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

MEDICAL STAFF

ORGANIZATION MANUAL

SAINT JOSEPH REGIONAL MEDICAL CENTER MISHAWAKA

Effective Date
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TABLE OF CONTENTS

PAGE

ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual:

(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.

(7) "MEDICAL EXECUTIVE COMMITTEE" OR "MEC" means the Executive Committee of the Medical Staff.

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

(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) "PATIENT CONTACTS" includes any admission, consultation, procedure (inpatient or outpatient), in-person response to emergency call, evaluation,

treatment or service provided by the Member in the Medical Center. It shall not include referrals for diagnostic or laboratory tests or x-rays.

(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 Medical Center.

(16) "PRESIDENT OF THE MEDICAL STAFF" means the individual elected by the Medical Staff to perform the functions outlined in the Medical Staff Bylaws and related 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 Manual 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

CLINICAL DEPARTMENTS

2.A: LIST OF DEPARTMENTS AND SECTIONS

The following clinical departments and sections are established:

- Anesthesiology
- Cardiovascular Services
- Dental
- Emergency
- Family Medicine
- Medical
  - Allergy
  - Dermatology
  - Endocrinology
  - Hematology
  - Infectious Diseases
  - Internal Medicine
  - Nephrology
  - Neurology
  - Oncology
  - Physical Medicine and Rehabilitation
  - Psychiatry
  - Pulmonology
  - Rheumatology
- Obstetrics & Gynecology
  - GYN Oncology
- Ophthalmology
- Orthopedics
  - Podiatry
- Pathology
- Pediatrics
- Radiology
- Surgery
  - Colon and Rectal Surgery
  - General Surgery
  - Neurosurgery
  - Otorhinolaryngology
  - Plastic and Reconstructive Surgery
  - Urological Surgery

2.B: FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, sections, department officers, and section chairpersons are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Medical Center that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Unless otherwise indicated, procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions.

3.C: BLOOD TRANSFUSION COMMITTEE

3.C.1. Composition:

(a) The Blood Transfusion Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.C.2. Duties:

The Blood Transfusion Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a

result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(c) 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.

3.D. BYLAWS COMMITTEE

3.D.1. Composition:

The Bylaws Committee shall consist of at least three members of the Medical Staff. At least one representative from Administration shall also serve on the committee.

3.D.2. Duties:

The Bylaws Committee shall:

(a) review the Medical Staff Bylaws, the Credentials Policy, the Policy on Allied Health Professionals, this Manual, and the Medical Staff Rules and Regulations, at least every three years, and make recommendations to the MEC for appropriate amendments and revisions; and

(b) review recommendations for changes to these documents proposed by committees, departments, members of the Medical Staff, Medical Center Administration or Board, and

(c) draft recommended language where a Bylaws change is anticipated; and

(d) make recommendation to the MEC.

3.E CARDIOVASCULAR SERVICES PEER REVIEW COMMITTEE

3.E.1. Composition:

(a) The Cardiovascular Services Peer Review Committee shall consist of one member nominated from each group practice and up to two at-large members from the solo practitioners assigned to the Cardiovascular Services Department. The Vice President of Clinical Services, Director of Surgical Services, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.E.2. Duties:

The Cardiovascular Peer Review Committee is a peer review committee of the medical staff and shall:

(a) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Cardiovascular Services Department and, as a result of such review, make a written report of its findings and recommendations to the Department Chair.

(b) 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.

3.F: CENTRALIZED WELL BEING COMMITTEE

3.F.1. Composition:

The Centralized Well Being Committee shall serve as the provider well being committee of this medical staff. The composition of the Centralized Well Being Committee is set forth in the Centralized Well Being Medical Staff Policy.

3.F.2. Duties:

The Well Being Committee shall:

(a) be the identified point within the Medical Center where early informal reports concerning suspected provider impairment can be delivered for consideration;

(b) seek, evaluate, and substantiate additional information to determine if significant impairment exists to determine if a provider is able to perform all of the essential functions of the job with or without a reasonable accommodation, or to determine if a provider poses a direct threat to the health or safety of himself/herself or others;

(c) select two or more individuals to be an adjunct to the Committee and act as an intervention team for each impaired provider; the intervention team is to review the Committee's findings with the provider and provide assistance to enter into a treatment program;

(d) serve as the recovering provider's advocate and facilitate rehabilitation and re-entry into practice without humiliation or rejection; the Committee will select a person who is responsible to the Committee to monitor the recovering provider's progress after re-entry into practice whenever necessary;

(e) educate Medical Staff, Medical Center personnel, and families of provider's concerning provider impairment; and

(c) perform any and all other functions as may be set forth in the Impaired Provider Policy.

(d) 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.

3.G: CREDENTIALS COMMITTEE

3.G.1. Composition:

The Credentials Committee shall consist of the officers of the Medical Staff and at least four additional physicians appointed by the President of the Medical Staff. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable in the credentialing and quality improvement processes.

3.G.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a

thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Licensed Independent Practitioners or Dependent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(e) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations; and

(f) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Medical Center, including specifically as set forth in Section 4.A.3 ("Clinical Privileges for New Procedures") and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

(g) 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.

3.H: CRITICAL CARE PEER REVIEW COMMITTEE

3.H.1. Composition:

(a) The Critical Care Peer Review Committee shall consist of the Medical Director of the ICU and at least four additional physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Vice President of Clinical Services, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.H.2. Duties:

The Critical Care Peer Review Committee is a peer review committee of the medical staff and shall:

(a) review, as may be requested, all information available regarding the current clinical competence and behavior of persons providing care in the ICU and, as a result of such review, make a written report of its findings and recommendations to the appropriate Department Chair.

(b) 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.

3.I. INFECTION PREVENTION COMMITTEE

3.I.1. Composition:

(a) The Infection Prevention Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(a) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.I.2. Duties:

The Infection Prevention Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(c) 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.

3.J: MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.D of the Medical Staff Bylaws.

3.K. MEDICAL REVIEW COMMITTEE

3.K.1. Composition:

(a) The Medical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(a) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(b) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.K.2. Duties:

The Medical Review Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(c) 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.

3.L: MEDICAL STAFF PROFESSIONAL PRACTICE COUNCL

3.L.1. Composition:

(a) The Medical Staff Professional Oversight Committee shall consist of 10-14 members of the medical staff including the President of the Medical Staff. Consideration is to be given to physicians who are knowledgeable in the credentialing and quality improvement processes.

(b) The President of the Medical Staff, in consultation with the MEC, shall appoint the members and the chair of the Medical Staff Professional Oversight Committee. If the chair is not a member of the MEC, he/she may be requested to attend MEC meetings in order to report on activities.

(c) The President of the Medical Center, the Chief Nursing Officer and the Chief Medical Officer and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(d) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(e) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.L.2. Duties:

The Medical Staff Professional Oversight Committee shall:

(a) Be the identified committee that assures the Medical Executive Committee that all required peer review steps are effectively implemented, including multidisciplinary peer review.

(b) Ensure consistency across departments by providing oversight of the peer review program carried out by medical staff departments and committees

(c) Reward physicians who provide exemplary care

(d) Ensure peer review is tied to privileging, Ongoing Professional Practice Evaluation (OPPE) and reappointment

(e) Monitor initial and ongoing compliance with standards outlined in Medical Staff Bylaws, Rules and Regulations, policies and procedures and guidelines

(f) Ensure adherence to external and internal guidelines to practice management which would include utilization pattern and variances

(g) Implement interventions, as needed, to improve operations and in situations that pose a threat to health/welfare of our patients

(h) Provide regular reports to the Credentials Committee and Medical Executive Committee

(i) 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.

3.M: MORBIDITY AND MORTALITY COMMITTEE

3.M.1. Composition:

(a) The Morbidity and Mortality Committee shall consist of a variety of members of the Medical Staff.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(d) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.M.2. Duties:

The Morbidity and Mortality Committee is a peer review committee of the medical staff and shall meet as necessary to:

(a) review, as may be requested, cases where there are interesting cases or other patients experienced as a result of their disease or their treatment while a patient in the Medical Center,

(b) forward cases to the appropriate peer review committee if it is identified that there may be a physician concern of quality.

(c) 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.

3.N. OBSTETRICAL REVIEW COMMITTEE

3.N.1. Composition:

(a) The Obstetrical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.N.2. Duties:

The Obstetrical Review Committee is a peer review committee of the medical staff and shall:

(a) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(c) 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.

3.O. PEDIATRICS REVIEW COMMITTEE

3.O.1. Composition:

(d) The Pediatrics Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined

by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(e) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(f) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.O.2. Duties:

The Pediatrics Review Committee is a peer review committee of the medical staff and shall:

(d) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(e) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(f) 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.

3.P: PERIPHERAL VASCULAR PEER REVIEW COMMITTEE

3.P.1. Composition:

(a) The Peripheral Vascular Peer Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. Committee membership shall contain, at a minimum, one representative each from the specialties of Interventional Cardiology, Interventional Radiology, Cardiothoracic Surgery, and General and Vascular Surgery. The Vice President of Clinical Services, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(b) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(c) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.P.2. Duties:

The Peripheral Vascular Peer Review Committee is a peer review committee of the medical staff and shall:

(a) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing peripheral vascular procedures and, as a result of such review, make a written report of its findings and recommendations to the appropriate Department Chair.

(b) 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.

3.Q. SURGICAL REVIEW COMMITTEE

3.Q.1. Composition:

(c) The Surgical Review Committee shall consist of at least four physicians appointed by the President of the Medical Staff, in consultation with the MEC. The Chief Medical Officer, Peer Review Coordinator, and any other representatives of Administration as determined by the President of the Medical Staff shall also serve on the committee, *ex officio*, without vote.

(d) Other members of the Medical Staff or Medical Center administration may be invited to attend on an as needed basis.

(e) Non-physician members may, at the discretion of the chairperson, be excused from deliberations regarding physician performance.

3.Q.2. Duties:

The Surgical Review Committee is a peer review committee of the medical staff and shall:

(d) review professional performance including the assessment and improvement of the quality of care, treatment, and services provided.

(e) review, as may be requested, all information available regarding the current clinical competence and behavior of persons performing procedures and, as a result of such review, make a report of its findings and recommendations to the appropriate Department Chair.

(f) 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.

ARTICLE 4

AMENDMENTS

(a) This Manual may be amended by the MEC (i) at any regular or special meeting where at least two-thirds (2/3) of the voting MEC members are present, and (ii) the amendment receives a majority vote of the MEC members present and voting at the meeting.

(b) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

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

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this Manual.

Saint Joseph Regional Medical Center

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