gender identity), race, color, age, religion or creed, disability, veteran status, genetic information, citizenship, and/or national origin or ancestry.

ARTICLE III: CATEGORIES OF MEMBERSHIP

The Medical Staff shall be divided into Active and Affiliate categories. All Medical Staff members, including Contract Physicians as described in Section 4 of this Article, shall be assigned to one of these categories.

Section 1. The Active Medical Staff

The Active Medical Staff shall consist of Contract Practitioners to the Hospital, who provide the specialty services of Orthopaedics, Physiatry, ***(excluding consultation only),*** Podiatry and Pain Management***, (excluding consultation only)*** and who shall have that representation on the Medical Executive Committee, as set forth in these Medical Staff Bylaws. These Contract Practitioners, serving on the Medical Executive Committee shall be located closely enough to

the Hospital to provide continuous care to patients and assume all the functions and responsibilities of appointment to the Active Medical Staff. Active Medical Staff members must have Clinical Privileges or serve in an administrative role.

The following rights and responsibilities of Active Staff members are in addition to Article II, Sections 3 and 4 of these Bylaws:

A. To assist in the clinical and administrative work as required for successful Hospital and Medical Staff operation.

B. To provide call coverage for unattached patients unless otherwise exempted by the Medical Executive Committee.

C. To participate on those special committees assigned as a member with vote.

D. To vote as a member of the Medical Executive Committee.

After one (1) year in which a member of the Active Staff fails to admit or provide consultation for patients in this Hospital or be regularly involved in Medical Staff functions as determined by the Medical Staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

Section 2. The Affiliate Medical Staff

The Affiliate Staff shall consist of those Practitioners who do not utilize the Hospital as their primary facility but are located in the same geographic proximity as Active Staff and can demonstrate that they are on Active Staff of a licensed hospital that requires participation in quality management activities consistent with those of this Hospital.

The following rights and responsibilities of Affiliate Staff members are in addition to Article II, Sections 3 and 4 of these Bylaws:

A. Practitioners are not required to attend regular Medical Staff meetings or serve on committees but are welcome to do so.

B. Practitioners may serve on any committee and vote, if appointed to a Committee, except the Medical Executive Committee.

C. Practitioners are not eligible to vote at Medical Staff meetings.

Section 3. Contract Practitioners

Contract Practitioners shall consist of those Practitioners who provide specialty services as contracted with the Hospital including Orthopaedics, Physiatry, ***(excluding consultation only),*** Podiatry, physicians specializing in pain management, ***(excluding consultation only)*** Anesthesia, Pathology and Radiology. Other than for Orthopaedics, Physiatry, Podiatry, and physicians specializing in pain management ***(excluding those who provide consultation services***

only as identified above), Contract Practitioners providing Anesthesia, Pathology, Radiology and Hospitalist services shall be assigned to the Affiliate Staff category. Other than for Orthopaedics, Physiatry, Podiatry and physicians specializing in pain management, ***(excluding those who provide consultation services only as identified above)*** Contract Practitioners must otherwise be Active Staff members at another licensed hospital that requires participation in quality management activities consistent with those of this Hospital. ***Any*** Emergency Room physicians contracted with the Hospital for code coverage, shall be members of the Affiliate Medical Staff.

Section 4. Leave of Absence (LOA)

Any member of any category may request a Leave of Absence (LOA) from the Medical Staff as described in the LOA policy.

ARTICLE IV: MEDICAL STAFF CREDENTIALING

Section 1. Applicant Requirements

For consideration for initial appointment, reappointment, and, if applicable, initial, renewed, or increased privileges, all applicants, including those desiring to provide services via Telemedicine, must:

A. Meet the qualifications for Medical Staff Membership (Article II, Section 2), the qualifications for specific categories of membership, and the delineation of privileges criteria, if any requested.

B. Accept and comply with the Responsibilities for Medical Staff Membership (Article II, Section 3) as well as the responsibilities appropriate to the staff category requested.

C. Accept the burden of producing adequate information for a proper evaluation of competence, character, ethics, any reasonable evidence of current ability to perform the Privileges requested, and other qualifications as outlined in associated Medical Staff policies and application forms, including but not limited to:

    1. Previously successful or currently pending challenges to any licensure or registration (state or district; Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

    2. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital or other health care organization.

    3. Involvement in a professional liability action, reporting at a minimum final judgments or settlements.

    4. Charges filed for any criminal felony.

D. Signify willingness to appear for interviews in regard to the application and so respond if requested.

E. Authorize consultation with members of the Medical Staff of other institutions with which the applicant has been associated and with any others who may have information bearing on competence, character, ethical qualifications, and ability to carry out the Clinical Privileges requested. This authorization includes acquiring information from any Central Verification Organization.

F. Release from liability all representatives of the Hospital and Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and their credentials, and all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for Staff appointment and, if applicable, Clinical Privileges, including otherwise privileged or confidential information.

G. Have sufficient patient care contact within the Practitioner's practice to permit the Hospital to evaluate the Practitioner's current clinical competence for any Clinical Privileges, whether being initially requested, renewed, or already granted.

Section 2. Applicant Assessment

All applicants for initial appointment, reappointment, and if applicable, initial, renewed, or increased Clinical Privileges will be evaluated for:

A. Patient Care

B. Medical / Clinical Knowledge

C. Practice Based Learning and Improvement

D. Interpersonal and Communication Skills

E. Professionalism

F. System Based Practices

Practitioner specific information is considered and compared to aggregate information when these measurements are appropriate for comparative purposes. Appropriate verifications will be obtained from primary or other TJC approved sources, according to associated Medical Staff policies and forms, whenever possible, and will at a minimum include:

A. Current licensure

B. Relevant training and experience

C. Current competence

D. Ability to perform the privilege(s) requested, if any

E. National Practitioner Data Bank (NPDB) query

F. Peer recommendations

G. Review and recommendation by the appropriate Clinical Advisor

Section 3. Delegation

The Medical Staff may delegate the verification portion of the credentialing process to other resources including Central Verification Organizations (CVO's) while maintaining authority for final approval of recommendations for membership and privileges.

Section 4. Clinical Privileges

Every initial or reappointment application must contain a written request for the specific Clinical Privileges desired, if any, which will be evaluated as described in Section 2 of this Article with focus on current competence. A request for Privileges that are covered by Contract Practitioners will not be considered unless the applicant is a member of the group holding the contract. In like manner, Clinical Privileges already granted may not be exercised unless the Practitioner is a member of the group holding the contract unless the contract provides exception.

In addition, periodic re-determination of Clinical Privileges and the increase or reduction of same shall be based upon factors including: an individual's documented experience in specific clinical service areas or with specific procedures; the results of treatment; demonstration of the required skills and judgment, and the conclusions drawn from organization performance improvement activities when available.

Section 5. Processing

All inquiries regarding appointment or re-appointment to the Medical Staff should be directed to the Medical Staff Services office.

A. All applications for initial appointment, reappointment, and if applicable, initial, renewed, or increased Clinical Privileges will be processed thoroughly and in as expeditious a manner as possible as outlined in the associated Medical Staff policies. In the event of unwarranted delay on the part of the Medical Executive Committee in making a recommendation to the Board of Managers (90 days from the date of initial presentation of a completed, verified application), the Board may act without such recommendation on the basis of documented evidence of the applicant's or Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

B. In the case of reappointment, if the delay is due to a Practitioner's failure to complete and return the reappointment application and materials in a timely manner, or provide requested documentation, the appointment shall terminate at the completion of the period of appointment.

C. Recommendation for the granting or revocation of all of the following will progress from the Hospital's Chief Medical Officer, upon input from others in the clinical area involved, to the Medical Executive Committee, unless otherwise executed via the

Disciplinary Procedures and Hearing and Appeal Procedures described in Articles V and VI of these Bylaws:

1. Professional criteria for clinical privileges
2. Initial Medical Staff membership
3. Initial Privileges
4. Renewal of Medical Staff membership
5. Renewal or modification in Privileges

These recommendations will be forwarded to the Hospital Board of Managers for approval, only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws and associated policies.

Section 6. Provisions of Appointment

A. Appointment to the Medical Staff does not guarantee that any Clinical Privileges shall be granted. Only such Privileges specifically granted by the Board of Managers, in accordance with these Bylaws and associated policies, shall be conferred.

B. Appointments for membership and, if applicable, Privileges shall be made for a period of not more than two (2) years.

C. All new appointments to the Medical Staff that include Clinical Privileges are considered provisional and may be subject to one hundred per cent (100%) quality assurance review for the first year. Concerns arising from this review will be brought to the attention of the Medical Staff member on an ongoing basis via the established peer review processes.

Section 7. Temporary and Disaster Privileges

Temporary Privileges may be granted by the President of the Hospital or his/her designee with the approval of the Chair of the Medical Executive Committee or his/her designee and the Chief Medical Officer or his/her designee in accordance with the associated Medical Staff Policies. Likewise, in the event of a disaster as defined by the Hospital disaster plan, Privileges shall be granted in accordance with the Disaster Privileges Policy.

ARTICLE V: DISCIPLINARY PROCEDURE

Section 1. Formal Procedure

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. Whenever the activities or professional conduct of any Practitioner with Clinical Privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Medical Staff or the Hospital. Disciplinary action with respect to such Practitioner may be requested by any Practitioner of the Medical Staff, by the President of the Hospital or his/her designee, or by any member of the Board of Managers.

For purposes of Disciplinary Procedures and Hearing and Appeal, a subgroup of the Medical Executive Committee may be delegated full authority of and for the Medical Executive Committee.

A. All requests for disciplinary action shall be in writing and shall be made to the Medical Executive Committee. The request shall be supported by reference to the specific activities or conduct that constitutes the grounds for the request. A copy of the request will be sent to the Hospital President and the Practitioner involved.

B. The Medical Executive Committee shall review all requests for disciplinary action and depending on the subject matter of the request may, at their discretion, appoint a preliminary inquiry committee (collectively referred to as the "Inquiry Body") to review such request. Upon receipt of such request, the Chair of the Inquiry Body shall promptly call a meeting to review the matter.

C. Within forty-five (45) days after the receipt of the request for disciplinary action, the Inquiry Body shall issue a report of its review to the Chair of the Medical Executive Committee. The Medical Executive Committee shall consider the report at its next regularly scheduled meeting. Prior to the making of such report, the Practitioner against whom disciplinary action has been requested shall be invited for an interview with the Inquiry Body. At such interview, said Practitioner shall be invited to discuss, explain, or refute the basis of the request for disciplinary action. This interview shall not constitute a hearing and shall be a preliminary inquiry in nature. An accurate record of such interview shall be made by the Inquiry Body and included with its report to the Medical Executive Committee. The mechanism for recording such interview may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes.

D. Within thirty-five (35) days following receipt by the Medical Executive Committee of a report from an Inquiry Body, or if no Inquiry Body was appointed, forty-five (45) days of receipt of the request for disciplinary action, the Medical Executive Committee shall take action upon the request. The affected Practitioner shall be invited to make an appearance before the Medical Executive Committee prior to its taking action on the request. This appearance shall not constitute a hearing and shall be preliminary in nature. An accurate record of such appearance shall be made by the Executive Committee. The mechanism for recording such interview may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes.

E. The action of the Medical Executive Committee on a request for disciplinary action includes but is not necessarily limited to the following:

    1. Reject the request
    2. Issue a warning or letter of reprimand
    3. Impose terms of probation or a requirement for consultation
    4. Require additional training

5. Recommend to the Hospital Board of Managers reduction, suspension, or revocation of all or any portion of the Clinical Privileges of the Practitioner
6. Recommend to the Hospital Board of Managers suspension or revocation of the Practitioner's Medical Staff appointment

F. Any action proposed by the Medical Executive Committee shall be in the form of a recommendation to the Board of Managers. Any recommendation by the Medical Executive Committee to issue a warning, a letter of reprimand, or the imposition of probation, or a requirement for consultation or additional training shall not entitle the affected Practitioner to the hearing and appeal procedure described in Article VI of these Bylaws. The Practitioner shall be entitled to place a letter in his/her Peer Review file setting forth his position with regard to any such recommendation for future reference.

G. Any recommendation by the Medical Executive Committee for reduction, suspension, or revocation of all or any portion of Clinical Privileges, or for suspension or revocation of Medical Staff appointment, shall entitle the affected Practitioner to the hearing and appeal procedure set forth in these Bylaws.

Section 2. Informal Procedure

Notwithstanding the procedure set forth in Section 1 above, the Medical Executive Committee may in instances it deems appropriate and in the exercise of its discretion, address and respond to a request for disciplinary action by entering into a written remedial agreement with the affected Practitioner. The Executive Committee shall provide written notice of such an agreement to the President of the Hospital and the Board of Managers as well. This informal procedure is intended to promote a collegial and educational approach to address questions and issues involving a Practitioner of the Medical Staff in appropriate circumstances. All efforts of the Medical Executive Committee in this regard are intended to be, and are a part of the Hospital's quality improvement and professional review activities. This informal procedure is voluntary on the part of the affected Practitioner and its use is discretionary with the Medical Executive Committee. Further, this informal procedure is considered confidential peer review activity, and shall not in and of itself give rise to procedural rights. In the event the affected Practitioner defaults on the remedial agreement in the judgment of the Medical Executive Committee or the Board of Managers, or the affected Practitioner elects to terminate the remedial agreement, the Medical Executive Committee shall make a recommendation to the Board of Managers as to appropriate disciplinary action and the procedures and rights set forth in this Article shall be applicable.

Section 3. Precautionary Suspension

A. Any 2 (two) of the following shall have the authority to suspend all or any portion of the Clinical Privileges of a Practitioner of the Medical Staff whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual.

1. The Chair of the Medical Executive Committee

2. The President of the Hospital
3. The Chief Medical Officer

B. Such Precautionary Suspension shall be deemed an interim precautionary step in the quality improvement and professional review activity related to the ultimate professional review action that may be taken with respect to the suspended Practitioner but is not a complete professional review action in and of itself. The Precautionary Suspension shall not imply any final finding of responsibility for the situation that gave rise to the suspension. Such Precautionary Suspension shall become immediately effective upon imposition and shall be reported to the President of the Hospital or his/her designee, the Chief Medical Officer and the Chair of the Medical Executive Committee. The Chief Medical Officer shall assign the responsibility for the care of the suspended Practitioner's patients to another Practitioner of the Medical Staff with appropriate Clinical Privileges. The wishes of the Practitioner and the patient shall be considered in the selection of the Practitioner assigned to provide such care.

C. Within a reasonable time, not to exceed 72 hours from the imposition of a precautionary suspension, an ad hoc committee of at least three active members of the Medical Staff shall be appointed by the Chair of the Medical Executive Committee. Such committee shall be responsible for reviewing the Precautionary Suspension and related circumstances leading to same. All efforts shall be made to appoint committee members who are not in direct competition with the affected Practitioner. No member of the ad hoc committee shall have actively participated in the precautionary suspension. Within seven (7) days, this ad hoc committee shall make a report/recommendation to the Medical Executive Committee with regard to their findings. The Medical Executive Committee shall meet within seven (7) days to act on this report/recommendation. Upon request, the affected Practitioner may address the Medical Executive Committee concerning the issues under investigation and the conditions the committee may impose. In no event shall this meeting constitute a hearing within the meaning of Article VI, nor shall any procedural rules apply. Action of the Medical Executive Committee shall be modification, termination, or continuance of the Precautionary Suspension.

D. If, after review, the Medical Executive Committee does not recommend immediate termination of the Precautionary Suspension, the Precautionary Suspension will continue and the affected Practitioner shall be entitled to the procedural rights of the Hearing and Appeal procedure as set forth in Article VI of these Bylaws. The terms of the Precautionary Suspension as continued or as modified shall remain in effect until the formal Hearing and Appeal process is completed.

Section 4. Automatic Suspension

A Practitioner of the Medical Staff may have any or all of his Clinical Privileges suspended in the following instances without affording the Practitioner the procedural rights to a hearing and appeal procedure as provided in these Bylaws.

A. Failure to complete medical records in a timely fashion as described in Medical Staff Rules and Regulations.

B. Loss or a failure to maintain professional liability insurance coverage in the amounts required by the Medical Malpractice Law (IC 34-18).

C. Failure to pay dues or assessments, if any exist and as determined by the Medical Executive Committee from time to time.

D. Failure to produce documentation of current Indiana licensure or failure to produce evidence of current DEA and CSR unless exempted.

E. Any action by the State Board of Medical Examiners revoking or suspending a Practitioner's license. (This action shall automatically suspend all of the Practitioner's Hospital Privileges.)

F. Should action be taken by the State Board restricting or placing on probation a Practitioner's license, DEA, or CSR, any privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

G. Failure or refusal to meet any special appearance requirement or request made by the Medical Executive Committee.

H. Failure by a Practitioner to provide information reasonably requested by the Medical Executive Committee to include by way of example and not limitation:

    1. Information regarding a professional review action or resignation from another facility or agency.

    2. Information from a Practitioner that is deemed necessary to address or resolve questions that have arisen during the course of credentialing and/or peer review processes.

    3. Information pertaining to the professional liability claims or actions involving the Practitioner.

    4. Information that the Practitioner has been charged with a felony.

The affected Practitioner shall be notified of the initiation of an Automatic Suspension in writing via certified mail, return receipt requested. The notification must outline what response is required to relieve the Practitioner of the suspension, as well as the timeframe and consequences if the Practitioner fails to respond. Items E, F, G, and H shall require referral to the Medical Executive Committee for possible referral to an Inquiry Body as described in Section 1 of this Article.

ARTICLE VI: HEARING AND APPEAL PROCEDURE

Section 1. Right to Hearing

A. When in the reasonable belief that an action is in furtherance of quality care, the Medical Executive Committee makes a recommendation to:

1. Terminate a Practitioner's staff appointment
2. Change a Practitioner's status to a lower category of membership for other than automatic reasons
3. Reduce a Practitioner's Clinical Privileges
4. Reject a Practitioner's application for staff appointment
5. Grant an applicant for Staff appointment less Clinical Privileges than Practitioner requests
6. Deny a Practitioner's request for increased Clinical Privileges

Such recommendation shall entitle the Practitioner to a hearing before an Ad Hoc Hearing Committee of the Medical Staff as described in Section 5 of this Article.

B. In the same manner, should the Board of Managers decide to proceed with any of the above listed actions, such recommendation shall entitle the Practitioner to a hearing before an Ad Hoc Hearing Committee of the Medical Staff as described in Section 5 of this Article.

Section 2. Request for Hearing

A. Upon receipt of an Adverse Recommendation from the Medical Executive Committee (as described above in Section 1A) or the Board of Managers (as described above in Section 1B), the Practitioner shall be given notice of the following by the Chair of the Medical Executive Committee.

1. That an Adverse Action against the Practitioner has been proposed
2. The reason(s) for the proposed Adverse Action (This should include the criteria upon which Medical Staff members are evaluated and the manner in which the Practitioner failed to meet the standard)
3. That the Practitioner has a right to request a hearing concerning the proposed action
4. The time limit within which the Practitioner must request a hearing concerning the proposed action
5. A summary of the Practitioner's rights in the hearing

B. A Practitioner who desires to claim his/her right to a hearing must provide such request in writing. Failure of a Practitioner to demand a hearing to which he/she is entitled by

these Bylaws within thirty (30) days from the date of receipt of the notification described in Section 2A above shall be deemed a waiver of the Practitioner's right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

C. Within seven (7) days after receipt of the demand for a hearing from a Practitioner entitled to the same, the Medical Executive Committee shall schedule and arrange for such a hearing and through the Chair shall notify the Practitioner of the time, date, and location of the same. The hearing date shall be not less than thirty (30) days from the receipt of the demand for a hearing, unless the Practitioner requests a shorter timeframe. A hearing for a Practitioner who is already under suspension shall be held as soon as arrangements can reasonably be made but not later than fourteen (14) days from the date of receipt of such Practitioner's request for hearing.

D. All correspondence with regard to hearings shall be made by certified mail, return receipt requested or hand delivered. This shall include but is not necessarily limited to dates, times, and locations of hearings; rights of the affected Practitioner to hearings and subsequent appeals; records of any proceedings; final determinations by the Medical Executive Committee, Board of Managers, or both.

Section 3. Ad Hoc Hearing Committee Appointment

Upon receipt of a request for hearing as described above in Section 2B, the Hospital Board of Managers or its designee, the Medical Staff Executive Committee, shall appoint the members and Chair of the Ad Hoc Hearing Committee. This committee shall be composed of not less than three (3) members of the Medical Staff with no member being in direct competition with the affected Practitioner. No member of this committee shall have actively participated in the consideration of the Adverse Recommendation. This exclusion extends to all members of the Medical Executive Committee, the person who made the original request for corrective action, and any member of the Hospital Board of Managers. Knowledge of the matter involved shall not preclude a member of the Medical Staff from service as a member of the Ad Hoc Hearing Committee. In the event that it is not feasible to appoint an Ad Hoc Hearing Committee from the Active Medical Staff, the Board of Managers or the Medical Executive Committee may appoint members from other Medical Staff categories or even Practitioners who are not members of the Hospital's Medical Staff but are members of the Medical Staff of other hospitals in the area and are willing to serve on this committee.

Section 4. Pre-Hearing Conference

Prior to the conduct of the hearing, the Chair of the Ad Hoc Hearing Committee shall provide reasonable notice to the Medical Executive Committee and to the affected Practitioner of a date and time for a pre-hearing conference. This conference shall be scheduled a reasonable time prior to the conduct of the hearing. Prior to the pre-hearing conference, the Practitioner shall identify his attorney or other person who is to be his representative at the hearing. At the pre- hearing conference, the Chair of the Ad Hoc Hearing Committee, the counsel or representative of the Medical Executive Committee, and the affected Practitioner shall convene for the purposes as follows:

A. Resolution of any procedural matters.

B. Exchange of witness lists.

C. Exchange of documents to be submitted at the hearing.

D. Discussion of anticipated time required for witnesses and evidence.

E. Resolution of any pre-hearing objections or questions.

Section 5. Conduct of Hearing

A. There shall be at least a majority of the members of the Ad Hoc Hearing Committee present when the hearing takes place, and no member may vote by proxy. At the discretion of the Chair of the Ad Hoc Hearing Committee, a representative of Hospital Administration may be invited to be present without vote.

B. An accurate record of the hearing must be kept. The mechanism shall be established by the Chair of the Ad Hoc Hearing Committee and may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes. Copies of the proceedings shall be made available to the Practitioner upon payment of any reasonable charges.

C. A Practitioner who fails to appear at such hearing without good cause shall be deemed to have waived his/her rights in the same manner as provided in Section 2B of this Article of these Bylaws and to have accepted the recommendation or decision involved. The recommendation shall thereupon become and remain in effect as provided in these Bylaws.

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

E. The affected Practitioner shall be entitled to call, examine, and cross-examine witnesses; to present evidence relevant to the hearing; and to submit a written statement at the close of the hearing. The Practitioner may be represented by an attorney or other person of his/her choosing during the course of the proceedings, but this counsel shall not be entitled to call, examine, or cross-examine witnesses; nor shall he/she present evidence. The Medical Executive Committee shall have all of these same rights.

F. The Chair of the Ad Hoc 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 Ad Hoc Hearing Committee may, without special notice, recess the hearing and reconvene at another time 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 adjourned. The Ad Hoc Hearing Committee may thereupon at a time convenient to itself, conduct its

deliberations outside the presence of the representatives of the Medical Executive Committee and the Practitioner for whom the hearing was convened.

Within ten (10) days after the final adjournment of the hearing, the Ad Hoc Hearing Committee shall make a written report and recommendation signed by the Chair and shall forward the same together with the hearing record and all of the documentation to the Medical Executive Committee. The report may recommend confirmation, modification, or rejection of the original Adverse Recommendation of the Medical Executive Committee or the decision of the Board of Managers. The affected Practitioner shall be entitled to receive the Hearing Committee's written report and recommendation.

H. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected Practitioner, the Practitioner shall be entitled to an appellate review by the Board of Managers before the Board of Managers makes a final decision on the matter.

Section 6. Appeal to the Board of Managers

A. Within thirty (30) 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, Practitioner may do the following by written notice to the Board of Managers:

1. Demand an appellate review by the Board of Managers: A demand for an appellate review will be held only on the record on which the Adverse Recommendation or decision is based, unless an exception is provided under this Section 6, Paragraph A.
2. Demand that oral argument be permitted as part of the appellate review.
3. Submit a written statement in Practitioner's behalf regarding those factual and procedural matters with which Practitioner disagrees. This statement shall specify the reasons for such disagreement and may cover any matter raised at any step in the procedure to which the appeal is related.

   If the Practitioner submits a written statement, a similar statement may be submitted by the Medical Staff within ten (10) days of receipt of the Practitioner's statement. If a statement is submitted by the Medical Staff, the Hospital Board of Managers' President shall provide a copy thereof to the Practitioner within five (5) days of receipt. The time limits may be shortened when the Practitioner is under suspension and an expedited review has been scheduled as provided in Section 2C of this Article.

B. If such appellate review is not demanded within thirty (30) days, the affected Practitioner shall be deemed to have waived his/her right to the same, and to have accepted the Adverse Recommendation or decision. The recommendation shall become effective immediately when acted upon by the Board of Managers.

C. Within seven (7) days after receipt of a notice of demand for appellate review, the Chair of the Board of Managers shall schedule a date for such review and shall notify the

Practitioner of the same. The date of appellate review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of demand for appellate review except that when the Practitioner demanding the review is under suspension in which case such review shall be scheduled as soon as arrangements can be reasonably 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 members of the Board of Managers or by a duly appointed committee of members of the Board of Managers of not less than three members. All action required of the Board of Managers may be taken by a committee of the Board of Managers duly authorized to act.

E. The affected Practitioner shall have access to the report and record of the Ad Hoc Hearing Committee and all other material, favorable or unfavorable, that was considered in making the Adverse Recommendation or decision against the Practitioner however, only the conclusion of the Board of Mangers' deliberation and not the record of the deliberations, shall be available.

F. The Board of Managers 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 statements submitted pursuant to paragraph A of this Section for the purpose of determining whether the Adverse Recommendations or decisions against the affected Practitioner were justified and were not arbitrary, unreasonable, or capricious. If oral argument is demanded as a part of the review procedure, the affected Practitioner shall be present at such appellate review and shall be permitted to speak against the Adverse Recommendation or decision, and shall answer questions put to the Practitioner by any member of the appellate review body. The Medical Executive Committee shall also be represented by an individual who shall be permitted to speak in support of the Adverse Recommendation and who shall answer questions posed by any member of the appellate review body. The appellate review body may call any witnesses it deems necessary.

G. New or additional matters not raised during the original hearing nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances and the appellate review body shall in its sole discretion determine whether such new matters shall be accepted.

H. The Board of Managers or its appointed review committee shall affirm the recommendation and subsequent decision of the Medical Executive Committee if the recommendation is supported by substantial evidence in the record of the hearing, if the recommendation will improve the quality of health care, if a reasonable effort was made to ascertain the facts before the recommendation was made, and if the procedures used in reaching the recommendation substantially complied with the Bylaws. If the Board of Managers or its appointed review committee determines that any of these review standards have not been met, it can either correct the deficiency or refer the matter to the Reconciliation process outlined in Section 6J of this Article.

I. The appeal procedure shall not be deemed concluded until all of the procedural steps provided in this Section have been completed or waived.

J. Within fifteen (15) days after the conclusion of the appeal procedure, the Board of Managers or its appointed review committee shall make its decision in the matter and shall send written notice thereof to the Medical Executive Committee and through the Board President to the affected Practitioner. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall immediately become effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Board of Managers shall refer the matter to a Reconciliation Committee comprised of two (2) members of the Board of Managers, two (2) members of the Medical Staff, and two (2) members of the Hospital Administration chosen by those bodies for further review. This review shall be completed and a subsequent recommendation shall be made by the Reconciliation Committee to the Board of Managers within fifteen (15) days. At its next meeting, after receipt of the Reconciliation Committee's recommendation, the Board of Managers shall make its final decision with like effect and notice as first above provided in this paragraph.

K. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of action by the Medical Staff or by the Board of Managers.

L. Any applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply for Medical Staff membership for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier Adverse Action no longer exists.

ARTICLE VII: ORGANIZATION OF THE MEDICAL STAFF

Section 1. The Medical Executive Committee

Unless otherwise specifically excepted in these Medical Staff Bylaws, the Medical Executive Committee shall consist of the entire Active Medical Staff. This Committee serves as the governing body of the Medical Staff as described in these Bylaws. The Chief Operating Officer of the Hospital must be invited to participate, without vote, at the Medical Executive Committee meeting.

The Active Medical Staff shall annually elect the Chair of the Medical Executive Committee from the Active Medical Staff, who shall be a physician in good standing with the Active Medical Staff. In the event that the Chair does not maintain the status of a physician in good standing with the Active Medical Staff at the Hospital, the Chair shall automatically be removed from office. The Chair of the Medical Executive Committee may also be removed from office upon a two-thirds vote of the Active Medical Staff, following discussion at a regular or specially called meeting of the Medical Executive Committee. Should a vacancy occur in the position of

Chair of the Medical Executive Committee, whether through voluntary resignation or involuntary action, the Medical Executive Committee shall immediately elect a new Chair to serve for the remainder of the term of the outgoing Chair of the Medical Executive Committee.

The Medical Executive Committee shall meet at least six (6) times per year and a permanent record of the proceedings and actions shall be maintained. Unless otherwise noted in these Bylaws, a Quorum shall consist of at least two (2) members of the Active Medical Staff. Decisions will be made by a majority vote of all members present.

The responsibilities of the Medical Executive Committee shall be:

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

B. To review and recommend amendments to the Medical Staff Bylaws, subject to the amendment process as described in Article XII.

C. To review Rules and Regulations, Policies and Procedures, and make recommendations regarding the same to the Board of Managers

D. To receive and act upon reports and recommendations from specifically assigned activity groups.

E. To review all applicants for initial appointment, reappointment, and when applicable Clinical Privileges and to make recommendations to the Board of Managers regarding the same.

F. To fulfill the Medical Staff's accountability to the Board of Managers for the medical care provided to patients.

G. To take all reasonable steps to ensure professional and ethical conduct as well as competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective action when warranted, in accord with the Medical Staff Bylaws provisions.

H. To lead the Medical Staff in collaboration with the Hospital's performance improvement activities and their implementation.

I. To be responsible for Medical Staff compliance with Indiana Department of Health Regulations, and accreditation standards of TJC , as well as other accreditation- granting organizations.

J. To keep the Medical Staff apprised of Medical Executive Committee activities on an ongoing basis.

K. To take reasonable steps to develop continuing education activities and programs for the Medical Staff.

L. To recommend action to the Hospital President and the Board of Managers on hospital management matters including but not limited to long range planning.

The Medical Staff may, at a regular or special meeting at which a quorum is achieved, remove and reassign any of the authority here delegated to the Medical Executive Committee for a stated period of time, for a reason identified and supported by the meeting, by a vote of three-fourths (3/4) of the voting members.

Section 2. The QRM Advisory Board

The QRM Advisory Board shall consist of up to six (6) members who shall be appointed by the Medical Executive Committee. Three of the members of the QRM Advisory Board shall be from the Orthopaedic specialty and one from anesthesia. The remaining members of the QRM Advisory Board shall be appointed from the Contract Practitioners providing other specialty services to patients of the Hospital. The purpose of the QRM Advisory Board is to provide clinical quality and operational input to the Active Medical Staff of the Hospital. All final decision-making is reserved to the Active Staff and to the Board of Managers as provided in these Bylaws and the Hospital governance documents.

Section 3. Special Committees

Special or "ad hoc" Committees may be appointed by the Chair of the Medical Executive Committee to carry out a specific function of the Medical Staff. These committees will confine their work to the purpose for which they were appointed and shall make a report to the Medical Executive Committee. When the specific function has been completed, the special committee will be dissolved.

ARTICLE VIII: PRIVILEGE AND IMMUNITY/CONFIDENTIALITY

Section 1. Privilege and Immunity

The Medical Staff, its members, any committees, along with third parties who supply information to the foregoing, shall be afforded all of the privileges and immunities provided by applicable State and Federal laws. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institutions' activities related, but not limited to:

A. Application for appointment or Clinical Privileges
B. Periodic reappraisals for reappointment or Clinical Privileges
C. Corrective action, including Precautionary Suspension
D. Hearings and appellate reviews

E. Quality assessment activities (peer review)

F. Utilization reviews

G. Other activities related to Professional conduct

Section 2. Confidentiality

Inasmuch as effective peer review as well as the consideration of the qualifications of Medical Staff Members and applicants for privileges, appointment, and reappointment must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with a peer review communication made to other hospitals, professional societies, or otherwise made to licensing authorities, and communications as to matters that are outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is deemed that such a breach has occurred, the Medical Executive Committee may undertake such disciplinary procedures as it deems appropriate, subject to the fair hearing procedures in ARTICLE VI.

ARTICLE IX: HISTORY AND PHYSICALS

A History and Physical is required for all inpatient admissions, observation patients and outpatients undergoing invasive procedures. The History and Physical must be completed within 24 hours after admission and before any invasive procedure is performed. A History and Physical performed and documented up to 30 days prior to an admission, readmission, or procedure may be used for that admission, readmission or procedure provided there is an examination and update performed within 24 hours after the admission, or readmission, and prior to any procedure documenting any significant changes. If there are no significant changes, there must be a notation on the original document, in the progress notes, or on a form specifically designed to document an H&P update so stating. A Podiatrist shall be responsible only for the history and examination pertinent to their area of specialty. The complete History and Physical must be performed by those Medical Staff Members with Privileges to do so. The History and Physical shall include the following elements:

A. History: Chief complaint; present illness; relevant past, social and family history; summary of psychological needs as appropriate to the patient's age; current medication; allergies; review of systems.

B. Examination: must include at least 2 of the 14 below:
    1. Vital and/or General appearance
    2. Eyes
    3. Ears, nose, mouth and throat
    4. Cardiovascular
    5. Respiratory
    6. Gastrointestinal
    7. Genitourinary
    8. Skin/breast
    9. Neurological

10. Hematologic/lymphatic
11. Allergic/immunologic
12. Psychiatric
13. Musculoskeletal
14. Endocrine

C. Diagnostic Impression
D. Treatment Plan

Complete details regarding the History and Physical can be found in the Medical Staff Rules and Regulations.

ARTICLE X: RULES AND REGULATIONS, MEDICAL STAFF POLICIES

The Medical Staff shall initiate and adopt such Rules, Regulations, and Policies as may be necessary for the proper conduct of its work and to implement more specifically the general principles found within these Bylaws. Such Rules, Regulations, and Policies shall be subject to the approval of the Medical Executive Committee, and shall be attendant to these Bylaws. Said Rules, Regulations, and Policies shall relate to the proper conduct of Medical Staff, organizational activities, and the level of practice that is to be required of each Practitioner in the Hospital.

Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted.
If there is a conflict between the Bylaws and Rules and Regulations, the Bylaws shall prevail. Those documents relating to the basis for granting membership and Privileges shall not become effective until also approved by the Board of Managers.

ARTICLE XI: DUES AND ASSESSMENTS

The Medical Staff has the authority to levy dues and assessments.

ARTICLE XII: AMENDMENTS/REVISIONS TO THE BYLAWS

Upon recommendation from the Medical Executive Committee, the Medical Staff Bylaws may be amended and/or revised in the following manner:

A. Proposed amendments or revisions to the Bylaws shall be distributed to the Active Members of the Medical Staff by mail, fax, or hand carried.

B. Action on such proposed amendments or revisions shall be carried out at the next Medical Executive Committee meeting, which shall be no less than ten (10) days after the amended document distribution.

C. Amendment or revision requires a vote of at least fifty (50%) percent of the Active Medical Staff eligible to vote, voting in person or by written ballot.

D. Amendments so made shall be effective when approved by the Board of Managers.

The Medical Staff and the Board of Managers acknowledge and agree that neither party may unilaterally amend these Bylaws or the Rules, Regulations, and Policies, which are a part of these Bylaws. Upon approval by the Board of Managers, significant changes will be forwarded to all members of the Medical Staff.

ARTICLE XIII: ADOPTION OF BYLAWS

These Bylaws are adopted by the Hospital Active Medical Staff on the date set forth below.
Approved and Effective: October 19, 2022

Parkview Ortho Hospital

By: _____
John Williams, MD
Chair, Medical Staff Executive Committee