MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF SAINT JOSEPH REGIONAL MEDICAL CENTER

CREDENTIALS POLICY

OF

SAINT JOSEPH REGIONAL MEDICAL CENTER MISHAWAKA

AND

SJRMC-PLYMOUTH CAMPUS, INC.

Effective Date
June 8, 2021

TABLE OF CONTENTS

PAGE

PAGE

PAGE

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "BOARD" means the Board of Trustees of Saint Joseph Regional Medical Center or Board of Directors of Saint Joseph Regional Medical Center-Plymouth Campus, Inc., as applicable.

(2) "CHIEF MEDICAL OFFICER" or "CMO" means the individual appointed by the Board to act as the chief medical officer of the Medical Center, in cooperation with the President of the Medical Staff.

(3) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(4) "DAYS" means calendar days.

(5) "HOSPITAL-TRAINED DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.") who is trained and experienced in hospital practice.

(6) "MEDICAL CENTER" means Saint Joseph Regional Medical Center or Saint Joseph Regional Medical Center-Plymouth Campus, Inc., as applicable.

(7) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Executive Committee of the respective Medical Staffs.

(8) "MEDICAL STAFF" means all physicians, hospital-trained dentists, and podiatrists who have been appointed to the respective Medical Staffs by the respective Boards.

(9) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section chairperson, and committee chair.

(10) "MEMBER" means any physician, hospital-trained dentist, and/or podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center.

(11) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.

(12) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

(13) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(14) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(15) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the respective Medical Centers.

(16) "PRESIDENT OF THE MEDICAL STAFF" means the individual elected by the Medical Staff to perform the functions outlined in this Credentials Policy and the related Medical Staff documents.

(17) "SJRMC" means Saint Joseph Regional Medical Center.

(18) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Medical Center management, by a Medical Staff member, or by a Medical Staff Committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, hospital-trained dentists, and podiatrists must:

(a) have a current, unrestricted license to practice in Indiana and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration and Indiana state controlled substance license;

(c) be located (office and residence) close enough to the Medical Center to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Medical Center (Emergency Medicine physicians are exempt from this requirement);

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;

(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties as defined in the federal or state statutes and regulations;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never had Medical Staff appointment, clinical privileges, employment, or other contractual arrangement denied, revoked, resigned, relinquished, or terminated by any health care facility, health plan, or group practice for reasons related to clinical competence or professional conduct;

(h) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, sexual misconduct, or violence;

(i) agree to fulfill all responsibilities regarding emergency call;

(j) have or agree to make acceptable coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

(k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges, a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (acceptable residency training programs for Emergency Medicine physicians are Emergency Medicine, Family Medicine, and/or Internal Medicine);*

(l) are certified in their primary area of practice at SJRMC by the appropriate specialty/subspecialty board of the ABMS, the AOA, the Commission on Dental Accreditation, or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or the American Board of Podiatric Surgery. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training;* and

(m) maintain certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at on an ongoing basis and at the time of applicable specialty/subspecialty board certification expiration.*

* These requirements shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. These requirements are not applicable to existing Medical Staff members at any facility. Existing Medical Staff members shall be grandfathered and shall be governed by the residency training and board certification requirements in effect at the time of their appointments. If a member of the Medical Staff was board certified in their area of practice as of January 1, 2007, the Medical Staff member is required to maintain their board certification in their area of practice for so long as the Medical Staff member maintains membership on the Medical Staff.

2.A.2. Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request in writing that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Medical Center and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Indiana or the National Practitioner Data Bank.

2.A.3. Factors for Evaluation:

Only those individuals who can document that they are qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, demonstrated current clinical competence, and judgment;

(b) adherence to the ethics of their profession;

(c) good reputation and character;

(d) ability to perform, safely and competently, the clinical privileges requested;

(e) ability to utilize medical resources efficiently; and

(f) ability to work harmoniously with others sufficiently to convince the Medical Center that all patients treated by them will receive quality care and that the Medical Center and its Medical Staff will be able to operate in an orderly manner.

2.A.4. No Entitlement to Appointment:

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

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(d) resides in the geographic service area of the Medical Center; or

(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, or national origin.

2.A.6. Ethical and Religious Directives:

All members shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Medical Center. No activity prohibited by said directives shall be engaged in at the Medical Center by any Member.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Medical Center and Medical Staff in force during the time the individual is appointed;

(c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as assigned;

(d) to provide immediately, with or without request, new or updated information to the President or CMO as it occurs, pertinent to any question on the application form;

(e) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(h) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(i) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(j) to seek consultation whenever necessary;

(k) to participate in monitoring and evaluation activities;

(l) to complete in a timely manner all medical and other required records, containing all information required by the Medical Center;

(m) to participate in an Organized Health Care Arrangement with the Medical Center, to abide by the terms of the Medical Center's Notice of Privacy Practices with respect to health care delivered in the Medical Center, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;

(n) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(o) to promptly pay any applicable dues, assessments, and/or fines;

(p) to satisfy continuing medical education requirements; and

(q) that, if there is any misstatement in, or omission from, the application, the Medical Center may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other

hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.

(c) Individuals who apply to exercise clinical privileges after the age of 72 must obtain appropriate health assessments. Individuals will be required to have a physical and mental health assessment performed by a physician who is acceptable to both the Credentials Committee and the applicant. The cost of the health assessment shall be borne by the applicant. The examining physician shall provide a written report addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

(d) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any member of the Medical Staff, their authorized representatives, and

appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Medical Center, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes the Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility.

(d) Authorization to Share Information among SJRMC Facilities:

The individual specifically authorizes the SJRMC facilities (Saint Joseph Regional Medical Center, or Saint Joseph Regional Medical Center-Plymouth Campus, Inc.) to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(f) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Medical Center and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the Board, upon recommendation by the MEC and Credentials Committee.

(b) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents and fellows who are in the final six months of their training and processed in accordance with this Policy. The Board may determine to appoint and grant privileges to qualified applicants, which shall become effective when the Medical Center receives confirmation of the successful completion of training.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office and the CMO (if necessary) to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified by the CMO that their application will not be processed.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

(d) The names of applicants may be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chairperson, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, the CMO, and/or the President.

3.A.4. Department Chairperson Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The department chairperson may also recommend that an application that raises no questions be considered for expedited processing.

(c) The department chairperson shall be available to the Credentials Committee, MEC, and the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

3.A.5. Expedited Process:

(a) If recommended by the relevant department chairperson, applications for initial appointment may be processed as set forth in this Section so long as they meet the following conditions:

(1) the applicant has successfully completed a residency in the specialty for which privileges are requested, with a consistent and excellent record, with no disciplinary actions taken or conditions imposed during residency training;

(2) the applicant has not changed practice locations more than three times in the past 10 years;

(3) all reference evaluations are completed and received within a reasonable time of the initial request;

(4) all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;

(5) the applicant's claims activity (including past malpractice claims, judgments, and settlements) is reasonable in light of his or her specialty, and there has been no unusual pattern or excessive number of liability actions resulting in a judgment against the applicant;

(6) there are no current or previously successful challenges to licensure or registration;

(7) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of Medical Staff appointment or clinical privileges at any hospital or other entity;

(8) there has been no investigation into and no disciplinary action taken relating to appointment or clinical privileges at any hospital or other entity; and

(9) no member of the Medical Staff has raised a significant and relevant question about the applicant's qualifications.

(b) The Chair of the Credentials Committee, acting on behalf of the Committee, shall review the report from each department chairperson and all relevant information and prepare a report containing a recommendation on appointment, clinical privileges, and department assignment. This report shall be forwarded to the President of the Medical Staff.

(c) The President of the Medical Staff shall review the report and recommendation made by the Chair of the Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the President.

(d) The President may grant the individual temporary clinical privileges for a period not to exceed 120 days.

(e) After determining that an applicant is otherwise qualified for appointment and privileges, the Chair of the Credentials Committee or the CMO shall review the applicant's "Confirmation of Ability to Perform Privileges Requested" form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If there is no question, the temporary privileges shall take effect when granted by the President.

If there is a question, the application shall be referred to the full Credentials Committee.

(f) If the department chairperson, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, or the President has any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.

(g) A report regarding all applicants who are granted temporary clinical privileges shall be forwarded to the Credentials Committee for information, and the application for appointment and clinical privileges shall be forwarded to the MEC for review and recommendation, and to the Board for final action.

3.A.6. Full Credentials Committee Procedure:

(a) For all other applications, the Credentials Committee shall review and consider the report prepared by the relevant department chairperson and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's "Confirmation of Ability to Perform Privileges Requested" form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to both the Credentials Committee and the applicant. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the President, explaining the reasons for the delay.

3.A.7. MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee (and/or its Chair), the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee (and/or its Chair) as its own; or

(2) refer the matter back to the Credentials Committee (and/or its Chair) for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's (and/or its Chair's) recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board through the President of the Medical Staff.

(c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC shall forward its recommendation to the President, who shall promptly send special notice to the applicant. The President shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.8. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee (and/or its Chair) and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Medical Center for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the President shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to the appropriate individuals, as required, reported to the appropriate entities within 7 days of Board decision.

3.A.9. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Medical Center. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Medical Center's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(c) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.

(d) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

(e) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;

(2) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;

(3) adequate professional liability insurance coverage for the clinical privileges requested;

(4) the Medical Center's available resources and personnel;

(5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(6) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(7) practitioner-specific quality and resource utilization data compared to aggregate data, when available; and

(8) results of performance improvement and peer review activities, including morbidity and mortality data, when available.

(f) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(g) The report of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

(h) During the term of appointment, a member may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Voluntary Relinquishment of Privileges:

(a) A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the MEC specifying the clinical privilege(s) to be relinquished and the reasons for the request. The department chairperson shall make a recommendation to the MEC concerning the request.

(b) The MEC may request a meeting with the member involved. The MEC shall make a recommendation to the Board.

(c) The Board shall make a final decision on the request, based upon, among other factors, how the request will affect the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. The Board's decision shall be reported in writing by the President to the member, the MEC, and the applicable department chairperson. If the Board permits the relinquishment of privileges, it shall specify the effective date of the relinquishment.

(d) Failure of a member to request relinquishment of clinical privileges as set forth above shall result in the member being maintained on the call schedule without any change to his or her call responsibilities.

(e) Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility or arrange for appropriate coverage.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Medical Center, and (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Credentials Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Medical Center has the capabilities, including support services, to perform the new procedure.

(c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Medical Center (such as from recognized sources including the American Medical Association, ACGME and AOA training programs, and specialty societies and academies). The Credentials Committee shall then develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that traditionally at the Medical Center have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

(c) The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

4.A.5. Clinical Privileges After Age 72:

(a) Individuals who desire to exercise clinical privileges after the age of 72 must obtain appropriate health assessments within three (3) months of turning 72 and annually thereafter.

(b) These individuals will be required to have a physical and mental health assessment performed by a physician who is acceptable to both the Credentials Committee and the applicant. The cost of the health assessment shall be borne by the applicant. The examining physician shall provide an written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

4.A.6. Clinical Privileges for Hospital-Trained Dentists and Oral and Maxillofacial Surgeons:

(a) The scope and extent of surgical procedures that a hospital-trained dentist or an oral and maxillofacial surgeon may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by hospital-trained dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chairperson of Surgery or of Dentistry (as applicable). A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee.

(d) The hospital-trained dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical

examination, as well as all appropriate elements of the patient's record. Hospital-trained dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

4.A.7. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of Orthopedic Surgery (Mishawaka) or Chairperson of Surgery (Plymouth). A medical history and physical examination of each patient shall be made and recorded by a physician member of the Medical Staff before podiatric surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Podiatrists who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee.

(d) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws and this Policy.

4.A.8. Physicians in Training:

Physicians in training shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the MEC or its designee. Such physicians in training will be under the continuous supervision of a Member of the Medical Staff with appropriate privileges. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.9. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services that may be provided through telemedicine after considering the recommendations of the appropriate department chairperson(s), the Credentials Committee, and the MEC.

(b) Individuals providing telemedicine services shall be credentialed in accordance with this section. In addition, as applicable, the contractual arrangement that authorizes them to provide services at the Medical Center shall address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

(c) In processing a request for telemedicine privileges, the Medical Center may utilize any of the following mechanisms:

(1) credential and grant privileges to the practitioner in accordance with the provisions of this Policy in the same manner as any other applicant; or

(2) credential and grant privileges to the practitioner in accordance with the provisions of this Policy, but utilize the credentialing information from the practitioner's primary hospital, provided that hospital is accredited by The Joint Commission; or

(3) credential and grant privileges to the practitioner based on the credentialing information and privileging decision from the practitioner's primary hospital, if the following conditions are met:

(i) the primary hospital is accredited by The Joint Commission;

(ii) the practitioner has clinical privileges at the primary hospital to perform the same service or procedure being requested at the Medical Center; and

(iii) the Medical Center reviews the practitioner's performance of the privileges being requested and provides information resulting from that review to the primary hospital.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the President, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following: (i) the care of a specific patient; (ii) an individual serving as a locum tenens for a member of the Medical Staff; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area. Prior to the granting of temporary privileges in these situations, current licensure and current competence shall be verified.

(b) Temporary privileges may also be granted by the President, upon recommendation of the President of the Medical Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the MEC and Board, following a favorable recommendation of the Credentials Committee (or its Chair). Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested; compliance with privileges criteria; and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration, and that the individual has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Medical Center.

(d) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days. Temporary privileges for an important patient care need may be extended beyond 120 days by action of the President in consultation with the President of the Medical Staff.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chairperson. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

(a) The granting of temporary privileges is a courtesy and may be terminated for any reason. The President may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the department chairperson, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged. A termination notice with explanation will be sent to the individual by certified mail.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the President, the department chairperson, or the President of the Medical Staff may immediately terminate all temporary privileges. The department chairperson or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician. A termination notice with explanation will be sent to the individual by certified mail.

(c) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chairperson or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. CONTRACTS FOR SERVICES

(1) From time to time, the Medical Center may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Medical Center. All individuals functioning pursuant to such contracts shall obtain and maintain Medical Staff appointment and/or clinical privileges at the Medical Center, in accordance with the terms of this Policy.

(2) To the extent that any such contract confers the exclusive right to perform specified services at the Medical Center on the other party to the contract, no other person may exercise clinical privileges to perform the specified services while the contract is in effect.

(3) If any such exclusive contract would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of this Policy. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application will be considered complete and processed further; and

(f) paid the reappointment processing fee.

5.A.2. Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

(a) current clinical competence, judgment, and technical skill in the treatment of patients;

(b) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Medical Center;

(c) participation in Medical Staff duties, including committee assignments and emergency call;

(d) behavior at the Medical Center, including cooperation with Medical Staff and Medical Center personnel, as it relates to patient care, the orderly operation of the Medical Center, and ability to work with others;

(e) use of the Medical Center's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (other practitioners shall not be identified);

(f) whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, or otherwise limited at any other hospital or health care facility, or are currently being investigated or challenged;

(g) whether the applicant's license to practice in any state, DEA registration, or any state controlled substances registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;

(h) whether the applicant's professional liability coverage and/or professional liability litigation experience has changed, including information concerning past and pending claims, final judgments, or settlements, the substance of the allegations as well as the findings and the ultimate disposition and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(i) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;

(j) capacity to satisfactorily treat patients as indicated by the results of the Medical Center's performance improvement and professional and peer review activities;

(k) appropriate resolution of any verified complaints received from patients and/or staff; and

(l) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least six months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.

(b) Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(c) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

(d) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

(e) Reappointment shall be for a period of not more than two years.

(f) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Office shall forward the application to the relevant department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment, except that applications for reappointment and renewal of clinical privileges shall not be eligible for the expedited process. Applications for reappointment and renewal of clinical privileges shall instead be processed through the full Credentials Committee and the MEC.

(b) If it becomes apparent to the Credentials Committee or the MEC that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and the Medical Center management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(3) All collegial intervention efforts by Medical Staff leaders and the Medical Center management are part of the Medical Center's performance improvement and professional and peer review activities.

(4) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(6) The President of the Medical Staff, in conjunction with the CMO and the President, shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Practitioner Health or the Code of Conduct Policy, or to direct it to the MEC for further determination.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Medical Center or the Medical Staff; and/or

(3) conduct by any member of the Medical Staff that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter may be referred to the President of the Medical Staff, the chairperson of the department, the chair of a standing committee, the CMO, or the President.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the MEC.

(c) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the Policy on Practitioner Health or the Code of Conduct Policy), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

(b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the Board, or an ad hoc committee.

(d) The President of the Medical Staff shall keep the President fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., another physician, dentist, or podiatrist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that:

(1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The individual being investigated shall be responsible for the cost of the examination.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. Neither the individual being investigated nor the investigating committee shall be represented by legal counsel

at this meeting. However, both parties shall have the right to seek guidance and counsel from an attorney prior to this meeting.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(1) relevant literature and clinical practice guidelines, as appropriate;

(2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

(3) any information or explanations provided by the individual under review.

6.B.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring or consultation;

(5) recommend additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the President, who shall promptly inform the individual by special notice. The President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the President shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

(a) Any two of the following the President of the Medical Staff, the chairperson of a clinical department, the Chair of the Credentials Committee, the CMO, or the President shall have the authority to suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

(b) If a member is precautionarily suspended, the President of the Medical Staff shall meet with the member (and with another appropriate Medical Staff colleague if the member is unable to comprehend the grounds or action) to explain the grounds and action at the time of the suspension. A written notice with explanation will also be sent to the affected individual by certified mail.

(c) Precautionary suspension or restriction is an interim step in the professional review activity. It is not a complete professional review action in and of itself and shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President, the CMO, and the President of the Medical Staff, and shall remain in effect unless it is modified by the President or the MEC.

6.C.2. MEC Procedure:

(a) The MEC shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Medical Center, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chairperson, the MEC, and the President in enforcing precautionary suspensions or restrictions.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records after notification by the medical records department of the delinquency shall result in automatic administrative relinquishment of all clinical privileges. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations and/or Policy. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations and/or Policy shall result in automatic resignation from the Medical Staff.

6.D.2. Action by Government Agency or Insurer:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the President or the CMO.

(b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

(1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or Indiana state controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Medical Center or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) sexual misconduct, or (v) violence against another.

(c) Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable. Requests for reinstatement shall be reviewed by the relevant department chairperson, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff

member may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.D.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the MEC, the CMO, the President, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

6.D.4. Failure to Attend Special Conference:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairperson or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.E. LEAVES OF ABSENCE

(1) Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.

(2) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(3) The President will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the President shall consult with the CMO, the President of the Medical Staff, and the relevant department

chairperson. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(4) During the leave of absence, the individual shall not exercise any clinical privileges in the Medical Center. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., committee service, emergency service call obligations) during this period.

(5) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Center. Requests for reinstatement shall then be reviewed by the relevant department chairperson, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

(6) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the President. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

(8) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days;

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

(8) denial of reinstatement following a leave of absence.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the MEC" shall be interpreted as a reference to "the Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, counsel, warning, or reprimand;

(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

(c) termination of temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) imposition of a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence, or for an extension of a leave;

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The President shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the President and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The President shall schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

(b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

(1) The President, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chair. The Hearing Panel shall be composed of members of the Medical Staff who did not actively participate in the matter at any previous level. Knowledge of the matter

involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Medical Center or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a referral relationship with, the individual requesting the hearing.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chair, the President may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) If no Presiding Officer has been appointed, the Chair of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

(3) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

(vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(4) The Presiding Officer may be advised by legal counsel to the Medical Center with regard to the hearing procedure.

(5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the President, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or to the Hearing Officer or Presiding Officer, shall be made in writing, within 10 days of receipt of notice, to the President. A copy of such written objections must be provided to the President of the Medical Staff and must include the basis for the objection, and may include proposed questions to be asked of the Panel member(s) regarding any potential bias. The Presiding Officer shall give the President of the Medical Staff a reasonable opportunity to comment. The Presiding Officer may pose some or all of the questions to the Panel member(s). The Presiding Officer shall then make a recommendation to the President regarding the objections, and the President shall determine whether to replace any Panel member(s).

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law who are licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(f) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact the Medical Center employees appearing on the MEC's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

7.B.3. Pre-Hearing Conference:

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The

Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

The parties and their counsel shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.B.5. Provision of Information to the Panel:

At least two weeks in advance of the hearing, the Presiding Officer shall transmit to the Hearing Panel the Statement of Reasons, any pre-hearing statement that the individual requesting the hearing may choose to submit, and an exhibit book agreed upon by the parties, without the need for authentication.

7.C. THE HEARING

7.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Medical Center. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit a written statement at the close of the hearing.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.C.4. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.5. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.C.6. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President or the President of the Medical Staff.

7.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the President. The President shall send by special notice a copy of the report to the individual who requested the hearing. The President shall also provide a copy of the report to the MEC.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with this Policy and/or the Bylaws of the Medical Center or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Chair of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the MEC for its information.

7.E.6. Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFIDENTIALITY AND PEER REVIEW PROTECTION

8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Medical Center employee and are for the purpose of conducting legitimate credentialing and peer review activities; or

(2) when the disclosures are authorized, in writing, by the President or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

8.B. PEER REVIEW PROTECTION

(1) All credentialing and peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with Indiana law. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Medical Center committees;

(b) Hearing Panels;

(c) the Board and its committees;

(d) any individual acting for or on behalf of the Medical Center, including but not limited to department chairpersons, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

(e) all departments.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of Ind. Code Ann. '16-21-2-8, '16-39-6-3, ''34-30-15-1 et seq., '34-6-2-44, '34-6-2-64, '34-6-2-99, '34-6-2-104, and ''34-6-2-116 through 34-6-2-118, and/or the

corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101 et seq.

ARTICLE 9

AMENDMENTS

(a) All amendments to this Policy must be approved by the MECs for each of the SJRMC facilities (Saint Joseph Regional Medical Center, and Saint Joseph Regional Medical Center-Plymouth Campus, Inc.).

(b) For an amendment to be adopted:

(i) Notice of all proposed amendments shall be provided to all voting Medical Staff members in each facility at least 14 days prior to the MEC meeting at which the amendment will be considered, and any member of the Medical Staff may submit written comments to the MEC; and

(ii) The quorum for the regular or special MEC meeting at which the amendment will be considered must be at least two-thirds (2/3) of all voting members; and

(iii) The amendment must receive a majority vote of the MEC members present and voting at the meeting.

(c) If there is any disagreement among or between the MECs for the two facilities concerning a proposed amendment, a joint meeting shall be called for the purpose of discussing and resolving the disagreement.

(d) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 10

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

Saint Joseph Regional Medical Center - Mishawaka

Adopted by the Medical Staff:	August 11, 2006 December 7, 2009 (MEC) September 13, 2010 April 11, 2011 (MEC) May 5, 2014 March 1, 2021
Approved by the Board:	September 19, 2006 June 24, 2008 (Board Resolution) December 21, 2009 September 20, 2010 April 25, 2011 May 21, 2014 March 30, 2021
Revised Effective Date:	March 20, 2007 effective date January 1, 2007 July 1, 2008 January 1, 2010 October 1, 2010 April 25, 2011 May 21, 2014 March 30, 2021

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Adopted by the Medical Staff:	July 28, 2006 August 23, 2010 (MEC) April 18, 2011 May 9, 2014 March 16, 2021
Approved by the Board:	September 11, 2006 September 14, 2010 June 14, 2011 May 21, 2014 June 8, 2021

Revised Effective Date:	April 11, 2007 October 1, 2010 June 14, 2011 May 21, 2014 June 8, 2021