MEDICAL STAFF BYLAWS
Amended October 25, 2005

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ARTICLE I: DEFINITIONS

A. The term "Medical Staff" shall mean all duly licensed physicians and other licensed individuals permitted by law and granted privileges by the Governing Body to provide patient care services independently in the Hospital.

B. The term "Governing Body" shall mean the Board of Directors of the Hospital.

C. The term "Executive Committee" shall mean the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

D. The term "President of the Hospital" shall mean the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.

E. The term "practitioner" shall mean an appropriately licensed medical or osteopathic physician with an unlimited license, appropriately licensed dentist or other licensed individuals permitted by law and by the Hospital to provide patient care services independently in the Hospital.

F. The term "Hospital" as used in these bylaws shall mean Ohio Valley General Hospital.

G. The term "Allied Health Professional" or "AHP" means an individual, other than a practitioner, as defined within these bylaws, whose patient care activities require that his or her authority to perform specific patient care services be processed through the usual staff channels delineating his or her qualifications, status, clinical duties and responsibilities. This shall include, but shall not be limited to, psychologists, surgical assistants, nurse practitioners, and physician assistants.

H. The term "medical staff year" means the period from June 1 through May 31.

I. The term "good standing" means the staff member has met the attendance requirements during the previous Medical Staff year, is not in arrears in dues payments and is not under suspension of his appointment, admitting privileges or clinical privileges.

J. The term "peer" shall mean someone of equivalent education, training and licensure. Within this definition, the peer of an oral surgeon is an oral surgeon and not a physician. A peer of a podiatrist is a podiatrist and not a physician.
ARTICLE II: RELATIONSHIP TO HOSPITAL

Section 1. Authority

The Medical Staff shall be an operating entity within the Hospital structure and shall have only that authority which is delegated to it by the Governing Body. Under no circumstances shall the Medical Staff be considered to be a separate entity operating independent from the Hospital.

Section 2. Deliberations Affecting the Medical Staff

The Medical Staff shall have the right to representation and participation in any Hospital deliberation affecting the discharge of Medical Staff responsibilities.

Section 3. The Medical Staff as a Single Entity

The Medical Staff shall exist as only one entity. At no time shall there be more than one Medical Staff nor shall the Staff be divided in separate parts.
ARTICLE III: PURPOSES AND RESPONSIBILITIES

Section I. Purposes

The purposes of the Medical Staff shall be:

A. To provide overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the Governing Body; provided, however, it is not the intention of the Medical Staff, its members, the Hospital, its Governing Body or its administrative staff to grant to any patient any right of recovery as a third party beneficiary of this provision;

B. To provide a mechanism for the review and evaluation of the clinical activities of the Medical Staff and allied health professionals;

C. To support and provide continuing education intending to improve the quality of patient care and the professional knowledge and skills of persons providing health services;

D. To initiate and maintain rules and regulations for self-government of the Medical Staff;

E. To provide a means whereby issues concerning the Hospital and the Medical Staff jointly may be discussed by the Medical Staff with the Governing Body and the President of the Hospital;

F. To participate in the development of broader community and area-wide services and facilities that seek to establish a continuous comprehensive system of personal health care for all residents of the hospital's primary and secondary service area and region; and

G. To promote and carry on scientific research related to the care of the sick and injured which, in the opinion of the Governing Body and the Medical Staff, can be appropriately carried on in, or in connection with, the Hospital.

Section 2. Responsibilities

The responsibilities of the Medical Staff, as delegated to it by the Governing Body, to be fulfilled through the actions of its officers, departments and committees, shall include, without limitation, the following:
A. To formulate for Governing Body approval, bylaws and rules and regulations to establish a framework for self-governance of Medical Staff activities in which Medical Staff members can act with a reasonable degree of freedom and confidence and provide a mechanism of accountability to the Governing Body.

B. To account for the quality and appropriateness of patient care rendered in the Hospital through the following measures:

1. A credentials program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed with the credentials verified from original sources and current demonstrated performance of the applicant, staff member or allied health professional;

2. A continuing education program, fashioned at least in part on the needs demonstrated through the patient care evaluation and other quality improvement programs.

3. A utilization review program to allocate inpatient and outpatient medical and health services based upon patient-specific determination of individual medical needs;

4. Provision of leadership for process measurement, assessment, and improvement, including but not limited to:
   a. Medical assessment and treatment of patients
   b. Use of medications
   c. Use and blood and blood components
   d. Use of operative and other procedures
   e. Efficiency of clinical practice patterns
   f. Significant departures from established patterns of clinical practice
   g. Participation in the measurement and assessment of other patient care processes, including:
      aa. Education of patients and families
      bb. Coordination of care with other practitioners and personnel
      cc. Accurate, timely and legible completion of medical records

5. Determining how the findings of clinical assessment in peer review or the ongoing evaluations of a licensed practitioners competence, will be used in the process of renewing or revising clinical privileges.

C. To recommend to the Governing Body action with respect to appointments, reappointments, Medical Staff categories, departmental assignments, clinical privileges, and corrective actions.
D. To account to the Governing Body and to communicate to Medical Staff members about the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning findings, conclusions, recommendations and actions taken to improve organizational performance.

E. To initiate and pursue corrective action with respect to practitioners, when warranted.

F. To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, and other patient care related Hospital policies.

G. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

H. To exercise the authority granted by these bylaws to adequately fulfill the foregoing responsibilities.

I. To insure that all patients with the same health problem are receiving the same level of care in the Hospital.

J. To insure continuity of care to patients as stipulated in the Rules and Regulations of the Medical Staff (See Article IV, Section 3, F.)
ARTICLE IV: MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professional practitioners who continually meet the qualifications, standards, and requirements set forth in these Bylaws. Medical Staff membership by itself does not confer category, department assignment or clinical privileges. Assignment of category, department and clinical privileges is the prerogative of the Governing Body, in accordance with these bylaws.

All members of the Medical Staff with clinical privileges shall be subject to the Medical Staff bylaws, rules and regulations and policies. In addition, all members with clinical privileges shall be subject to review as part of the Hospital’s performance improvement program.

Section 2. Qualifications for Membership

A. Membership on the Medical Staff shall be limited to practitioners currently licensed to practice in the Commonwealth of Pennsylvania* who have completed a residency approved by the Accreditation Council for Graduate Medical Education or oral surgery residency approved by the American Dental Association, or an equivalent program, who are eligible for certification or certified by the practitioners' respective major specialty board, or its equivalent, or podiatrists who are board eligible, have completed an approved residency program and who:

1. can document their background, experience, training and demonstrated competence, and physical and mental health status, with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that they will provide care to patients at the generally recognized professional level of quality, in an economically efficient manner taking into account patients' needs, the available Hospital facilities and resources as well as the utilization standards in effect at the Hospital;

2. are committed, on the basis of documented references, to strict adherence to the ethics of their respective professions, who can document their good reputations, their ability to work cooperatively with others and their willingness to participate in the discharge of responsibilities;

3. can provide evidence of professional liability insurance coverage in an amount consistent with the applicable standards of the Commonwealth of Pennsylvania and subject to approval by the Governing Body; and

* Licensure shall be verified at time of initial appointment, reappointment, and at the time of licensure expiration and renewal (if such renewal does not coincide with appointment or reappointment)
4. have a current unrestricted Drug Enforcement Agency number.

B. Each new applicant admitted to the Medical Staff shall attain board certification within five (5) years of becoming board eligible as determined by the specific board, or already board certified, or shall be subject to an automatic loss of privileges.

C. Each new applicant for clinical privileges shall submit verification that he has the physical capacity and mental health status to safely exercise the privileges requested.

D. No practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he is duly licensed to practice in Pennsylvania or any other state, or that he is a member of any professional organization, or that he is certified by any clinical board, or that he had in the past, or presently has, staff membership or privileges at another Hospital or health care facility or in another practice setting.

E. Individuals in administrative positions who desire membership/privileges shall be subject to the same procedures as all other applicants.

F. All criteria for membership or privileges shall be uniformly applied. No applicant shall be denied Medical Staff membership and/or clinical privileges on the basis of sex, race, age, creed, national origin, or on the basis of any other criteria unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the Hospital.

G. Whenever it is specified hereunder that an applicant for Medical Staff appointment or staff privileges, or a new admittee, is required to have completed a particular approved residency program, or to have graduated from a particular approved medical or dental school, or to have attained eligibility for certification by a particular board, such applicant, in lieu of compliance with such standard, shall be permitted to demonstrate to the satisfaction of the Medical Staff and the Governing Body that he has attained that level of education, experience, training, expertise and competence which he would have attained had he complied with such standard. The burden of proof and of production of evidence concerning such equivalency shall be upon the applicant, and shall only be satisfied upon a showing of clear and convincing evidence. The Medical Staff and the Governing Body, in formulating their decision as to the issue of equivalency, shall be guided first and foremost by the hospital's duty to provide competent medical care to its patients. Accordingly, doubtful cases shall be decided against the applicant.

Section 3. Basic Responsibilities of Medical Staff Membership

Each member of the Medical Staff shall pledge to:
A. Provide his patients with continuous care at the generally recognized level of quality and efficiency;

B. Abide by the Medical Staff Bylaws and Rules and Regulations, Department Rules and Regulations and by all other established standards, policies and rules of the Hospital;

C. Discharge such Medical Staff, department, committee and Hospital functions for which he is responsible by appointment, election, or otherwise;

D. Prepare and complete in a timely manner medical and other required records for all patients he admits or in any way provides care to in the Hospital;

E. Participate in and actively support the Hospital’s Performance Improvement and Quality Control Programs.

F. Abide by the ethical principles of his profession, including, but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing for continuous care of his patients; refraining from deceiving a patient as to the identity of an operating surgeon, or any other medical practitioner providing treatment or services; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; and seeking consultation whenever necessary;

G. Promptly notify the Chairperson of his department, the President of the Hospital and the President of the Medical Staff in writing of the revocation, suspension or voluntary relinquishment of his professional license, drug enforcement agency (DEA) number or the imposition of terms of probation or limitation of practice, by any state, or of his loss of Medical Staff membership or privileges at any Hospital or other health care institution, or of the commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States, the Commonwealth of Pennsylvania, or any other state, or of the filing of a suit against the practitioner in coverage of medical malpractice insurance, or loss of membership in the state or county medical or dental society;

H. Provide services to medical assistance patients and other patients without personal physicians, in the emergency department and those admitted to the Hospital through the emergency department, in accordance with the policies adopted by the Medical Staff delineating responsibilities for services to such patients; and

I. Participate in continuing medical education programs relevant to his delineated clinical privileges, both through the Hospital and through outside sources and maintain
documented eligibility for the American Medical Association Award for Continuing Education or documented equivalence in the time and quality of study.

**Section 4. Leave of Absence**

Medical Staff members may be granted a leave of absence for a specified period of time for cause as evaluated by the credentials committee, and approved by the Executive Committee and forwarded to the Governing Body for action. If a leave of absence is granted for a period of longer than one year, the Medical Staff member shall annually report his status and his intentions concerning resuming practice at the Hospital for review by the credentials committee.

Medical Staff members on leave of absence at the time of their reappointment, must meet and comply with all requirements for reappointment, including submission of a completed application and all related documents as specified in Article VI of these bylaws. Failure to complete an application as required shall result in termination of the Medical Staff member's leave of absence and Medical Staff membership.
ARTICLE V: CATEGORIES OF THE MEDICAL STAFF

Section 1. Medical Staff Categories

The Medical Staff shall be divided into Honorary, Consultant, Courtesy, Special Emergency Department, and Active categories.

Section 2. Honorary Medical Staff Category

The Honorary Medical Staff Category shall consist of former members of the Active Medical Staff Category who are not active in the administrative affairs of the Medical Staff, and who are honored because of previous service to the Hospital. Honorary Medical Staff Category members shall not be required to discharge Active Medical Staff Category duties, pay medical staff dues, accept committee appointments, serve as officers, or have the right to vote. They may attend meetings and have privileges of the floor at any Medical Staff meeting.

Section 3. Consultant Medical Staff Category

A. The Consultant Medical Staff Category shall consist of specialists of recognized rank and standing who by their affiliation will provide a source of expert assistance to the Medical Staff.

B. Appointment to the Consultant Medical Staff Category shall be made by the Governing Body based upon recommendations of the Medical Staff. Members of the Consultant Medical Staff Category shall not be required to discharge Active Medical Staff Category duties, or be required to attend meetings. Members of the Consultant Medical Staff Category shall be ineligible for election to office or appointment to committees, and shall have no voting rights.

C. Members of the Consultant Medical Staff Category shall be required to provide services upon the request of any member of the Medical Staff, or in any case in which consultation is required by the rules of the Hospital. This does not preclude any other qualified member of the Medical Staff, regardless of rank, from providing consultation when required or requested.

D. Members of the Consultant Medical Staff Category shall have privileges consistent with their recognized abilities as may be determined by the Medical Staff, with the approval of the Governing Body. Members of the Consultant Medical Staff Category shall not admit
patients. When an admitted case is clearly limited to the specialty of the consultant, the patient may be transferred to the service of the consultant who will be responsible for the patient's record from the time of transfer.

Section 4. Courtesy Medical Staff Category

A. The Courtesy Medical Staff Category shall consist of practitioners qualified for staff membership but who only occasionally use the Hospital.

B. Members of this staff category may have no more than twenty-four patient contacts (as defined in section 6 below) per year, will not be placed on the Emergency Department on-call schedule, will not be required to attend meetings, will not serve on committees, will have no voting rights, and will be required to pay staff dues.

C. This will be for a two (2) year period at which time a review will be conducted by the Credentials Committee and a decision made as to whether the practitioner in the Courtesy Medical Staff Category should advance to Active Medical Staff category at that time or remain in the Courtesy Staff Category.

Section 5. Special Emergency Department Medical Staff Category

A. The Special Emergency Department Medical Staff Category shall consist of all part-time emergency department physicians with privileges in Emergency Medicine.

B. All members of the Special Emergency Department Medical Staff Category shall be credentialed as outlined in these Bylaws except they shall not be required to attain board certification as written in Article IV.

C. All members of the Special Emergency Department Medical Staff category shall abide by all provisions of the Medical Staff Bylaws with the exception that they will not be required to attend meetings or serve on committees; they will not have to pay yearly dues and they will not be permitted to vote.

Section 6. Active Medical Staff Category

A. The Active Medical Staff Category shall consist of practitioners who admit at least 12 patients to the Hospital per year, or who have 24 surgical procedures per year, or who have at least 24 consultations per year or who have at least 50 patient contacts per year. “Patient contacts” shall be defined as admissions, surgical procedures, consultations, interpretation of nuclear scans, pathology reports and interpretations of x-rays and any other clinical service provided to patients at hospital.
The patient contact requirements shall apply to each member of a group. The Credentials Committee shall monitor these and report to the Medical Staff Executive Committee as part of the reappointment process.

Any questions regarding interpretation of patient contacts shall be referred to the Medical Staff Executive Committee.

Failure to meet patient contact requirement will automatically result in change of staff status from Active to Courtesy at the time of reappointment without notice or hearing as outlined in Article IX of these bylaws. Under no circumstances shall the automatic change in staff status pursuant to the preceding sentence be deemed an adverse action or recommendation pursuant to Article IX of these bylaws. The automatic change in staff status from Active to Courtesy is solely to assist the Hospital in promoting and furthering the legitimate organizational and institutional objectives of insuring that medical policy decisions of the Hospital and Medical Staff are made by practitioners who treat patients on a regular rather than casual basis.

B. All members of the Active Medical Staff Category shall be located geographically near enough to the Hospital to provide continuous care of their patients.

C. All members of the Active Medical Staff Category shall be required to attend staff meetings as provided for in Article XIII of these bylaws and shall be expected to participate on at least one standing committee of the staff.

D. During his first two years of membership in the Active Medical Staff Category, a member shall not be entitled to hold office or serve as a member of the Executive Committee or the Credentials Committee, but shall have the other rights and privileges of staff membership.
Section 1. Request for Application and Application for Appointment

A. All requests for applications and applications for appointment to the Medical Staff, shall be signed by the applicant and shall be submitted to the President of the Hospital on a form prescribed by the Governing Body after consultation with the Executive Committee and the Credentials Committee. The Governing Body shall have the continuing right to modify any forms used in the application process as it deems appropriate in consultation with the Medical Staff.

B. 1. A request for application form shall be completed by each applicant for appointment to the Medical Staff. This request for application form shall be submitted to the Credentials Committee for initial review.

2. The request for application form shall require the following information from each applicant:

   a. Educational background, which shall evidence that the applicant is a graduate of an American Medical Association (AMA), American Dental Association (ADA), or American Osteopathic Association (AOA), approved medical school or the equivalent thereof, as set forth in Article IV, Section 2, F hereof, and that the applicant has graduated from an Accreditation Council for Graduate Medical Education or ADA approved residency program or the equivalent thereof, as set forth in Article IV, Section 2, F hereof.

   b. Licensure, which shall evidence that the applicant holds a valid Pennsylvania license with no restrictions.

   c. Liability coverage, which shall evidence that the applicant has procured appropriate professional liability insurance and shall include details of any claims made against the applicant during the past five years and the disposition of such claims.

   d. Location, which shall evidence that the applicant has located his practice and intends to reside within the hospital's primary or secondary service area or which shall otherwise set forth the applicant's ability to provide an appropriate mechanism for Hospital patient care and coverage.
3. Information contained in the request for application form shall be subject to appropriate verification from original sources.

4. The request for application form must be returned to the Hospital within thirty (30) days after the time sent out by the Hospital as evidenced by the postmarked date. If a request for application is not returned within thirty (30) days it shall be presumed as a voluntary withdrawal of the request for application.

5. The Credentials Committee shall review the completed request for application form in light of the hospital's needs and overall strategic plan and the overall needs of the community which the Hospital serves as determined by the Governing Body as well as the ability of the Hospital to provide adequate facilities and support services for the applicant and his patients. A request for application form shall be deemed completed when all the items specified in this Article Section 1, B, 2 are furnished to the Credentials Committee.

6. If the Credentials Committee issues a favorable recommendation as a result of its review of the request for application form, it shall forward an application for Medical Staff membership to the applicant. The applicant shall be instructed to return the application form, together with all supporting materials and a non-refundable application fee as determined by the Medical Staff, (not to exceed $250), to the Credentials Committee within thirty (30) days.

7. If the Credentials Committee makes an unfavorable determination, it shall transmit to the Executive Committee the completed request for application form and its written report and recommendation, which shall then be processed in the same manner as an unfavorable recommendation of the Credentials Committee at the application stage and the due process rights specified in Article IX, Section 3 shall apply accordingly.

C. The applicant shall provide such information and conform to such application procedures as requested.

1. Each application for Medical Staff privileges shall include, but not be limited to, the following information:

   a. Letters of reference from at least three peers and the applicant's residency director concerning the professional qualifications and abilities of the applicant as they apply to the clinical privileges requested;

   b. A list of all the applicant's professional society memberships, together with a photocopy of the certificate and/or membership card, and any revocations thereof, or proceedings therefore;
c. A list of all state licenses or registrations granted to the applicant, together with a photocopy of such license or registration, and information regarding previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

d. A list of all professional activities engaged in by the applicant during the previous five years;

e. A list of other hospitals to which the applicant has, or had, medical staff privileges and the type of privileges granted along with information regarding the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

f. Applicant's Drug Enforcement Agency number, together with a photocopy of the certificate, and information regarding revocation thereof or proceedings therefore or of the voluntary relinquishment of such registration;

g. Evidence of applicant's board certification, or eligibility, or evidence that applicant has obtained the equivalent thereof, as set forth in Article IV, Section 2, F, hereof, together with a photocopy of the certificate, if applicable, and the status thereof;

h. A completed delineation form devised by the Credentials Committee specifically detailing the privileges requested and the applicant's qualifications therefore, as set forth in Article VII;

i. A statement verifying that he has the physical capacity and mental health status to safely exercise the privileges requested.

j. A written statement signed by the applicant that he pledges to comply with the Medical Staff Bylaws, Rules and Regulations whether appointed or not, and with the hospital and Medical Staff policies that apply to his activities at the time of his appointment;

k. A statement that the applicant will comply with the ethical standards of his profession as are commonly accepted and as may be further specified in these Bylaws or the Rules and Regulations of the Medical Staff;

l. A waiver of responsibility of the Hospital signed by the applicant;

m. A statement that the applicant agrees to provide such records as are necessary for the Credentials Committee to conduct its biannual review of Medical Staff members;
n. Applicant's requested Medical Staff status: Consultant, Honorary, Special Emergency Department, Courtesy, or Active;

o. A general statement concerning the applicant's anticipated use of the hospital;

p. A statement signed by the applicant indicating that all information contained in the application form is true and correct and that any additional documentation requested will be provided by the applicant.

q. A summary of all professional liability actions which are pending or have been previously settled.

Provision of the above information is the responsibility of the applicant.

2. The failure to supply any requested information or documentation within one hundred twenty (120) days of the date the application is sent to the applicant by the Credentials Committee shall be conclusively presumed to be a voluntary withdrawal of such application for admission to the Medical Staff. If any former applicant wishes to reapply for Medical Staff membership, he must begin with the request for application process set forth in Article VI, Section 1.

3. The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving to the hospital's satisfaction and any doubts about such qualifications.

D. The completed application with all supporting materials shall be submitted to the Credentials Committee of the Medical Staff for evaluation. An application shall be deemed completed whenever those items specified in Article VI, Section 1, C have been provided and verified.

E. By applying for appointment to the Medical Staff, each applicant thereby signifies his willingness to appear for interviews regarding his application; authorizes the hospital to consult with members of the Medical Staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence, character, and qualifications; consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, as well as of his moral and ethical qualifications for staff membership; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials; and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information.
Section 2. Appointment Process

A. Upon receipt of the completed application for membership, the Credentials Committee shall conduct a thorough and comprehensive investigation of the licensure status, relevant training/experience, ability to perform privileges requested character, professional competence, and ethical standing of the practitioner from primary sources wherever possible and shall determine whether the practitioner has established and meets all the necessary qualifications for the category of Medical Staff membership and the clinical privileges requested by him, specifically criteria directly related to the quality of care provided. The Credentials Committee shall consult with the department Chairperson. The department Chairperson shall make a technical, clinical evaluation of the applicant's qualifications and abilities and assist the Credentials Committee and the Governing Body in making a final determination regarding the applicant. The Credentials Committee shall review information contained in references given by the practitioner and from other sources available to the committee, including a written report of personal interviews conducted by the President of the Medical Staff or his designee and the Chairperson of the Department or his designee in the presence of the Credentials Committee and information from the national practitioner data bank. In addition, the committee shall have the authority to employ a consultant to evaluate the qualifications of the applicant if no such expertise exists on the Medical Staff. Upon completion of its review, but in any case no later than ninety (90) days from the time the completed application form was received, the Credentials Committee shall transmit to the Executive Committee the completed application, the written report of the Credentials Committee and its recommendation that the practitioner either be provisionally appointed to the Medical Staff, be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions related to such clinical privileges.

B. All recommendations and supporting materials must be transmitted by the Credentials Committee to the Chairperson of the Executive Committee prior to the next regularly scheduled meeting of the Executive Committee. At its next regular meeting, the Executive Committee shall determine whether to forward the recommendation of the Credentials Committee to the Governing Body, or to defer the application for further consideration.

C. When the determination of the Executive Committee is to defer the application for further consideration, the application, report and recommendation of the Credentials Committee and supporting documentation shall be returned to the Credentials Committee along with a written list of specific issues that the Executive Committee requests the Credentials Committee to investigate. Subsequent review by the Credentials Committee must be completed and a recommendation for provisional appointment with specified clinical privileges, or for rejection of the application for Medical Staff membership, must be
returned to the Executive Committee within forty-five (45) days of receipt by the Credentials Committee. The Executive Committee shall then forward recommendation to the Governing Body.

D. When the recommendation by the Executive Committee is favorable to the applicant, the file shall be forwarded to the Governing Body, which shall then act upon such recommendation within 45 days.

E. When the recommendation forwarded by the Executive Committee is adverse to the applicant either with respect to appointment or as to specific clinical privileges, the President of the Hospital shall promptly so notify the applicant, in accordance with the procedures set forth in Article IX, by certified mail, return receipt requested. Notice of adverse recommendation must be forwarded to the Governing Body at their next regularly scheduled meeting. The applicant shall have such rights as are specified in Article IX, Section 3, of these Bylaws.

F. The Executive Committee shall be permitted to prepare and append to the file forwarded to the Governing Body its own comments concerning the issues of appointment of the applicant to the Medical Staff and delineation of clinical privileges.

Section 3. Conditions and Duration of Appointment

A. Initial appointment and reappointment to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided, however, in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

B. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been specifically delineated by the Governing Body in accordance with these Bylaws.

Section 4. Appointments Provisional

A. All initial appointments to any category of the Medical Staff shall be provisional.

B. At the end of twelve months from the date of the initial appointment, a review of the Medical Staff member's performance shall be conducted by the Credentials Committee. This review shall consist of comments from and recommendations of the Medical Staff member's department Chairperson or his designee or Chairperson.
C. If the results of this initial review are deemed satisfactory by the Credentials Committee, the Medical Staff member may be appointed to regular Active or Consulting Medical Staff Category or may be retained on provisional status for an additional six (6) month period.

D. If the results of this initial review are deemed unsatisfactory by the Credentials Committee, the staff member may be terminated or may be retained on provisional status for an additional six (6) month period.

E. Any Medical Staff member retained on provisional status for an additional six (6) month period after the initial review shall be subject to another review at the conclusion of the second six (6) month period. This review shall be conducted in the same manner as the initial review. At the conclusion of this review, the Medical Staff member shall be either appointed to regular Active Medical Staff Category status or terminated.

F. Any provisional Medical Staff member whose membership is terminated in accordance with subsections D or E hereof shall be entitled to those rights accorded under Article IX, Section 3 of these Bylaws to a member of the Medical Staff who has not been reappointed.

G. All provisional appointees to the Active Medical Staff Category shall be required to attend a combination of at least fifty percent (50%) of the Medical Staff and departmental meetings scheduled during the provisional period.

Section 5. Reappointment and/or Reappraisal of Clinical Privileges

A. Current members of the Medical Staff shall be subject to reappointment and reappraisal of clinical privileges every two years at such time as the Credentials Committee shall determine. Reappointment and/or the granting of delineated clinical privileges shall be for a period not to exceed two (2) years.

B. The written reappointment form completed by the practitioner shall contain the following information:

1. any request for changes in Medical Staff category (i.e. Active Status to Honorary Status) along with supporting reasons;

2. any request for change in delineation of privileges and the requisite documentation;

3. any change in board certification status;

4. proof of continuing liability insurance coverage in satisfactory amounts and information regarding any claims made over the past two years and a summary of professional liability claims pending or settled during previous two years;
5. evidence of current unrestricted state license and information regarding previously successful or currently pending challenges to any license or registration including DEA registration or the voluntary relinquishment of such licensure or registration;

6. current unrestricted Drug Enforcement Agency number;

7. a listing of all courses attended while meeting requirements for compliance with continuing American Medical Association, American Dental Association or American Osteopathic Association medical and educational standards, which require 150 Continuing Medical Education (CME) credits over a three (3) year period of which sixty (60) must be Category I as defined by the AMA Physicians Accreditation Award or demonstrated equivalence which relate, in part, to the clinical privileges held by the practitioner, type and nature of care provided and findings of performance improvement activities.

8. reasonable evidence verifying that he has the physical capacity and mental health status to safely exercise the privileges requested.

9. information concerning voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitations, reductions, or loss of clinical privileges at another hospital.

10. written peer recommendations for continued membership and/or delineation of individual clinical privileges.

11. evidence of ability to safely exercise privileges requested.

C. The Credentials Committee shall gather the following information, and any other relevant data, to be used during the reappointment process:

1. review by department Chairperson or Chairperson reflecting professional competence, ability to work with others in a harmonious manner, verification that the practitioner has the physical capacity and mental status to safely exercise the privileges requested, ethics and compliance with Bylaws;

2. evidence of the practitioner's use of the hospital;

3. a certification by the secretary/treasurer of the Medical Staff as to payment of dues; and

4. evidence of satisfactory patterns of practice, including professional performance, judgement and clinical/technical skills, competency, clinical outcomes as
demonstrated by reports from utilization review, performance improvement and diagnostic regulated group review (DRG).

5. a review of privileges requested compared to privileges exercised.

6. correspondence from other facilities where the practitioner has privileges at the time of reappointment to verify the practitioner's statement regarding sanctions or changes in privileges.

7. a review of continuing education courses attended relative to clinical privileges requested.

8. a record of the practitioner's attendance at Medical Staff meetings, department meetings and all assigned committee meetings.

D. The completed reappointment form and any written report of the Credentials Committee shall be sent to the Chairperson of the Executive Committee prior to the next regularly scheduled Executive Committee meeting. The Executive Committee shall forward its written recommendations to the Governing Body concerning the recommendation for reappointment, or failure to recommend reappointment. If the renewal or revision of clinical privileges is not recommended, the reasons for such recommendations shall be stated and documented.

E. Failure on the part of individuals to submit the form in the prescribed time shall be considered an automatic resignation from the staff and the party must reapply to the Medical Staff in accordance with the Bylaws if he wishes to be reinstated.

F. A practitioner shall have those procedural rights during the reappointment process as specified in Article IX, Section 3.

Section 6. National Practitioner Data Bank Queries

Prior to the appointment or reappointment of any practitioner, an inquiry shall be made, in compliance with federal statute, with the National Practitioner Data Bank and such information shall be provided to the Credentials Committee for its review prior to taking any action on a practitioner's application.
Section 1. Clinical Privileges Restricted

A. Every practitioner practicing at the hospital, by virtue of Medical Staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body, except as otherwise provided in Sections 2 and 3 of this Article VII. The denial of clinical privilege requested by an applicant shall give rise to those procedural rights set forth in Article IX. The initial and/or subsequent grant of clinical privileges shall be for not more than a two (2) year period.

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

C. The Executive Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

D. Periodic determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided by the practitioner, and a review of the records of the Medical Staff which document the evaluation of the practitioner's participation in the delivery of medical care. A practitioner must apply in writing for additional clinical privileges and must state his relevant recent training or experience. Such application shall be processed in the same manner as applications for initial appointment.

E. Privileges granted to dentists and podiatrists shall be based on their training, experience, and demonstrated competence and judgment. Podiatrists may be granted admitting, as well as limited surgical privileges. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services supplemented by an examination of the oral cavity completed by the dentist. All podiatric patients shall receive the same basic medical
appraisal as patients admitted to other surgical services, supplemented by a pedal examination completed by the podiatrist. A physician member of the Medical Staff shall be responsible for the care of any medical problem which may be present at the time of admission or which may arise during hospitalization.

F. All Allied Health Professionals shall work under the direct supervision of a Medical Staff member or Medical Staff members, and shall be subject to review of credentials and assignment of privileges by the Medical Staff. The Medical Staff may recommend to the Governing Body the granting of clinical privileges to limited health practitioners, including, but not limited to podiatrists, physicians' assistants and nurse practitioners. Podiatrists shall be classified as independent limited practitioners; physicians' assistants and nurse practitioners shall be classified as dependent limited practitioners. Investigation and evaluation of the education, training, experience, and demonstrated ability and judgment of individuals requesting privileges as limited practitioners will be accomplished according to procedures established by the Credentials Committee in compliance with the Rules and Regulations of the Medical Staff, the Hospital, and government laws and regulations, including those of the Pennsylvania Department of Health.

The granting of privileges to an employed dependent limited practitioner is conditioned upon the employing Medical Staff member accepting full responsibility and accountability for the conduct of his employee within the hospital, accepting responsibility to acquaint the dependent limited practitioner with the applicable Rules and Regulations of the Medical Staff and of the department to which the Medical Staff member is assigned, and furnishing evidence of adequate professional liability insurance coverage, in amounts determined to be adequate by the Executive Committee, for the acts and omissions of the dependent limited health practitioner. Such employed persons shall be subject to similar rules of conduct as Hospital employees. Independent limited practitioners shall be similarly and personally responsible and accountable for their own conduct.

The privileges of dependent limited practitioners who are employees of Medical Staff members shall be automatically terminated upon termination of Medical Staff membership of the employing physician or upon curtailment of the employee's clinical privileges relating to the services of the employee. Limited health practitioners employed by the hospital shall be subject to all the Rules and Regulations of Hospital employment.

Privileges of limited practitioners may be modified, suspended, or terminated without recourse to the review and appeal procedures of the Medical Staff Bylaws. Privileges will be automatically terminated on loss of licensure or other regulatory status.

A review of all Allied Health Professionals, independent limited or dependent limited practitioners, will be made by the Credentials Committee every two years, and this report will be submitted to Executive Committee and the Governing Body. Such review will include: (1) delineation of privileges, (2) evidence of continuing education, (3) evidence of adequate liability insurance, and (4) results of any disciplinary actions.
Section 2. Temporary Privileges

A. Upon receipt of an application or Medical Staff membership from an appropriately licensed practitioner, the President of the Hospital, upon sufficient review has been conducted of the applicant's qualifications including, the primary source validation of a Pennsylvania license, adequate liability insurance, Drug Enforcement Agency number and a check on references provided and clinical competence, and with the written concurrence of the Department Chairperson, Credentials Committee Chairperson and Medical Staff President may grant temporary admitting and clinical privileges to the applicant. In exercising such privileges, the applicant agrees to abide by the Bylaws, Rules and Regulations of the Medical Staff and act under the supervision of the Chairperson of the department to which he is assigned. Temporary privileges shall remain in effect for no longer than 90 days.

B. Temporary clinical privileges may be granted by the President of the Hospital for the care of specific patients to a practitioner who is not an applicant for Medical Staff membership in the same manner and upon the same conditions as are set forth in Article VII, Section 2, A, above.

C. The President of the Hospital may permit a practitioner serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed thirty (30) days, providing that the adequacy of his license, liability insurance coverage, references provided, his Drug Enforcement Agency number and all of his credentials have first been approved by the departmental Chairperson concerned and by the President of the Medical Staff and by the Chairperson of the Credentials Committee. Such practitioner must adhere to all Medical Staff Bylaws, Rules and Regulations.

D. Special requirements of supervision and reporting may be imposed by the departmental Chairperson concerned on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President of the Hospital upon notice of any failure by the practitioner to comply with such special conditions.

E. The President of the Hospital may at any time, upon consultation with the Chairperson of either the Executive Committee or the department(s) concerned, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patients then under his care in the Hospital. However, when it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, or because of a detrimental impact upon the operations of the hospital, the immediate termination of temporary privileges may be effectuated by any of those persons entitled to impose a summary suspension pursuant to Article VIII, Section 2, A of these Bylaws. In such event the appropriate departmental Chairperson or, in his absence, the President of
the Medical Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. When feasible the wishes of the affected patient(s) shall be considered in the selection of such substitute practitioner.

F. The denial, termination or reduction of temporary privileges, or any other actions, except those specified herein shall not give rise to any right to hearing or appellate review.

Section 3. Emergency Privileges

In the case of an emergency, any practitioner, to the degree permitted by his license and regardless of clinical privileges, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition, in the reasonable perception of the practitioner, in which serious permanent harm would result to a patient or in which the life of the patient is in danger and any delay in administering treatment would add to that danger.

Section 4. National Practitioner Data Bank Queries

Prior to granting of clinical privileges at the time of appointment or reappointment or the granting of additional privileges for Medical Staff Members, a query shall be made to the National Practitioner Data Bank as required by law. Any such information obtained shall be furnished to the Credentials Committee for their deliberation prior to finalization of a recommendation for the practitioner. A similar inquiry shall be made for allied health professionals requesting the granting of initial privileges, renewal of privileges or the addition of privileges.
ARTICLE VIII: CORRECTIVE ACTION

Section 1. Procedure

A. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be detrimental to patient safety or inconsistent with the efficient delivery of patient care at a generally recognized level of quality, or are in danger of being disruptive to hospital operations, or are considered to be in violation of these Bylaws, Medical Staff Rules and Regulations, department rules or other hospital policies or the practitioner exhibits signs of physical or mental impairment, corrective action against such practitioner may be requested by an officer of the Medical Staff, by the chief of any clinical department, by the Chairperson of any standing committee of the Medical Staff, by the President of the Hospital, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the President of the Hospital, and shall be supported by references to the specific activities or conduct which constitutes grounds for the request. The President of the Hospital shall immediately forward any such request to the executive committee for further action.

B. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the President of the Medical Staff shall immediately appoint an ad hoc committee, consisting of three practitioners, to investigate the matter.

C. Within fourteen (14) days after the appointment of the committee, the committee shall conduct and complete an investigation of the charges. The practitioner against whom the corrective action has been requested shall have the opportunity for an interview with the ad hoc investigating committee. At such interview, he shall be informed of the general nature of the charges against him and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the committee and such record shall be included with the committee's report to the Executive Committee made at the conclusion of the investigation.

D. Within forty-five (45) days following its receipt of the report from the ad hoc committee concerning the investigation of a request for corrective action involving reduction or suspension of clinical privileges, the Executive Committee shall take action upon the request. If the corrective action could result in a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with
respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

E. The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, or a letter of admonition, to impose terms of probation or requirements for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that its already imposed summary suspension of clinical privileges be terminated, modified, or sustained, to recommend reduction of staff category or limitation of Medical Staff prerogative directly related to patient care, or to recommend suspension or revocation of Medical Staff appointment, and/or to take such other actions as the Executive Committee deems reasonable under the circumstances.

F. The Executive Committee shall continue to keep the President of the Hospital fully informed of all actions taken in connection with any requests for corrective action forwarded to it.

G. Any recommendations by the Executive Committee for imposition of the requirements of consultation, for probation, reduction, suspension, or revocation of clinical privileges, for reduction of Medical Staff category or limitation of staff prerogatives directly related to patient care, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article IX of these Bylaws.

Section 2. Precautionary Suspension

A. Whenever, in the reasonable belief of the President of the Hospital, a Medical Staff member willfully disregards or grossly violates the provisions of these bylaws, Medical Staff Rules and Regulations, or other Hospital policies, or whenever his conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Medical Staff member materially disrupts the operations of any department or unit of the hospital, the President of the Hospital, acting on behalf of the Governing Body, and in concurrence with the President of the Medical Staff, Department Chairperson and Credentials Committee Chairperson, shall have the authority to suspend on a precautionary basis the Medical Staff appointment, or all or any portion of the clinical privileges, of such Medical Staff member.

Such precautionary suspension shall be deemed an interim step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual, but is not a complete professional action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
Such precautionary suspension shall become effective immediately upon imposition, and the President of the Hospital shall promptly give special notice of the suspension to the Medical Staff member, and notice to the Executive Committee of such action.

B. As soon as reasonably possible after such precautionary suspension, a meeting of the Executive Committee shall be convened to review and consider the action taken by the President of the Hospital. The Executive Committee may recommend modification, continuation or termination of the terms of the precautionary suspension.

C. Unless the Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Medical Staff member shall be entitled to the procedural rights as provided in Article IX. The terms of the precautionary suspension as sustained or as modified by the Executive Committee shall remain in effect pending a final decision by the Governing Body at the conclusion of the hearing and/or appeal process.

Section 3. Automatic Suspension

A. If a Medical Staff member's license to practice his profession in the Commonwealth of Pennsylvania is revoked or suspended, or the licensing agency imposes terms of probation or limitation of practice on the practitioner, such Medical Staff member shall immediately and automatically be suspended from practicing in the hospital.

B. If a Medical Staff member is convicted of any felony relating to the practice of medicine, (including, but not limited to, a finding or verdict of guilt, and admission of guilt or a plea of nolo contendere), such Medical Staff member shall immediately and automatically be suspended from practicing in the Hospital.

C. A Medical Staff member whose Drug Enforcement Agency number is revoked, limited or reduced, restricted, suspended or voluntarily relinquished shall immediately and automatically be suspended from practicing in the Hospital. As soon as reasonably possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the Drug Enforcement Agency number was revoked or suspended or relinquished. The Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

D. If a Medical Staff member’s professional liability insurance coverage (as mandated by the Commonwealth of Pennsylvania) is revoked, limited, reduced, restricted, suspended, voluntary relinquished or in any way changed such that the coverage does not meet the requirements of these bylaws, such Medical Staff member shall be immediately and automatically suspended from practicing in the Hospital.
E. When a member of the Active Medical Staff Category has not admitted a patient to the Hospital or has not provided professional services to any patient in the Hospital for twelve (12) consecutive months, at the discretion of the Credentials Committee and with concurrence of the Executive Committee he shall be given special notice that his Medical Staff appointment will be automatically terminated within sixty (60) days unless he either admits a patient to the Hospital or provides services to a patient in the Hospital during that sixty (60) day period.

F. When a member of the Active Medical Staff has failed to comply with the requirements of the hospital's Rules and Regulations B (2), B(5) and B (17) such member shall be suspended as a precaution until he shall bring himself into full compliance with such requirements.

Section 4. Continuity of Patient Care

Upon the imposition of a precautionary suspension or upon the occurrence of an automatic suspension, the President of the Medical Staff or the Chairperson of the Department to which the suspended Medical Staff member is assigned shall provide for alternative coverage for the patients of the suspended Medical Staff member then in the Hospital. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The suspended Medical Staff member shall confer with the substitute practitioner to the extent necessary to safeguard the patient.
ARTICLE IX: INTERVIEWS, HEARINGS AND APPELLATE REVIEW

Section 1. Definitions

The following definitions, in addition to those stated in other provisions of these Bylaws, shall apply to the provisions of this article, also referred to herein as the Fair Hearing Plan:

A. The term "appellate review body" shall mean the group designated pursuant to Section 8, D below to hear a request for appellate review properly filed and pursued by a practitioner.

B. The term "hearing committee" shall mean the committee appointed pursuant to Section 5, C below of this plan to hear a request for a evidentiary hearing properly filed and pursued by a practitioner.

C. The term "parties" shall mean the practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or requested appellate review is predicated.

Section 2. Interviews

When the Executive Committee or the Governing Body received or is considering initiating an adverse recommendation (as herein defined) concerning a Medical Staff member, the Medical Staff member may be afforded an interview before the committee or the Governing Body making the adverse recommendation. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Medical Staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

Section 3. Right to Hearings and Appellate Review

A. When any Medical Staff member receives special notice of an adverse recommendation or action of the Executive Committee which will adversely affect appointment, status, or exercise of privileges, as further set forth in Section 4 A and B below, he shall be entitled, upon request, to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Executive Committee following such hearing is still adverse to the Medical Staff member, he shall then be entitled, upon request, to an appellate review by the Governing Body before a final decision is rendered.
B. When any Medical Staff member receives special notice of an adverse decision by the
Governing Body taken either contrary to a favorable recommendation by the Executive
Committee where no right to a hearing existed, or on the Governing Body's own initiative
without benefit of a prior recommendation by the Executive Committee where no right to a
hearing existed, such Medical Staff member shall be entitled, upon request, to a hearing by
an ad hoc hearing committee appointed by the Governing Body. If such hearing does not
result in a favorable recommendation, he shall then be entitled, upon request, to an
appellate review by the Governing Body before a final decision is rendered.

C. All hearings and appellate reviews shall be in accordance with the procedures and
safeguards set forth herein.

Section 4. Initiation of Hearing

A. Recommendations or Actions. The following recommendations or actions shall, if deemed
adverse pursuant to Section 4, B below, entitle the practitioner affected thereby to a
hearing:

1. Denial of initial Medical Staff appointment (including denial at the request for
application stage);

2. Denial of reappointment;

3. Suspension of Medical Staff appointment;

4. Revocation of Medical Staff appointment;

5. Denial of requested modification of Medical Staff category;

6. Reduction in Medical Staff category (except for reduction in staff category relating to
Article IX, Section 6A);

7. Limitation of admitting privileges;

8. Denial of requested department assignment;

9. Denial of requested clinical privileges;

10. Reduction in clinical privileges;

11. Suspension of clinical privileges;
12. Revocation of clinical privileges;

13. Imposition of terms of probation; and


B. When Deemed Adverse.

A recommendation or action listed in Section 4, A above shall be deemed adverse action only when it is:

1. Adopted by the Executive Committee for recommendation to the Governing Body; or

2. A suspension continued in effect after review by the Executive Committee; or

3. Taken by the Governing Body contrary to a favorable recommendation by the Executive Committee under circumstances where no prior right to a hearing existed; or

4. Taken by the Governing Body on its own initiative without benefit of a prior recommendation forwarded by the Executive Committee.

C. Notice of Adverse Recommendation or Action. A practitioner against whom adverse action has been taken pursuant to Section 4, B above shall promptly be given special notice of such action, and a brief statement of the reasons therefore, by the President of the Hospital. The notice shall indicate that the practitioner may request a hearing in accordance with the Medical Staff Bylaws.

D. Request for Hearing. A practitioner shall have fifteen (15) days following receipt of a notice pursuant to Section 4, C to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the President of the Hospital in person or when sent by registered or certified mail to the President of the Hospital, properly addressed and postage prepaid.

E. Waiver by Failure to Request a Hearing. A practitioner who fails to request a hearing within the time and in the manner specified in Section 4, D waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver in connection with:

1. An adverse action by the Governing Body shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Governing Body.

2. An adverse recommendation by the Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending
the final decision of the Governing Body. The Governing Body shall consider the committee's recommendations at its next regular meeting following the waiver. In its deliberations, the Governing Body shall review all the information and material considered by the committee and may consider all other relevant information received from any source in making its final decision.

The President of the Hospital shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section 4, E and shall notify the President of the Medical Staff of each such action.

Section 5. Hearing Prerequisites

A. Notice of Time and Place of Hearing. Upon receipt of a timely request for hearing, the President of the Hospital shall deliver such request to the President of the Medical Staff or the Governing Body depending on whose recommendation or action prompted the request for hearing. The President of the Medical Staff or the Governing Body, as applicable, shall promptly schedule and arrange for a hearing. At least seven (7) days prior to the hearing, the President of the Hospital shall send the practitioner special notice of the time, place, and date of the hearing. The hearing date shall not be less that seven (7) days nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall be scheduled to be held as soon as the arrangements for it may reasonable be made, but not later than fourteen (14) days from the date of receipt of the request for hearing.

B. Statement of Charges. The notice of hearing required by Section 5, A shall contain a concise and specific statement of the reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

C. Appointment of Hearing Committee.

1. By Medical Staff

   A hearing occasioned by an Executive Committee recommendation pursuant to Sections 4, B, 1 and 4, B, 2 shall be conducted by an impartial hearing committee appointed by the President of the Medical Staff and composed of at least three (3) members of the Active Medical Staff Category. One of the members so appointed shall be designated as Chairperson, and shall have the right to vote.
2. By Governing Body

A hearing occasioned by an adverse action of the Governing Body pursuant to Section 4, B, 2 or Section 4, B, 3 of this article shall be conducted by an impartial hearing committee appointed by the Chairperson of the Governing Body and composed of at least five (5) persons. At least three (3) Active Medical Staff Category members chosen with the advice of the President of the Medical Staff shall be included on this committee when the issues concern professional competence or performance. The remaining appointees must be members of the Governing Body. One of the appointees to the committee shall be designated as Chairperson.

3. Service on Hearing Committee

A Medical Staff or Governing Body member shall not be disqualified from serving on a hearing committee merely because he has heard of the case or has knowledge of the facts involved or what he supposes the facts to be. In any event, all members of a hearing committee shall be required to consider the case with good faith and objectivity.

Section 6. Hearing Procedure

A. Personal Presence. The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner and with the same consequences as provided in Section 4, E.

B. Presiding Officer. Either the hearing officer, if one is appointed pursuant to Section 11, or the Chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral testimony and documentary evidence. He shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, or admissibility of evidence.

C. Representation. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his local professional society. The Executive Committee or the Governing Body shall be represented by one of its members at the hearing, who shall present the facts in support of its adverse recommendation or action and examine any witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Section 11, B.
D. Rights of Parties. During a hearing, each of the parties shall have the right to:
1. Call and examine the witnesses;
2. Introduce exhibits;
3. Cross-examine any witness on any matter relevant to the issues;
4. Rebut any evidence; and/or
5. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit, subject to provisions of Sections 6, H hereof.

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

E. Procedure and Evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The hearing committee may require one or both parties to prepare and submit to the committee written statements of their position on the issues, prior to, during, or after, the hearing. The hearing committee may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and exhibits. The presiding officer may, but shall not be required to, order that oral evidence by taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents.

F. Evidentiary Notice. In reaching a decision, the hearing committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the Commonwealth of Pennsylvania. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained on file in the Hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with the applications for appointment or reappointment to the Medical Staff and for clinical privileges.

G. Burden of Proof. When a hearing relates to Sections 4, A, 1, 5, 8 or 9, the practitioner who requested the hearing shall have the burden of providing, by clear and convincing
evidence, that the adverse recommendation or action lacks any substantial factual basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

H. Record of Hearing. A record of hearing shall be kept that is of sufficient accuracy to assure that an informed and valid report can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee Chairperson, unless his decision is reversed by a majority vote of the hearing committee, shall select the method to be used for making the record, such as court report, electronic recording unit, detailed transcription, or minutes of the proceedings. A practitioner requesting an alternate method shall bear the cost thereof.

I. Postponement. Requests for postponement of a hearing shall be granted by the hearing committee only upon a showing of good cause as determined by the committee, and only if the request therefore is made as soon as is reasonably thereof.

J. Recesses and Adjournment. The hearing committee may recess the hearing and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.


A. Hearing Committee Report. Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. All findings and recommendations of the hearing committee shall be supported by reference to the hearing record and the other documentation considered by it.

B. Action on Hearing Committee Report. Within fifteen (15) days after receipt of the report of the hearing committee, the Executive Committee or the Governing Body, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or
action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the President of the Hospital and the President of the Medical Staff.

C. Notice and Effect of Result

1. Notice

The President of the Hospital shall promptly send a copy of the result to the practitioner by special notice, and to the President of the Medical Staff and the Governing Body.

2. Effect of Favorable Result

a. Adopted by the Governing Body - If the Governing Body's result pursuant to Section 7, B is favorable to the practitioner, such result shall become the final decision of the Governing Body and the matter shall be considered closed.

b. Adopted by Executive Committee - If the Executive Committee's result pursuant to Section 7, B is favorable to the practitioner, the President of the Medical Staff shall promptly forward it, together with all supporting documentation, to the Governing Body for its final action. The Governing Body shall take action thereon by adopting or rejecting the Executive Committee's result in whole or in part, or by referring the matter back to the Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Governing Body must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the President of the Hospital shall take final action. The President of the Hospital shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section 7, C, 2. b. Favorable action shall become the final decision of the Governing Body, and the matter shall be considered finally closed. If the Governing Body's action is adverse in any of the respects listed in Section 4, A, the special notice shall inform the practitioner of his right to request an appellate review by the Governing Body as provided in Section 8, A of this article.

3. Effect of Adverse Result

If the result of the Executive Committee or of the Governing Body pursuant to Section 7, B continues to be adverse to the practitioner in any of the respects listed in Section 4, A, the special notice required by Section 7, C, 1 shall inform the practitioner of his right to request an appellate review by the Governing Body as provided in Section 8, A of this article.
Section 8. Initiation and Prerequisites of Appellate Review

A. Request for Appellate Review. A practitioner shall have fourteen (14) days following his receipt of a notice pursuant to Section 7, C, 2, b or 7, C, 3 to file a written request for an appellate review. Such request shall be deemed to have been made when delivered to the President of the Hospital in person or when sent by certified or registered mail to the President of the Hospital, properly addressed and postage prepaid, and may include a request for a copy of the report and record of the hearing committee and all other material, favorable and unfavorable, that was considered in making the adverse action or result.

B. Waiver by Failure to Request Appellate Review. A practitioner who fails to request an appellate review within the time and in the manner specified in Section 8 waives any right to such review. Such waiver shall have the same force and effect as provided in Section 4, E.

C. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the President of the Hospital shall deliver such request to the Governing Body. The Governing Body shall promptly schedule and arrange for an appellate review which shall be not less than fourteen (14) days nor more than thirty (30) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than seven (7) days from the receipt of the request for appellate review. At least five (5) days prior to the appellate review, the President of the Hospital shall send the practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause, if the request therefore is made as soon as is reasonably practical.

D. Appellate Review Body. The Governing Body shall determine whether the appellate review shall be conducted by the Governing Body as a whole or by an appellate review committee composed of at least five (5) members of the Governing Body appointed by the Chairperson. If a committee is appointed, one of its members shall be designated as Chairperson.

Section 9. Appellate Review Procedure

A. Nature of Proceedings. The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 9, B and such other materials as may be presented and accepted under Sections 9, D and 9, E.
B. **Written Statements.** The practitioner seeking the review shall submit a written statement dealing with the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the President of the Hospital at least seven (7) days prior to the scheduled date of the appellate review, except in cases of a practitioner under suspension, in which case such statement must be submitted at least three (3) days prior to the scheduled review. Such time limit may be waived by the appellate body. A written statement in reply may be submitted by the Executive Committee or by the Governing Body. The President of the Hospital shall provide a copy thereof to the practitioner at least four (4) days, or one (1) day for practitioners under suspension, prior to the scheduled date of the appellate review.

C. **Presiding Officer.** The Chairperson of the appellate review body shall be the presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

D. **Oral Statement.** The appellate review body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their position. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

E. **Consideration of New or Additional Matters.** New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

F. **Powers.** The appellate review body shall have all powers granted to a hearing committee, and such additional powers as are reasonable appropriate to the discharge of its responsibilities.

G. **Recesses and Adjournment.** The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations the appellate review shall be declared finally adjourned.

H. **Action Taken.** The appellate review body may recommend that the Governing Body affirm, modify or reverse the adverse result or action taken by the Executive Committee or by the Governing Body pursuant to Section 7, B or 7, C, 2, b, or, in its discretion, may
refer the matter back to the hearing committee for further review and require that a recommendation be returned to it within fourteen (14) days. Within seven (7) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Governing Body as provided in this Section 9, H.

I. Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 9 have been completed or waived.

Section 10. Final Decision of the Governing Body

Within seven (7) days after the conclusion of the appellate review, the Governing Body shall render its final decision in the matter in writing and the President of the Hospital shall send notice thereof to the practitioner by special notice, and to the President of the Medical Staff and the Executive Committee.

Section 11. General Provisions

A. Hearing Officer Appointment and Duties. The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such office shall be determined by the Governing Body after consultation with the President of the Medical Staff. A hearing officer may or may not be an attorney at law, but must be experienced at conducting hearings. He shall act in an impartial manner as the presiding officer of the hearing. If requested by the hearing committee, he may participate in its deliberations and act as its legal advisor, but he shall not be entitled to vote.

B. Attorneys. If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to Section 11, B his initial request for such hearing or appellate review must so state and reasons therefore must be specified. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation. If, and only if, it allows the practitioner to be so represented shall the Executive Committee or the Governing Body be allowed representation by an attorney. The foregoing shall not be deemed to limit the practitioner, the Executive Committee or the Governing Body in the use of legal counsel in connection with preparation for a hearing or an appellate review.

C. Waiver. If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this article, he shall be deemed to have consented to such adverse recommendation, action or result, and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws than in effect or under this article with respect to the matter involved.
D. Number of Reviews. Notwithstanding any other provision of the Medical Staff Bylaws or of this article, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

E. Extensions. Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in this article may be extended upon the agreement of the parties and, when necessary, the hearing committee or appellate review body.

F. Release. By requesting a hearing or appellate review under this article, a practitioner agrees to be bound by the provisions of Article XIV of the Medical Staff Bylaws in all matters relating thereto.

Section 12. National Practitioner Data Bank Reporting Requirements

A report shall be furnished to the National Practitioner Data Bank relative to disciplinary actions in accordance with applicable statute or regulation.
ARTICLE X: OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

A. President
B. President-Elect
C. Immediate Past President
D. Secretary-Treasurer

Section 2. Qualifications of Officers

Officers must be members of the Medical Staff in the Active Medical Staff Category at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. To be eligible for nomination a candidate must have served at least one year, without breaks in service, as Chairperson of a medical staff department or standing medical staff committee.

Section 3. Nominations

A. The Nominating Committee shall convene at least thirty (30) days prior to the May meeting and shall submit to the secretary-treasurer of the Medical Staff a list of one or more qualified nominees for President, President-Elect, Secretary-Treasurer, two delegates, and two alternates. Attached to a list of the nominees shall be a statement from the Chairperson of the Nominating Committee that each nominee has agreed to stand for election to office.

B. Nominations may also be made from the floor at the annual Medical Staff meeting for President, President-Elect, Secretary-Treasurer, delegates and alternates.

Section 4. Election of Officers

Officers shall be elected every two years at the annual meeting of the Medical Staff at which elections are scheduled. Only members of the Active Medical Staff Category shall be eligible to vote for the election of officers. Elections shall be conducted by secret ballot unless the nominating committee's slate of suggested officers is accepted by proper motion and ratified by
voice vote. Those officers who are elected shall be subject to final approval by the Governing Body.

Section 5. Term of Office

All officers shall serve a term of two years until the next annual meeting at which an election shall be held or until their successors are duly elected and qualified. Officers may be elected to only one term, but may be reelected after a one term hiatus.

Section 6. Vacancies in Office

Vacancies in any office occurring during the Medical Staff year, except for the Presidency, shall be filled by the Executive Committee of the Medical Staff. If there is a vacancy in the office of President, the President-elect shall serve out the remaining term.

Section 7. Removal from Office

A. Causes for Removal from Office

Medical Staff Officers may be removed from office for any of the following reasons:

1. Failure to maintain full status in the Active Medical Staff Category;

2. Revocation or suspension of their license to practice medicine in the Commonwealth of Pennsylvania;

3. Conviction of a felony related to the practice of medicine;

4. Revocation, reduction or suspension of the practitioner’s Drug Enforcement Agency number for cause;

5. Failure to maintain professional liability coverage as mandated by the Commonwealth of Pennsylvania;

6. For any other cause as approved by a two-thirds vote of the member of the Active Medical Staff Category;

B. Procedure for Removal from Office

In the event that an action occurs that warrants the removal of an officer from office, a hearing committee shall be appointed to conduct an investigation. The committee shall
Section 8. Duties of Officers

The officers of the Medical Staff shall have such authority as is granted to them by the Governing Body as more specifically described below.

A. President

1. The President shall also be known as the Chief of the Medical Staff.

2. He shall call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

3. He shall act in coordination and cooperation with the President of the Hospital in all matters of mutual concern within the Hospital.

4. He shall serve as Chairperson of the Executive Committee and as an ex-officio member of all other Medical Staff committees without maintaining any voting privileges on such committee.

5. He shall be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where the need for such is indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

6. He shall appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees, except the Executive Committee.

7. He shall serve to assure communications between the Medical Staff, Administration and Governing Body.

8. He shall present to the Governing Body, on behalf of the Medical Staff, recommendations regarding the structure of the Medical Staff, revisions to its bylaws and mechanisms to review credentials and delineate clinical privileges.
9. He shall present to the Governing Body, on behalf of the Executive Committee, recommendations of individuals for medical staff membership and/or delineated clinical privileges.

10. He shall interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

11. He shall be responsible for the educational activities of the Medical Staff.

12. He shall be the spokesperson for the Medical Staff in its external professional and public relations.

B. President-Elect

1. In the absence or disability of the President, the President-elect shall assume all of the President’s duties and authority.

2. The President-elect shall be expected to perform such duties of supervision as may be assigned to him by the president.

3. The President-elect shall serve as a member of the Executive Committee of the Medical Staff and as Chairperson of the Quality Council. He shall automatically succeed the President should the President resign, be removed from office or otherwise cease to serve as President.

C. Immediate Past President

1. In the absence or disability of the President and President-elect, the immediate Past President of the Medical Staff shall perform the President’s duties.

2. The immediate Past President shall serve as a member of the Executive Committee of the Medical Staff.

3. The immediate Past President shall serve as Medical Staff parliamentarian.

D. Secretary-Treasurer

1. The secretary-treasurer, or person acting on his behalf, shall keep accurate and complete minutes of all Medical Staff meetings and Executive Committee meetings. The secretary-treasurer, or such person acting on his behalf, shall be the custodian of the minute books and all other papers relating to the Medical Staff.
2. The secretary-treasurer shall call Medical Staff meetings to order for the President, attend to all correspondence and perform other such duties as ordinarily pertain to the office of secretary-treasurer. He shall provide notice of meetings to each individual member of the Medical Staff in the manner prescribed in Article XIII.

3. The secretary-treasurer shall be responsible for all Medical Staff financial matters. He shall render statements for dues to the members of the Medical Staff, the amount of which shall be determined by vote of the Medical Staff at the annual meeting.

4. The outgoing secretary-treasurer will provide his successor with a receipt for all funds and records turned over to him, a copy of which shall be entered in the minutes, and an additional copy submitted for audit prior to the successor's appointment.
ARTICLE XI: CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments and Services

Each department shall be organized as a separate part of the Medical Staff and shall have a Chairperson, and at the discretion of the department, a vice Chairperson who fulfill the duties of the Chairperson in his absence, who shall be responsible for the overall supervision of the clinical work within his department.

Section 2. Departments

The Medical Staff shall include the following departments:

A. The Department of Medicine, which shall include the following specialties: general medicine, family practice, gerontology, internal medicine, pulmonology, neurology, psychiatry, dermatology, allergy, cardiology, physical medicine, oncology, gastroenterology and radiation oncology.

B. The Department of Surgery, which shall include the following specialties: general surgery, otolaryngology, ophthalmology, urology, neurosurgery, thoracic surgery, vascular surgery, dental surgery, orthopedic surgery, proctology, plastic surgery and podiatry.

C. The Department of Obstetrics and Gynecology, which shall include pediatrics.

D. The Department of Pathology.

E. The Department of Radiology.

F. The Department of Anesthesiology.

G. The Department of Emergency Medicine.

Section 3. Future Departments

The establishment of new departments and the discontinuance or change of existing departments may be accomplished by amendment to these Bylaws as provided in Article XVI.
Section 4. Department Members

The practitioners in each department shall be qualified by training, experience, and demonstrated competence, and shall be granted privileges commensurate with their individual abilities. Members of the Active Medical Staff Category shall not be required to be exclusively specialists, but it is required that they will be well skilled in the particular branch of medicine to which they are assigned.

All practitioners shall be assigned membership in only one department, but may be granted privileges in other Departments as appropriate, subject to the rules and regulations and to the authority Chairperson of all Departments in which they have privileges.

Section 5. Department Chairpersons

The chairperson of each department may be either elected by the members of the department at the first departmental meeting following election of officers, or, if no such election occurs, may be appointed by the Governing Body after consultation with the Medical Staff. Those chairpersons who are elected must be board certified in their specialty or possess equivalent training, experience and competency; must be good standing and shall be subject to final approval by the Medical Staff Executive Committee and Governing Body. Each chairperson shall:

A. Be responsible for all administrative and clinical activities within his department, particularly for the continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

B. Recommend to the Medical Staff Executive Committee the criteria for clinical privileges that are relevant to the care provided in the department;

C. Provide guidance to the members of his department on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding policies and procedures that guide and support the provision of services in his own department;

D. Maintain continuing review of the qualifications and competency of all practitioners with clinical privileges and of all personnel who are not licensed independent practitioners and who provide patient care services and when findings of any assessment process are relevant, insuring that such information is utilized in the Medical Staff's process for renewing or revising clinical privileges.

E. Transmit to the appropriate authorities their departmental evaluations concerning appointment and category, reappointment, delineation of clinical privileges, and corrective action with respect to applicants to, and Medical Staff members of, their departments
including recommending clinical privileges for each member of the department; and for individuals with privileges in the department, but who are not members of the department.

F. Appoint such committees as are necessary to conduct the functions of the departments, as specified in Section 8 of this article and designate a Chairperson for each;

G. Enforce the Hospital and Medical Staff Bylaws, Rules, Policies and Regulations within their departments, including initiating corrective action, investigate clinical performance and order required consultations;

H. Implement within their departments actions taken by the Executive Committee;

I. Be responsible for integration of the Department into the primary functions of the Hospital and for coordination and integration of interdepartmental and intradepartmental services.

J. Develop and implement policies and procedures that guide and support the provision of services.

K. Provide recommendations for a sufficient number of qualified and competent persons to provide care.

L. Recommend requirements for space and other resources needed by the Department.

M. Implement and maintain quality control programs, as appropriate.

N. Assist in the preparation of such annual or other reports pertaining to their departments as may be required by the Executive Committee, the President of the Hospital, or the Governing Body.

O. Act as presiding officer at all departmental meetings and assure that the continuous assessment and improvement of the quality of care is conducted; and insure that communications are provided to the appropriate Medical Staff members, including the Medical Staff Executive Committee, of the findings, conclusions and recommendations and actions taken to improve organizational performance.

P. Develop a departmental on-call system to insure adequate coverage for emergency calls.

Q. Insure that all individuals in the Department receive orientation and continuing education as appropriate.

R. Conduct a review and evaluation of departmental rules and regulations in accordance with Article XV.1.
S. Assess and recommend to the Medical Staff Executive Committee, Administration and Governing Body off-site sources for needed patient care services not provided by the Department or the Hospital.

T. Perform such duties commensurate with their offices as may from time to time be reasonably requested of them by the President of the Medical Staff, the Executive Committee, the President of the Hospital, or the Governing Body.

Section 6. Department Vice Chairperson

Established Medical Staff Departments have the option of electing a Vice Chairperson who may serve in the absence of the Department Chairperson. The Vice Chairperson’s selection shall be subject to the approval of the Executive Committee and Governing Body.

Section 7. Removal of a Department Chairperson or Vice Chairperson

A. A department Chairperson or Vice Chairperson may be removed from office for any of the following reasons:

1. Failure to maintain full status in the active Medical Staff category;

2. Failure to carry out the responsibilities of office as outlined in these bylaws;

3. For any other cause as approved by a two thirds affirmative vote of the active members of the department.

B. Procedure for removal from office

In the event that an action occurs that warrants removal of a department Chairperson or Vice Chairperson from the office, the department, by two thirds vote of its active members, may remove such officer and elect a replacement. Such action shall be subject to approval by the Executive Committee and Board of Directors.

In the event that the department fails to act, the Executive Committee may revoke the appointment of Chairperson or Vice Chairperson, pending approval of the Board of Directors.
Section 8. Medical Directors

For established medical staff departments, the Chairperson shall also serve as medical director. For other programs which by statute or accreditation standard require a medical director, such position shall be appointed by the Medical Staff Executive Committee, subject to final approval by the Governing Body. In all cases, medical directors shall be board certified in their specialty or possess equivalent training and experience.

Section 9. Functions of Departments

A. Each department's primary responsibility is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

1. Participate in patient care evaluation studies for the purpose of reviewing and evaluating the quality of patient care within the department. Each department shall review clinical work performed under its jurisdiction;

2. Establish guidelines for the granting of clinical privileges within the department.

3. Conduct or participate in continuing education programs;

4. Monitor, on a continuing and concurrent basis, adherence to:
   a. Medical Staff and Hospital policies and procedures;
   b. Requirements for alternate coverage of patients and consultations, and
   c. Sound principles of clinical practice;

5. Coordinate patient care provided by department members with nursing and ancillary patient care services and with administrative support services;

6. Meet at least bimonthly (January, March, May, July, September, and November) to consider findings from the on-going monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients and shall maintain a record of minutes which include the resultant conclusions, recommendations and actions taken.
7. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

Section 10. Quorum; Conduct of Meetings

A. A quorum of at least the Chairperson or Vice Chairperson and at least one member of a department shall be necessary for conducting department business. Except for standing bimonthly meetings, at least five days notice must be provided to all active members of a department before a special meeting can be held.

B. Representatives from administration, nursing service and other clinical areas shall be invited, at the discretion of the department chairperson, to attend department meetings when issues relevant to the department are being discussed.

C. Rules and regulations regarding the conduct of meetings shall be developed by each department, provided no conflict is created between any other requirements under these Bylaws.
Section 1. Executive Committee

A. Composition. The Executive Committee shall consist of the following members: The President of the Medical Staff, the immediate Past President of the Medical Staff, the President-elect of the Medical Staff, the Secretary-Treasurer of the Medical Staff, Chairperson of the Departments of Surgery, Medicine, Obstetrics and Gynecology, Anesthesiology, Radiology, Pathology, Emergency Medicine, and two delegates elected at the annual meeting. The President of the Hospital or his appointed representative, the Vice President, Patient Care Services, the Chairperson of the Credentials Committee, the Health Information Management Committee, the Infection Control Committee and Pharmacy and Therapeutics Committee and the Utilization Review Committee shall serve as a non-voting ex-officio member(s) of this committee and may attend each meeting of the committee. The president of the Medical Staff shall act as Chairperson of the Executive Committee. All Medical Staff members shall be eligible for membership on the Executive Committee. A majority of the voting members of the Executive Committee shall be fully licensed physician members of the Medical Staff actively practicing at the Hospital.

B. Duties. The Executive Committee shall be empowered to act on behalf of the Medical Staff in the intervals between Medical Staff meetings. The duties of the Executive Committee shall be to:

1. make recommendations directly to the Governing Body for its approval pertaining to the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual clinical privileges, recommendations of individuals for Medical Staff membership, Approval of Delineation of clinical privileges for each eligible individual, the participation of the Medical Staff in organization performance improvement activities as well as the mechanism used to conduct, evaluate and revise such activities, the mechanism by which the membership on the Medical Staff may be terminated, and the mechanism for fair-hearing procedures; and

2. represent and act on behalf of the Medical Staff, subject to such limitation as may be imposed by these bylaws;

3. receive and act on reports and recommendations from Medical Staff committees, clinical departments and assigned activity groups;

4. receive and act upon committee appointments;
5. implement policies of the Medical Staff not otherwise the responsibility of the departments;

6. provide liaison between the Medical Staff, the President of the Hospital, and the Governing Body.

7. recommend action to the President of the Hospital on matters of a medico-administrative nature;

8. make recommendations on Hospital management matters, such as long range planning, to the Governing Body through the President of the Hospital;

9. implement the Medical Staff quality improvement activities and establish a mechanism to conduct, evaluate and revise such activities as approved by the Governing Body to insure a process to assess and continuously improve the quality of care provided by the organization;

10. review the credentials of all applicants for Medical Staff membership and to forward recommendations concerning such applicant's department assignments, and delineation of clinical privileges as set forth in Article VII;

11. review periodically all information available regarding the performance and clinical competence of Medical Staff members and other practitioners with clinical privileges and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;

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

13. issue a report of its activity at each general Medical Staff meeting;

14. review utilization reports and reports of any committees responsible to it for transmission of appropriate data to the Governing Body for review;

15. review the Governing Body's actions or recommendations for appropriate procedures concerning the affected departments, committees, or individuals;

16. provide an assessment and recommendation regarding off-site sources for needed patient care services including, but not limited to hemodialysis, blood banking, radiation oncology and level III nurseries.
17. participate, as appropriate, in risk management activities including the identification of general areas of potential risk in the clinical aspects of patient care and safety; the development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care, safety and evaluation of these cases; the correction of problems in the clinical aspects of patient care and safety identified by risk management activities; and the design of programs to reduce risk in the clinical aspects of patient care and safety.

18. participate in the oversight of the Hospital's Safety and Hazardous Materials Management program internal and external disaster response planning.

C. Meetings. The Executive Committee shall meet at least once a month and shall maintain a permanent record of its proceedings and actions.

Section 2. Credentials Committee

A. Composition. The Credentials Committee shall consist of at least five members of the Active Medical Staff Category selected on a basis that will ensure representation of the major clinical department and shall include a representative from administration and from nursing when nursing related issues are discussed. An ex-officio member may be appointed by the Governing Body who shall be encouraged to observe and advise in committee deliberations.

B. Duties. The duties of the Credentials Committee shall be to:

1. review the credentials of all applicants to the Medical Staff and make recommendations for membership and delineation of clinical privileges in compliance with Articles VI and VII of these Bylaws;

2. report to the Executive Committee on each application for Medical Staff membership or clinical privileges, including specific consideration of the evaluation from the departments in which such applicant requests privileges;

3. review periodically all information available regarding the competence of Medical Staff members and as a result of such reviews, to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles VI, VII and XI of these Bylaws;

4. investigate any breach of ethics that is reported to it;

5. recommend to the Executive Committee and to the Governing Body the committee's assessment of the needs of the Hospital with respect to practitioners in each
department so that the applications for Medical Staff membership can be evaluated and acted upon by the Governing Body based upon the professional personnel requirements of the Hospital as determined by its strategic plan;

6. investigate, evaluate, and delineate the responsibilities and privileges of all health professionals through a review of all independent and dependent limited practitioners, made every two years, focused on: (1) delineation of clinical privileges, (2) results of performance improvement, (3) comparison of privileges to practice, (4) evidence of continuing education, (5) evidence of adequate liability insurance, and (6) results of any disciplinary actions and (7) other such information as required in article VI of these bylaws, followed by the submission of a report to the Executive Committee and Governing Body.

7. interview all applicants at the regular monthly meeting of the Credentials Committee at which the President of the Medical Staff and appropriate department Chairperson or their representatives shall also be present.

C. Meetings. The Credentials Committee shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

Section 3. Health Information Management Committee

A. Composition. The Health Information Management Committee shall consist of at least two members of the Medical Staff and representatives from Health Information Management, Nursing Service, Administration, Information Systems and the Library.

B. Duties. The Health Information Management Committee shall strive to continuously improve Information Management in the Hospital by:

1. More timely and easy access to complete information throughout the organization
2. Improved data accuracy
3. Demonstrated balance of proper levels of security versus ease of access
4. Use of aggregate data, along with external knowledge bases and comparative data, to pursue opportunities for improvement
5. Redesign of important information-related processes to improve efficiency
6. Greater collaboration and information sharing to enhance patient care.

Implementation of these objectives, and use of the information, shall be specified in a Performance Improvement Plan developed by the committee, subject to approval by the Governing Body.
C. Meetings. The Health Information Management Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

Section 4. Surgical and Invasive Procedure Review Committee

A. Composition. The Surgical and Invasive Procedure Review Committee shall consist of at least two members from the Surgical Department, one member from the Obstetrics-gynecology Department, one member from the Pathology Department and representatives from Health Information Management, Nursing Service and Administration.

B. Duties. The Surgical and Invasive Procedure Review Committee shall provide a cooperative effort of the medical staff, nursing management, and appropriate departments/services designed to (1) review surgical and other invasive procedures on an ongoing basis to continuously improve the appropriateness of the selection of surgical and other invasive procedures, the preparation of patients for procedures, the performance of the procedures and patient monitoring and the provision of post procedure care. (2) assess and improve activities focused on the ordering of appropriate blood and blood components, distribution, handling and dispensing of blood and blood components, administration of blood and blood components and monitoring of the effects of blood and blood components on patients.

Implementation of these objectives and use of the information provided shall be specified in a performance improvement plan developed by the committee, which shall be subject to approval by the Medical Staff and the Governing Body.

C. Meetings. The Surgical and Invasive Procedure Review Committee shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

Section 5. Critical Care Committee

A. Composition. The Critical Care Committee shall consist of a Cardiologist, who shall serve as Chairperson of the committee and Medical Director of the Critical Care Suite, and a physician representative from Anesthesia, Surgery, Emergency Medicine and Pulmonary Medicine as well as a representative from Administration, Nursing Administration, the Critical Care Suite Clinical Manager, the Emergency Department Clinical Manager and the Director of Cardio/Respiratory Services.

B. Duties. The Critical Care Committee shall provide a multi-disciplinary effort of the Medical Staff, Nursing and other clinical departments to guide the activities and performance improvement functions of the Critical Care Unit.
C. Meetings. The Critical Care Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings.

Section 6. Utilization Review Committee

A. Composition. The Utilization Review Committee shall be composed of Active Medical Staff Category members and at least one representative from administration, nursing service, Case Management, Health Information Management and the Business Office.

B. Duties. The Utilization Review Committee shall be responsible for addressing, through the Medical Staff Executive Committee, overutilization, underutilization, inefficient scheduling of resources and the effective use of discharge planning to insure discharge as soon as acute care is no longer required.

C. Utilization Review Plan. The committee shall formulate a written utilization review plan for the Hospital. Such plan, as approved by the Medical Staff and the Governing Body, must be in effect at all times and must include all of the following elements:

1. delineation of the responsibilities and authority of those involved in the performance of utilization review activities, including members of the Medical Staff, the Utilization Review Committee, non-physician health care professionals, administrative personnel and when applicable, qualified off-site organizations contracting to perform review activities specified in the plan.

2. a conflict of interest policy applicable to all involved in utilization review activities.

3. a confidentiality policy applicable to all utilization review activities, including findings and recommendations.

4. a description of the method(s) for identifying utilization related problems, including the appropriateness and medical necessity of admissions, continued stays and supportive services, as well as delays in the provision of supportive services.

5. the procedures for conducting concurrent review, including the time period within the time period within which the review is to be initiated following admission and the length of stay norms and percentiles to be used in assigning continued-stay review dates.

6. a mechanism for the provision of discharge planning.

D. Extended Duration Evaluations. The committee shall evaluate the medical necessity for continued Hospital services for particular patients where appropriate. In making such evaluations, the committee shall be guided by the following criteria:
1. No practitioner shall have review responsibility for any extended stay cases in which he was professionally involved.

2. All decisions that continued inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out-of-Hospital facilities and services.

3. Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-Hospital services for the patient, the judgment of the attending physician shall be given great weight.

4. All decisions that additional inpatient stay is not medically necessary shall be provided by written notice to the Executive Committee, to the Chairperson of the appropriate departments, to the President of the Hospital, and to the attending physician. Such written notice shall also state the reasons for the committee's decision.

5. All decisions that inpatient stay is medically necessary shall be subject to additional review.

E. Meetings. The Utilization Review Committee shall meet monthly, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a monthly report thereof to the Executive Committee.

Section 7. Pharmacy and Nutritional Support Committee

A. Composition. The Pharmacy and Nutritional Support Committee shall consist of two Medical Staff representatives, and one representative from each of the following departments: Pharmacy, Food Services, Nursing Service, Administration and other departments as appropriate.

B. Duties. The Pharmacy and Nutritional Support Committee shall provide a cooperative effort between the Medical Staff, Nursing Service, Pharmacy, Food Services, Administration and other Departments to:

1. strive to continuously improve the processes related to the prescription of appropriate medications, preparation and dispensing of medications, administration of medications and the monitoring of the effects of medications on patients.

2. perform the pharmacy and the therapeutics monitoring function including the development and approval of policies and procedures relating to the selection, distribution, handling, use and administration of drugs, diagnostic testing materials
and nutritional products; the development and maintenance of a drug formulary and
dietetics manual; the evaluation, and when no other mechanism exists, the approval
of protocols concerned with the use of investigational and experimental drugs; and
the definition and review of all significant withdrawal drug reactions.

Implementation of these objectives and use of the information provided shall be specified
in a performance improvement plan developed by the committee, which shall be subject to
the approval by the Medical Staff and Governing Body.

C. Meetings. The Pharmacy and Nutritional Support Committee shall meet at least quarterly
and shall report its findings and recommendations to the Executive Committee.

Section 8. Radiation Safety Committee

A. Composition. The Radiation Safety Committee shall be composed of two members of the
Medical Staff appointed by the President of the Medical Staff, and shall include one
representative from the Departments of Nuclear Medicine and Radiology, one of whom
shall be the Radiation Safety Officer. In addition to the Medical Staff members, the
Committee shall also be composed of one representative from Administration, from
Nursing Service, and the Administrative Director of Radiology, and Nuclear Medicine,
and Cardio/Respiratory Therapy Departments. The Consultant Health Physicist shall serve
as an ad hoc member.

B. Duties. The Radiation Safety Committee shall conduct a procedural review and assurance
of safe usage of all radiopharmaceutical; assure that radiation exposure to patients,
employees, and visitors is maintained at lowest possible levels in accordance with ALARA
policy; review all reports submitted by the consultant health physicist relative to
maintenance of records, handling and storage of materials, inspection of equipment and
holding facilities and records of personnel exposure; approve all proposed licensure
changes and new procedures; and review of usage and patient data relative to investigation
radiopharmaceutical.

C. Meetings. The committee shall meet at least quarterly and will submit reports to the
Executive Committee.

D. Quorum. A Quorum for this meeting shall be fifty percent (50%) to comply with Nuclear
Regulatory Commission (NRC) Regulations.

Section 9. Infection Control Committee

A. Composition. The Infection Control Committee shall be composed of three (3) members
of the Medical Staff appointed by the president of the Medical Staff. In addition to the
Medical Staff members, the committee shall also be composed of one representative from each of the following departments: administration, nursing services, material management (central sterile), housekeeping/laundry and the infection control practitioner. Other departments, including food services, facilities management, pharmacy and the operating suite shall be included on a consultative basis as required.

B. Duties. The Infection Control Committee shall approve the type and scope of surveillance activities, based on surveillance data, which shall include: the review of designated microbiological report; the review of patient infections, as appropriate, to determine whether an infection is nosocomial, using definitions and criteria approved by the committee with emphasis on those infections that present the potential for prevention or intervention to reduce risk of future occurrence; the review of prevalence and incidence studies; personnel and the environment for infectious agents as approved by the committee.

The committee shall approve actions to prevent or control infection, based on an evaluation of surveillance reports of infections and of the infection potential among patients and hospital personnel.

The committee reviews and approves, at least every two years, all policies and procedures related to the infection surveillance, prevention and control program and to infection surveillance, prevention, and control activities in all departments/services.

The Chairperson of the committee, or the infection control practitioner shall have the authority to institute any surveillance, prevention, control measures or other reasonable action to protect patients and staff.

C. Meetings. The committee shall meet at least every two months and will submit reports to the Executive Committee.

Section 10. Nominating Committee

A. Composition. The Nominating Committee shall consist of five members of the Active Medical Staff Category elected at the January meeting prior to the tri-annual May election meeting. Any elected member shall not succeed himself, but may be re-elected after an interim period of one term.

B. Duties. Develop a slate of candidates for the positions of officers and members at large. At least thirty (30) days prior to the annual meeting, the nominating committee shall submit its list of nominations in writing, by mail, to all members of the Active Medical Staff Category for the offices of:
1. President
2. President-elect
3. Secretary-treasurer
4. two delegates and a first and second designated alternate member to serve should an elected member be elected to a voting position on the Executive Committee through other means.

C. Meetings. The Nominating Committee will meet as often as necessary to develop the above list of candidates.

D. Quorum. Three of the five members who must be present represent a quorum.

Section 11. Patient Rights and Ethics Committee

A. Composition. The Patient Rights and Ethics Committee shall consist of one internist, one surgeon and one obstetrician-gynecologist along with representatives from Administration, Education, Nursing, Pastoral Care, Governing Body and a consulting ethicist. In addition, at the discretion of the Chairperson, representatives of the clergy and community may be invited to participate in committee deliberations.

B. Chairperson. The Chairperson shall be appointed by the President of the Medical Staff. The Chairperson shall be a member of the Medical Staff or the consulting ethicist.

C. Duties. The duties of the Patient Rights and Ethics Committee shall be to:

1. Establish and support mechanisms to address ethical issues.
2. Foster processes to insure respect for patient’s rights to treatment or service.
3. Ensure the recognition of the patient, or when appropriate, the family or surrogate decision maker’s rights to be involved in all aspects of care and care decisions including those affecting spiritual, psychosocial and cultural values.
4. Establish mechanisms to resolve conflicts in care decisions.
5. Formulate and insure compliance with policies and guidelines for advance directives, decisions to withhold resuscitation, decisions to forgo and/or withdraw life-sustaining treatment, decisions relative to the end of life, organ procurement and the protection of patient rights during research, investigation and/or clinical trials involving human subjects.
Section 12. Patient Safety Committee

A. Composition. The Patient Safety Committee shall consist of Medical Staff members one of whom shall serve as Chairperson and a representative from Administration, Nursing, Quality Assessment, the Safety Officer and the Hospital Risk Management Consultant.

B. Duties. The duties of the Patient Safety Committee shall be to:

1. coordinate efforts between the Medical Staff, Administration, Quality Assessment and Safety Programs to develop and oversee operations of the Hospital’s risk management function.

2. identify general areas of potential risk in the clinical aspects of patient care and safety.

3. develop and modify as needed criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and to evaluate these cases.

4. correct or recommend course of action to correct problems in the clinical aspects of patient care and safety identified through risk management activities.

5. design programs to reduce risk in the clinical aspects of patient care and safety.

C. Meetings. Patient Safety Committee shall meet monthly and shall submit written reports to the Executive Committee. A quorum shall not be required to meet.

Section 13. Quality Council

A. Composition. The Quality Council shall be a standing joint committee of the Hospital’s leadership, representing the Board of Directors, Medical Staff, Administration, Nursing and other operational areas. The Quality Council shall consist of an officer of the Board and two Board members appointed by the Chairperson of the Board; an officer of the Medical Staff and two active Medical Staff members appointed by the Medical Staff President; Senior Vice President; Vice President Patient Care Services; Vice President Finance; Nursing Representative; Director Case Management; Safety Officer; and Performance Improvement Coordinator.
The committee assignments shall be made in January of each year. Chairpersonship of the committee shall alternate between the Board and Medical Staff. One of the Board members appointed by the Board Chairperson shall chair the Committee on odd-numbered years. One of the Medical Staff members appointed by the Medical Staff President shall chair the committee on even-numbered years.

B. Duties. The Quality Council shall have the authority to make recommendations to the Board with respect to the functions assigned to it, subject to any prior limitations imposed by statute, by the Hospital’s Charter or these Bylaws or by the Board. Specifically, the Quality Council shall:

1. set expectations, develop plans, and implement procedures to assess and improve the quality of the organization’s governance, management, clinical and support processes, including:
   
a. providing education to the Hospital leadership concerning the methods and approaches to quality improvement;
   
b. setting of priorities for organization-wide quality improvement activities designed to improve patient outcomes;
   
c. insuring allocation of adequate resources are available for assessment and improvement of the organization’s governance, managerial, clinical and support processes;
   
d. assuring that training is provided for the Hospital staff in assessing and improving the processes that contribute to improved patient outcomes;
   
e. insuring that leaders individually and jointly develop and participate in mechanisms to foster communication among individuals and among components of the organization and to coordinate internal activities;
   
f. evaluating and assessing the leadership contributions to quality;
   
g. providing a mechanism to inform the Board of Directors and nursing issues in the Hospital, including an annual review of the nursing plan and a quarterly update on nursing issues, specifically recruitment and retention strategies.

2. insure the establishment of a mechanism to assure the provision of one (1) level of patient care by the organization;

3. receive Medical Staff recommendations and make recommendations to the Board on the adoption, amendment, or repeal of Medical Staff bylaws and related manuals,
rules, regulations and policies, including required Staff authority and administration needs to accomplish the Hospital’s quality and efficiency of care objectives;

4. monitor, investigate, report and make recommendations to the Board concerning the Hospital’s risk management and safety and infection control programs;

5. oversee Hospital compliance with the laws and regulations of federal, state and local governmental agencies and with the standards, rules and regulations of the various other accreditation and approval agencies (including the Joint Commission on Accreditation of Healthcare Organizations and third party payors); and

6. perform such other duties concerning Medical Staff and other matters as may be assigned to it by the Chairperson or the Board.

Section 14. Safety Committee

The Medical Staff shall assign a Medical Staff member to serve as an advisor to the Safety Committee. The Medical Staff member shall not be required to attend meetings of the committee but shall be available on a consultative basis as needed.

Section 15. Special Committees

As duties of the Medical Staff require and Hospital services and interests expand, the Medical Staff shall create and/or expand appropriate committees to direct, monitor, review and/or analyze, such services and interests. The President of the Medical Staff shall appoint the members of these committees which shall report to the Executive Committee. These special committees shall include but not be limited to the following:

A. Bylaws and Accreditation. This committee shall be responsible for the continuing review and necessary revision of the Bylaws, Rules and Regulations of the Medical Staff. The committee shall also be responsible for surveying standards of performance to ensure that they meet criteria of accrediting agencies with which the Hospital is affiliated.

B. Continuing Medical Education and Library Committee. This committee shall be responsible for the continuing education programs and the scientific meetings of the Medical Staff.

C. Impaired Practitioner Committee

1. Composition. The impaired practitioner committee shall consist of the President of the Medical Staff, the Chief Operating Officer or his designee, and two Active Medical Staff Category members.
2. **Duties.** The impaired practitioner committee shall have the following duties:

   a. Evaluate reports from the Medical Staff, Administration of the Hospital, or other relevant sources concerning suspected functional and professional impairment resulting from alcoholism, drug dependency, mental, physical or aging problems that would harm a patient.

   b. Initiate an investigation to gather facts concerning the nature, severity, implications and validity of alleged impairment. Investigations may include direct contact with the practitioner.

   c. Encourage the practitioner, if impaired, to voluntarily contact an appropriate treatment program.

   d. Monitor the ongoing treatment/rehabilitation as specified by the treatment program.

   e. Report to the Executive Committee if unsuccessful in communicating with an impaired practitioner, or if an impaired practitioner has not complied with a treatment or rehabilitation protocol.

   f. Act independently from any formal disciplinary or enforcement action, unless failure to comply with treatment plans presents concerns for patient safety.

   g. Maintain strict confidence relative to any investigations.

   Special Committees shall meet as necessary and shall submit written reports to the Executive Committee as required.

**Section 16. General**

A. Unless otherwise specified, all committee appointments will be for a period of two years.

B. A quorum for a meeting of any committee shall be not less than two (2) members, one of whom shall be the Chairperson or his/her designee.

C. Ex-officio members shall not vote nor shall they be counted for the determination of a quorum.
ARTICLE XIII: MEETINGS

Section 1. Annual Meeting

A. The annual meeting of the Medical Staff shall be held the second Tuesday in May. The agenda for such meeting shall include final reports of officers and committees for the previous year including review and evaluation of the work done in the clinical departments and performance of the required Medical Staff functions.

B. Officers of the Medical Staff for the ensuing two (2) years and two (2) delegates and two (2) alternates of the Executive Committee shall be elected at the annual meeting during which elections are scheduled.

Section 2. Regular Meetings

A. The regular meetings of the Medical Staff shall be held on the second Tuesday of January, May and October. There shall be a scientific session immediately preceding the business portion of all regular meetings, the topic of which shall be determined by the Continuing Medical Education and Library Committee. The purpose of the scientific program shall be to present timely clinical material.

B. The agenda for the regular meeting shall be as follows:
   1. Call to order;
   2. Acceptance of the minutes of last regular Medical Staff meeting and all special meetings;
   3. Unfinished business;
   4. Communications;
   5. Medical Staff officers reports;
   6. Hospital President’s reports;
   7. New business (including elections, where appropriate); and
   8. Adjournment.

Section 3. Special Meetings

A. Special meetings of the Staff may be called:
   1. at the request of the Governing Body;
   2. at the request of the Executive Committee;
   3. at the request of the President of the Medical Staff; and
   4. at the request, in writing, of any five members of the Active Medical Staff Category.
B. Special meetings of any committees may be called:
   1. at the request of the President of the Medical Staff, and
   2. at the request of the Chairperson of the committee involved.

C. The agenda at special meetings shall be:
   1. Reading of the notice calling the meeting;
   2. Transaction of the business for which the meeting was called; and
   3. Adjournment.

D. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any special meeting shall be a notice posted on the official Medical Staff bulletin board, or transmitted by mail, telephone or telegraph, so that forty-eight (48) hours advance notice may be reasonable presumed from receipt of notice until the meeting.

Section 4. Attendance at Meetings.

A. Attendance at all meetings of the Medical Staff shall be recorded. All members of the Active Medical Staff Category, including those on provisional status, shall be required to attend a combination of at least thirty-three percent (33%) of the scheduled Medical Staff and departmental meetings on a biennial basis. (6 meetings out of 18 (6 Medical Staff and 12 departmental) on a biennial basis). All members of the Active Medical Staff Category, including those on provisional status, shall also be required to attend thirty-three percent (33%) of the meetings of any committee to which they are assigned. Attendance at Committee meetings shall be combined with department and staff meetings when determining if the attendance requirement has been met. Failure to meet attendance requirements shall be considered a sufficient reason for transfer from Active Staff Category to Provisional status such transfer shall be for a minimum of twelve months. Reinstatement on full active status shall only occur if the Medical Staff member has met attendance requirements during the preceding six months of provisional status.

B. Application for reinstatement to a former position in the Active Medical Staff Category after demotion shall be in the discretion of the Executive Committee, subject to approval of the Governing Body.

C. Members of the Honorary, Consultant, Courtesy, and Special Emergency Department Medical Staff category shall not be required to attend meetings, but are encouraged to be present.

D. A member of any category of the Medical Staff who has attended a case which he is requested to present for review, shall be notified two weeks in advance and shall be required to be present at the scheduled review meeting. Failure to attend, on receipt of
such notice, unless excused by the Executive Committee of the Medical Staff, shall result in demotion to provisional status.

Should the member so notified be absent from any meeting during which a case which he attended is discussed, the case shall be presented, nevertheless, unless the member is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted beyond the next regularly scheduled meeting.

**Section 5. Quorum**

Thirty percent of the total membership of the Active Medical Staff Category shall constitute a quorum. All voting shall be decided by a simple majority of the Active Medical Staff Category members present, except for amendment and adoption of Bylaws and Rules and Regulations specified in Article XVI of these Bylaws. The President of the Medical Staff may direct that a written vote of the total Active Medical Staff Category by registered mail be substituted as a voting procedure if he deems such voting method to be advisable.

**Section 6. Attendance at Meetings - Hospital President**

The President of the Hospital or his designee shall have a standing invitation to all meetings of the Medical Staff.

**Section 7. Executive Session**

At any time upon the request of a Medical Staff member and without vote, an executive session shall be in order, at which time all those without the right to vote shall leave the meeting room.

**Section 8. Dues/Application Fee**

At the annual meeting in May, the membership of the Active Medical Staff Category shall set the Medical Staff dues for the coming year by majority vote and shall set an application processing fee not to exceed $250.00. The application processing fee shall be used to defray expenses of the Hospital in processing the application.
ARTICLE XIV: CONFIDENTIALITY, IMMUNITY AND RELEASE

Section 1. Special Definitions

For the purposes of this article, the following definitions shall apply:

A. The term "information" shall mean records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 5, B of this Article.

B. The term "malice" shall mean the dissemination of a known falsehood or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

C. The term "practitioner" shall mean a Medical Staff member or applicant.

D. The term "representative" shall mean the Governing Body and any member or committee thereof, the President of the Hospital, the Medical Staff organization and any member, officer, department or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

E. The term "third parties" shall mean both individuals and organizations providing information to any representative.

Section 2. Authorizations and Conditions

By applying for, or exercising, Medical Staff and/or clinical privileges within this Hospital, a practitioner:

A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his professional ability and other qualifications;

B. Agrees to be bound by the provisions of this article and to waive all legal claims against any representative who acts in accordance with the provisions of this article; and

C. Acknowledges that the provisions of this article are express conditions to his application for, or acceptance of, Medical Staff membership, or his exercise of clinical privileges at this Hospital.
Section 3. Confidentiality of Information

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the practitioner, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Hospital records.

Section 4. Immunity from Liability

A. No representative of the Hospital or Medical Staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendations made within the scope of his duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

B. No representative of the Hospital or staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or Medical Staff or to any other Hospital, organization of health professionals, or other health practitioner who is or has been an applicant to or member of the Medical Staff or who did or does exercise clinical privileges at this Hospital, provided that such representative or third party acts in good faith and without malice.

Section 5. Activities and Information Covered

A. The confidentiality and immunity provided by this article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

1. Request for Applications and applications for appointment and clinical privileges;
2. Periodic reappraisals for reappointment and clinical privileges;
3. Corrective action;
4. Hearings and appellate reviews;
5. Patient care evaluations;
6. Utilization reviews; and
Other Hospital, department, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

B. The acts, communications, reports, recommendations, disclosures, and other information referred to in this article may relate to a practitioner's professional qualifications, clinical ability, character, and physical and mental health, professional ethics, ability to work cooperatively with others or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

Section 6. Releases

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Pennsylvania, and such releases or copies thereof may be submitted to third parties from whom information as described in Section 5, B is sought. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this article.

Section 7. Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protection provided by law and not limitation thereof.

Section 8. Limits of Liability

The bylaws are written to provide guidance for the operation the Medical Staff. The bylaws are not intended and do not define standards of care for and liability of physicians, dentists or other healthcare workers for professional conduct.
ARTICLE XV: GENERAL PROVISIONS

Section 1. Medical Staff Policies (Rules and Regulations)

Subject to approval by the Governing Body, the Medical Staff shall adopt such policies as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Medical Staff member or Allied Health Professional in the Hospital, and shall be revised as needed to reflect the Hospital's current practices with respect to Medical Staff organization and functions. Such policies may be amended at any regular meeting of the Medical Staff Executive Committee at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Governing Body. Medical Staff policies may not be unilaterally amended by the Medical Staff or Board of Directors.

Section 2. Departmental Policies (Rules and Regulations)

Subject to the approval of the Executive Committee and the Governing Body, each department shall formulate, at its own option, policies for the conduct of its affairs and the discharge of its responsibilities. Such policies shall be consistent with these Bylaws, the general policies Medical Staff, or other policies of the Hospital. Such departmental policies shall be revised as needed to reflect the Hospital's current practices with respect to Medical Staff organization and functions. Such changes shall become effective when approved by the governing body. Departmental policies may not be unilaterally amended by the Medical Staff or Board of Directors.

Section 3. Medical Staff Minutes Books

The Medical Staff minute books shall be open for inspection at any time by any member of the Medical Staff or by the President of the Hospital.

Section 4. Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Executive Committee after considering the advice of the Credentials Committee.
Section 5. Headings

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

Section 6. Designees to Perform Functions of the Hospital President

Any responsibility assigned, or authority granted, to the President of the Hospital may be fulfilled or exercised by the Senior Vice President, except as otherwise provided by the Governing Body or in the Hospital Bylaws.

Section 7. Good Standing

The prerogatives and rights provided by these Bylaws to staff members to vote at staff meetings, to be nominated for and to hold staff office and to serve as a department Chairperson or committee Chairperson, shall be limited to Active Medical Staff Category members in good standing.

Section 8. Singular and Plural; Gender

As used herein, the singular shall include the plural, the plural and singular and the use of any gender shall be applicable to all genders.
ARTICLE XVI: ADOPTION AND AMENDMENT OF BYLAWS

Section 1. Medical Staff Responsibility and Authority

The Medical Staff shall have the initial responsibility and delegated authority to formulate and to submit recommendations to the Governing Body regarding Medical Staff Bylaws and amendments thereto. All amendments or revisions shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. A standing or special committee of the staff shall revise the Medical Staff Bylaws as needed to reflect the Hospital’s current practices with respect to Medical Staff organization and functions. The Medical Staff Bylaws shall not be effective until adopted by the Medical Staff and the Governing Body.

Section 2. Methodology

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

A. The affirmative vote of a majority of the Medical Staff members eligible to vote on the matter who are present at a meeting at which a quorum is present, provided that at least fifteen (15) days written notice, accompanied by the proposed revised Bylaws and/or alterations, has been given of the intention to take such action; and

B. Affirmative vote of majority of the Medical Staff members eligible to vote on the matter by proxy letter, provided that at least fifteen (15) days written notice, as accompanied by the proposed revised Bylaws and/or alterations, has been given the intention to take such action. Failure to return proxy will be counted as a positive vote for proposed revision; and

C. The affirmative vote of the Governing Body at a regular scheduled meeting after due notice.

D. Neither the Medical Staff nor the Governing Body may unilaterally amend, alter or repeal the foregoing Bylaws.
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