BYLAWS

of the

MEDICAL STAFF

St. Luke's Hospital
Bethlehem, Pennsylvania

Adopted:
January 23, 1989

Amendments to April 28, 2014
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BYLAWS

of the

MEDICAL STAFF

Saint Luke's Hospital
Bethlehem, Pennsylvania

PREAMBLE

WHEREAS, Saint Luke's Hospital is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania with the purpose of operating a hospital to provide health care, health education, and health research; and

WHEREAS, it is recognized that the Hospital's Board of Trustees' has the ultimate responsibility for all aspects of the Hospital's operations including the activities and actions of the Medical Staff; and

WHEREAS, the physicians and dentists affiliated with Saint Luke's Hospital possess the education, training, experience and competence to both provide medical care and monitor and evaluate its quality; and

WHEREAS, the Hospital's Board of Trustees wishes to assign the Medical Staff the responsibility for the quality of medical care in the Hospital and the Medical Staff agrees to accept and discharge such responsibility consistent with the provisions of these Bylaws; and

WHEREAS, it is recognized that the cooperative efforts of the Medical Staff, the Hospital's Administration and the Board of Trustees are necessary in order for the Medical Staff to fulfill its assigned responsibilities and for the Hospital to meet its health care obligations; now therefore be it

RESOLVED, that in order to effectively discharge the duties and responsibilities assigned by the Board of Trustees and to fulfill their patient care obligations, the physicians and dentists affiliated with Saint Luke's Hospital shall function and act in accordance with the organizational framework and operational procedures set forth in these Bylaws.
ARTICLE I - DEFINITIONS

For the purpose of these Bylaws, the following terms shall have the meaning and definition assigned to them in this Article except as otherwise expressly provided in these Bylaws:

1. "Administration" or "Administrative Staff" means the personnel employed by the Hospital, including the Chief Executive Officer, who are responsible for carrying out the day-to-day management of the Hospital's operations, under the authority of the Board.

2. "Board" or "governing body" means the Board of Trustees of Saint Luke's Hospital.

3. "CEO" or "Chief Executive Officer" of the Hospital means the individual with the title of President of the Hospital, appointed by the Board to act in its behalf in the overall management of the Hospital.

4. "Clinical functions" or "clinical duties" means the authority recommended by the Medical Staff and approved by the Board to allow an allied professional (Revised 10/96) to provide specific medical and/or other patient care services in the Hospital.

5. "Clinical privileges" or "privileges" means the authority recommended by the Medical Staff and granted by the Board of Trustees to a practitioner to provide medical and/or other patient care services in the Hospital, such approved clinical privileges to be within defined limits and to be based on the individual's professional license, education, training, experience, and demonstrated competence.

6. "Dentist" means an individual who is fully licensed by the Pennsylvania Board of Dentistry to practice dentistry in all its phases.

7. "Executive Committee" means the Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Board.

8. "Ex officio" means by virtue of office or official position and includes full voting privileges unless stated otherwise.


10. "Allied Professional" (Revised 10/96) means an individual, other than a practitioner, who meets the categorical requirements established by the Board and who is either duly licensed or certified or otherwise qualified by training and experience to provide specified patient care services either under the supervision of or in consultation with a physician member of the Active Medical Staff.

11. "Medical Staff" or "Staff" means the body of practitioners at Saint Luke's Hospital, known as the Medical Staff of Saint Luke's Hospital.
12. "Medical Staff year" and "Medical Staff fiscal year," means the twelve (12) month period beginning on July 1 and ending on June 30 of the following calendar year.

13. "Member" means an individual practitioner who currently holds Medical Staff appointment.

14. "Physician" means an individual with an unrestricted license to practice medicine or osteopathy as authorized by either the Pennsylvania Board of Medicine or the Pennsylvania Board of Osteopathic Medicine.

15. "Surgical Podiatrist" means a podiatrist who has completed a fully approved podiatric surgical residency program approved by the Council on Podiatric Medical Education. (Added 1/97)

16. "Practitioner" means a physician, dentist or surgical podiatrist (Added 1/97) as defined in this Article.

17. "President of the Medical Staff" or "President" means that member elected to that position by the Medical Staff according to election procedures set forth in these Bylaws.

18. Whenever a personal pronoun is used, it shall mean a person of either gender.

19. Vice President of Medical and Academic Affairs - A hospital position filled by a physician who is responsible for maintaining liaison between the Medical Staff and the Board/Administration and who will be a member of the active medical staff of the hospital.
ARTICLE II - NAME

The name of this organization shall be the Medical Staff of Saint Luke's Hospital of Bethlehem, Pennsylvania.
ARTICLE III - PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff of Saint Luke's Hospital are to:

1. strive for an acceptable level of professional performance of all practitioners and allied professionals authorized to practice in the Hospital through:
   
   (a) the appropriate delineation of the clinical privileges or clinical functions, as appropriate, that each practitioner or allied health professional may exercise in the Hospital; and
   
   (b) an ongoing review and evaluation of the performance of each practitioner and allied health professional;

2. monitor the quality of medical care in the Hospital and its outpatient services and to take action and make recommendations to the Board so that patients admitted to or treated in any of the facilities, departments, or services of the Hospital can reasonably expect to receive medical care consistent with the circumstances and the available resources, manpower, and facilities;

3. make recommendations to the Board concerning both the appointment of an applicant or the reappointment of a member to the Medical Staff and the nature and extent of clinical privileges to be granted each applicant or member;

4. recommend the classifications for allied health professionals and the nature and extent of clinical functions assigned to applicants in any allied health professional category established by the Board;

5. provide an appropriate educational setting for members of the Medical Staff and Hospital personnel in order to maintain scientific standards and to enhance continuous advancement in professional knowledge and skill;

6. recommend policy and procedures pertaining to corrective action including a hearing and appeal mechanism;

7. maintain these Medical Staff Bylaws and specific rules and regulations necessary for the effective functioning and self-government of the Medical Staff;

8. establish procedures whereby issues concerning the Medical Staff and the Hospital may be discussed both within the Medical Staff and with the Board and the Chief Executive Officer;

9. evaluate programs associated with community health needs;

10. participate in a spirit of mutual cooperation with the Board of Trustees and the Chief Executive Officer in all appropriate projects where the unique qualifications of the Medical Staff are an essential ingredient;
11. evaluate the Hospital's equipment needs and services and make recommendations to the administration and Board relative to the replacement of equipment and the addition of new equipment and services;

12. cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and postgraduate education; and

13. encourage and support such clinical and basic research as is recommended by the Medical Staff and authorized by the Board.

14. perform history and physicals: (rev. 4/13)

   a. An admission history and physical examination shall be performed and recorded within 24 hours of admission. If a history and physical examination has been performed within a 30 day time frame and recorded prior to the patient’s admission to the hospital, a copy of this report may be used in the patient’s hospital medical record in lieu of the admission history and physical examination provided they were performed and recorded by a licensed practitioner. If the H&P has been performed 24 hours or more prior to admission, or out-patient procedure requiring general anesthesia or conscious sedation, an update note will be documented on the H&P form progress note, or preoperative note. The update documentation may be accomplished with the pre-anesthesia assessment. The update note will be dated, timed and signed by a licensed practitioner. All available information from licensed practitioners on the chart within 24 hours can be applied towards the composition of an H&P.

   b. A history and physical shall consist of a chief complaint, history of present illness, past medical history, allergies, medications, alcohol history, tobacco history, heart exam lung exam, relevant organ exam and impression/plan.

   c. A history and physical as described in (b) is required for any patient receiving procedural sedation or general anesthesia except outpatient endoscopy patients.

   d. An outpatient endoscopy history and physical shall consist of a chief complaint, chest exam, heart exam, ASA classification, airway classification, impression and plan.

   e. As applicable to the hospital setting, the current obstetrical record shall include a complete prenatal record. A copy of the attending practitioner’s office record transferred to the hospital before admission is acceptable. An interval admission note shall be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
ARTICLE IV - EXCLUSION OF PATIENTS' THIRD PARTY BENEFICIARY RIGHTS

It is not the intention of the Medical Staff, its members, the Hospital, its Board or its administrative staff to grant to any patient any right of recovery solely by virtue of these Bylaws.
ARTICLE V - MEDICAL STAFF MEMBERSHIP

Section 1 - Eligibility for Medical Staff Membership

Membership on the Medical Staff of Saint Luke's Hospital is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and related rules and regulations.

Section 2 - Qualifications for Membership

a. Practitioners shall be qualified to apply for membership on the Medical Staff of Saint Luke's Hospital if they:

1. are licensed to practice in the Commonwealth of Pennsylvania and can provide proof of medical liability insurance as required by the Commonwealth of Pennsylvania;

2. can document their background, education, training, experience and clinical competence;

3. can meet the Medical Staff’s specific educational and postgraduate training requirements as well as the standards of the department(s) to which they will be assigned;

4. can demonstrate, on the basis of documented references, their adherence to the ethics of their respective profession, their good reputation and character, their ability to work cooperatively with others, and their willingness to participate in the discharge of Medical Staff responsibilities;

5. can satisfy the Medical Staff and the Board that the status of the applicant's physical and mental health will not hinder them in treating patients according to generally recognized professional standards of quality medical care; and

6. can demonstrate their ability to provide continuous patient care and to respond adequately to patient care emergencies, including referral of unassigned patients from the emergency department, and to specify the arrangements for alternative coverage when the practitioner will not be available.

The following guidelines will be used in determining the ability of either an applicant for membership or a Medical Staff member to provide continuous patient care and to respond adequately to patient care emergencies:

(a) the practitioner's type of practice;

(b) the geographic location of the practitioner's primary office and home; and
(c) the arrangements the practitioner has made for alternative coverage of
his practice either for emergency care or when he will not be available.

b. No practitioner shall be entitled to membership on the Medical Staff or to the exercise
of particular clinical privileges in the Hospital merely because the practitioner:

1. is licensed to practice medicine or dentistry;
2. is a member of any professional organization;
3. has had such privileges at another hospital;
4. is a member of a group practice whose members already have privileges on the
   Medical Staff; or
5. has completed a residency training program at the Hospital.

c. Neither Medical Staff membership nor clinical privileges shall be denied on the basis of
sex, race, creed, color, or national origin. Medical Staff membership and clinical privileges shall be
based on:

1. the delivery of quality patient care;
2. professional ability and judgment;
3. moral character and ethical conduct;
4. ability to work cooperatively with others;
5. willingness, availability and ability to discharge Medical Staff responsibilities
   and comply with these Medical Staff Bylaws and related rules and regulations;
6. availability of adequate facilities and support services; and
7. community need.

d. Applicants for membership and all members of the Medical Staff must pledge in writing
that they: will not receive from, or pay to, any practitioner, either directly or indirectly, any part of a
fee received for professional services; will not deceive a patient about the identity of any other
practitioner providing treatment or services; will only delegate the responsibility for the diagnosis
and treatment of patients to practitioners they believe are qualified.

7. Board Certification – Effective January 1, 2009, all new appointments and
reappointments of currently board certified applicants must meet one of the following: (added 5/08)
a. Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, as applicable;

b. Are board certified in their primary area of practice. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training [or within the time period set by the applicable Board];

c. Maintain board certification and, to the extent required by the applicable specialty/subspecialty board in their primary area of practice, satisfy recertification requirements. Recertification will be assessed at reappointment as follows:

1. board certification should be continuously maintained.

2. from the closest board recertification exam date prior of the primary practicing specialty board certification expiration, the applicant will be allowed two more documented tries to recertify within a period of 5 years.

3. not enrolling in the recertification exam immediately prior to the certification expiration date or those two exams scheduled immediately after will be considered as failed recertification exam(s).

8. Effective January 1, 2009, all new appointments and reappointments of not currently board certified applicants must meet the following: (added 6/08)

   a. any physician appointed to the medical staff since February 21, 1995 must be board certified within five years of appointment to the staff or as required by their respective national board. This applies to all staff categories with the exception of affiliate staff, ambulatory staff and consulting staff (added 12/10).

Section 3 - Other Considerations

In addition to the applicant's qualifications, the Hospital must consider its ability to provide adequate facilities and support services for the applicant and his patients. The Hospital must also consider whether patient care needs merit additional practitioners with the applicant's qualifications.

Section 4 - Basic Responsibilities of Medical Staff Membership

Each member of the Medical Staff shall:
a. Provide patient care according to generally recognized professional standards of quality and efficiency in the community;

b. Provide continuous patient care, respond adequately to patient care emergencies, including referral of unassigned patients from the emergency department, and make arrangements acceptable to the Executive Committee for alternative coverage when the member will not be available. The guidelines for evaluating continuous patient care are included in Section 2.a.6. of this Article.

c. Abide by the Medical Staff Bylaws, rules and regulations and by all other lawful standards and policies of the Medical Staff;

d. Discharge such Medical Staff, departmental, committee and Hospital functions for which the member is responsible by medical staff category assignment, appointment, election or otherwise;

e. Prepare and complete in a timely fashion and in accordance with policy established by the Medical Staff, the medical and other required records for all patients the member admits or in any way provides care to in the Hospital;

f. Abide by the ethical principles established by applicable professional societies or organizations and the specific requirements of Section 2.d. of this Article;

g. Adhere to accepted standards of practitioner decorum and demonstrate the ability to work cooperatively with Hospital personnel, fellow practitioners, and others;

h. Show evidence of continuing medical education credit as required by Medical Staff Rules and Regulations;

i. Immediately report in writing to the President of the Medical Staff if he has been convicted of a felony; and

j. Immediately report to the President of the Medical Staff when sanctions of any kind are either imposed or pending by any other health care institution or organization or licensing or regulatory agency or any request by same to withdraw an application or to voluntarily resign.

Section 5 - Qualifications for Admitting Privileges

Privileges to admit patients to Saint Luke's Hospital will be granted only to practitioners on either the Active, Provisional, or Courtesy staffs who hold an unrestricted license to practice medicine and surgery in Pennsylvania, such admitting privileges to be recommended by the Executive Committee and granted by the Board of Trustees consistent with the prerogatives set forth in the membership categories set forth in Section 7 of this Article.
Section 6 - Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff and the granting of clinical privileges shall be made by the Board. The Board shall act on appointments, reappointments or revocation of appointments and clinical privileges only after there has been a recommendation from the Executive Committee as provided in these Bylaws.

The following six areas of General Competencies will be considered at the time of initial appointment and reappointment: patient care – practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life; medical/clinical knowledge – practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others; practice-based learning and improvement – practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices; interpersonal and communication skills – practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams; professionalism – practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society; and systems-based practice – practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care (added 11/06).

b. All initial appointments shall be to the Provisional (Rev. 7/97) Staff with the exception of appointment to either the Consulting, Affiliate, Honorary or Associate (Revised 8/95) staffs. All initial appointments shall be provisional for an twelve (12) month period, from the time of appointment, such period to begin at the time the appointment is approved by the Board, notwithstanding the fact that the applicant may have been practicing under temporary privileges. Following the provisional period the member must either: (1) be appointed to another membership category, (2) have provisional status extended for no more than six (6) months, or (3) have Medical Staff membership and clinical privileges terminated. Reappointments shall be for a period of not more than two (2) Medical Staff years.

c. In the event membership is terminated or an application is rejected, the practitioner is not eligible to reapply for one (1) year after the termination or rejection, unless exception to this requirement is specifically stated in the official notice of termination or rejection.

d. Members who voluntarily resign from the Medical Staff may reapply at any time, such reapplication to be processed according to the procedures required for a new applicant.

e. Appointments to the Medical Staff shall confer on the member only such clinical privileges as have been recommended by the Executive Committee and granted by the Board, in accordance with these Bylaws.
f. Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations and basic responsibilities as set forth in these Bylaws and Medical Staff rules and regulations.

**Section 7 - Medical Staff Categories**

The Medical Staff shall be divided into the following categories: Active, Consulting, Honorary, Affiliate (Rev. 4/10), Ambulatory (Added 12/09) and Active Associate (Added 4/10). Applicants who intend to admit or otherwise care for patients in the Hospital will be initially assigned to the Active Staff, except for those requesting Consulting, Ambulatory, Affiliate or Active Associate Staff membership.

**Part 1 - Active Staff**

a. Each active and provisional staff member may choose one campus in which to fulfill citizenship obligations such as department meetings. Membership on the active staff at each campus will carry with it the responsibilities and prerogatives applicable to each campus. Any member of the active or provisional staff treating greater than twelve (12) patients per year at a particular campus shall be responsible for participation in the schedule of emergency coverage at that campus. (Added 8/02) The Active Medical Staff shall consist of practitioners who: (1) have satisfactorily met the requirements for provisional staff appointment; (2) either regularly admitted or otherwise demonstrated a minimum of twelve (12) contacts for a one year period or who are employed by the Hospital in a medico-administrative position if the position is approved by the Medical Staff for Active Medical Staff membership; (3) in the judgment of the Executive Committee and the Board, are located closely enough to the Hospital to provide continuous care to their patients; and (4) assume all the functions and responsibilities of membership on the Active Medical Staff, including the transaction of Medical Staff business.

Members of the Active Medical Staff must fulfill the basic responsibilities of membership set forth in Section 4 of this Article and be willing to assume reasonable service assignments. The Term "reasonable service" includes:

1. acceptance of clinical department appointments and responsibilities as set down by the chairman of the department;

2. service on the Executive Committee, other Medical Staff committees and Board committees; and

3. acceptance of emergency call responsibilities and care of unassigned patients as designated by the appropriate department and specified in the Medical Staff rules and regulations.

b. Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff committees, and shall be required to attend committee, departmental and Medical Staff meetings and to pay Medical Staff dues and assessments.
c. A member of the Active Staff who is either disabled (as determined to the satisfaction of the Executive Committee and the Board) or has attained the age of 65 and who intends to continue patient care activities may request to be relieved of the requirement to pay dues and assessments, emergency service coverage, mandatory committee service and departmental meetings, such request to be considered by the Executive Committee. At age 60 a practitioner may request relief from emergency service coverage if approved by the relevant section chief, a majority of the section members and the respective department chief. (Added 2/02)

d. Each Active Staff member must assume responsibility, within his area of professional competence, for the daily care and supervision of each patient under his care in the Hospital, or arrange for a suitable alternative practitioner to provide the necessary care and supervision during his absence or unavailability.

e. If a minimum number of hospital contacts has not been fulfilled, the practitioner can no longer remain a member of the active medical staff and will be so notified by the Medical Affairs Office at the time of reappointment. The practitioner may request a transfer to the active affiliate consulting staff or courtesy staff. However, if no request is received from the practitioner for a change in staff category, it will be assumed that the practitioner does not wish to seek reappointment to the medical staff of St. Luke's Hospital. (Revised 7/97)

Part 2 - Consulting Staff

Members in this category shall be specialists who, by virtue of special skills and limited availability, do not limit their work to any one hospital or to this community alone and are appointed for the specific purpose of providing consultation, at the request of the attending physician in the diagnosis and treatment of patients. Appointment to the Consulting Staff does not entitle the member to admit patients, or to vote at Medical Staff meetings or hold an office of the Medical Staff. A Consulting Staff member may serve as the chairman of or as a member of a committee with voting rights. Members of the Consulting Staff may, but are not required to, attend meetings of the Medical Staff and their assigned department. Members of the Consulting Staff are not required to pay dues or assessments.

Members of the Consulting Staff shall give their services, without charge, in the case of free or part-pay patients, on request of any member of the Medical Staff.

Part 3 - Honorary Staff

The Honorary Staff shall consist of members of the Medical Staff who are no longer clinically active in the Hospital and practitioners outside of the Bethlehem area, who are recognized by the Medical Staff for their outstanding reputations, their noteworthy contributions to the health and medical sciences, their unselfish dedication to the betterment of the health of their patients.

Persons appointed to the Honorary Staff shall not be eligible to attend patients, to vote at Medical Staff meetings, or hold office. Honorary members may be appointed to committees with
vote and as chairman of a committee. They may, but are not required to, attend any Medical Staff meetings. Members of the Honorary Staff are not required to pay dues or assessments.

**Part 4 - Affiliate Staff** (Rev. 4/10)

a. The Affiliate Staff shall consist of those physicians, dentists, and podiatrists in the community who hold medical staff appointment at this hospital and: 1) do not reside in the geographic service area of the hospital and so do not intend to admit or treat patients at the hospital; or 2) reside in the geographic service area of the hospital, but care for patients only in an office setting, or outpatient.

b. Affiliate Staff members: 1) may, but are not required to, attend meetings of the Medical Staff and departments; 2) shall have no staff committee responsibilities, but may be assigned to special committees with vote; 3) attend educational programs of the Medical Staff; 4) may refer patients to Active Staff physicians, visit those patients when hospitalized and review their medical records, may make medical record entries, but may not write orders or perform consults; 5) may order services through the hospital’s diagnostic facilities including the Infusion Center (added 12/10); 6) shall not be granted clinical inpatient privileges and shall not admit or treat patients at the hospital; 7) shall pay medical staff dues of $50.00.

c. Any Affiliate Staff member who wishes to transfer to another staff category must complete and submit an appropriate application.

**Part 5 - Ambulatory Staff** (Added 12/09)

a. The Ambulatory Staff will be members who are employed to provide services at affiliated outpatient facilities and clinics operated under the St. Luke’s Hospital & Health Networks license. Being a member of the Ambulatory Staff does not imply automatic eligibility for inpatient hospital privileges. The primary purpose of the Ambulatory Staff is to permit these members to work at SLHN affiliated facilities and allow access to hospital services for their patients by referral while at the same time providing follow-up care, on an outpatient basis, for unassigned patients presenting to the Emergency Department. Individuals assigned to the Ambulatory Staff are not required to be board certified. Qualified residents in training with an unrestricted or interim limited (added 4/10) Pennsylvania license may be considered for appointment to this category with approval of their residency program director.

**Part 6 – Active Associate Staff** (Added 4/10)

a. The Active Associate Staff shall consist of those physicians, dentists, and podiatrists in the community who hold medical staff appointment at this hospital and: 1) use hospitalists or other physician with admitting privileges, for inpatient management of their patients at the Hospital, but who wish to maintain limited inpatient privileges as set forth in this section; 2) refer for admission at least 12 patients per year to the hospital, 3) actively participate in Medical Staff
functions and responsibilities, such as committee and section assignments; 4) at each reappointment time, provide evidence of clinical performance in such form as may be required by the Credentials Committee, other committee, or Board, in order to allow for an appropriate assessment of continued qualifications for Medical Staff appointment and clinical privileges; and 5) pay all staff dues in the amount of $70 and assessments.

b. Active Associate Staff members may: 1) attend Medical Staff, department, and section meetings; 2) serve on Medical Staff committees, as assigned; 3) participate in the peer review and performance improvement process; 4) provide telephone on-call coverage for the emergency department solely for the purpose of accepting follow-up care for unassigned patients or to assist in arrangements for follow-up care for patients to be discharged from the emergency department; and upon request, accept and assume follow-up outpatient care for a reasonable number of unassigned patients who present to the Hospital’s emergency department; 5) vote in all general and special meetings of the Medical Staff and applicable section and committee meetings, hold office, serve on Medical Staff committees, and serve as chairpersons of such committees; 6) admit patients to the service of a hospitalist or other physician with admitting privileges, when requested provide histories and physicals for those patients, advise on previous medical care of those patients, and provide consultations about the care of their patients to a hospitalist; and 7) visit their hospitalized patients and review their medical records, but not make entries regarding inpatient care or actively participate in the provision of management of inpatient care except to provide consultations for their patients when requested to do so by a hospitalist.

ARTICLE VI - ALLIED PROFESSIONALS (Revised 10/96)

Section 1 - Definitions

For the purposes of these Bylaws, the following definitions shall apply:

a. Dependent Allied Professional (Revised 10/96) - Dependent allied professional staff are individuals, other than licensed practitioners and independent allied professional staff, who: (1) are duly qualified by training, experience or certification and/or licensure to provide specific patient care services under the direct supervision of a physician member of either the Active or the Provisional Medical Staff; (2) are employed by either an Active or a Provisional member of the Medical Staff or by the Hospital, which must meet the statutory requirements for physician supervision; and (3) qualify for a dependent allied professional staff category established by action of the Board.

b. Independent Allied Professional (Revised 10/96) - Independent allied professionals are individuals other than licensed practitioners who: (1) are duly licensed by the appropriate licensing board of the Pennsylvania Department of State; (2) are authorized by Pennsylvania law to provide specific patient care services without direct physician supervision; and (3) qualify for an allied professional staff category established by action of the Board.
c. Medical Associates - Physicians who provide specific services pursuant to a contract with the hospital who do not qualify for staff appointment or who do not wish to apply for appointment. Medical Associates must have their application reviewed and approved by the Credentials Committee of the Medical Staff. Individuals in this category do not have the rights and privileges of the Medical Staff By-Laws. (Added 11/91)

**Section 2 - Categories for Allied Professionals** (Revised 10/96)

When it is recommended by the Medical Staff and approved by the Board that the services of any recognized allied professional are proper and necessary to the Hospital's function and patient treatment, the Board may establish a category for the particular discipline of allied professional in question. These Bylaws and any related rules and regulations do not apply to limited health professionals unless the Board specifically establishes a category which falls under the purview of these Bylaws.

Within those categories there will be two designations: APS – Active and APS – Affiliate. APS – Active includes APS members who fulfill all activity criteria for their category at SLHN and APS – Affiliate includes APS members without the minimum amount of SLHN activity to be active members but who provide evidence of satisfactory activity from another acceptable healthcare facility. (Added 8/03)

**Section 3 - Clinical Functions**

Individuals who qualify as allied professional staff in any category established by the Board may be considered for specific clinical functions in accordance with the credentialing procedures recommended by the Executive Committee and approved by the Board. Such clinical functions shall be recommended by the Executive Committee and approved by the Board, such approval to be consistent with applicable State licensing statutes and regulations; recognized education, training, certification and/or licensure; experience, demonstrated competence and judgment; available facilities and resources; and patient care needs of the community.

Clinical functions approved for allied professional staff shall be specifically delineated and need not include all modes of treatment or surgery that may be within the definition of the practice of any particular discipline of allied professional staff as set forth in Pennsylvania statutes.

**Section 4 - Rights and Responsibilities**

The Executive Committee shall recommend for Board approval the rights and responsibilities of allied professional staff as such rights and responsibilities relate to the organization and operation of the Medical Staff and the clinical aspects of patient care.

**Section 5 - Clinical Evaluation and Assignment to Department**

Each limited health professional with approved clinical functions shall be assigned to the department recommended by the Executive Committee that is most appropriate to the clinical functions approved. The clinical performance of each allied professional staff member shall be
monitored and evaluated according to policies and procedures recommended by the Executive Committee and approved by the Board.

Section 6 - Allied Professional Staff Committee (Revised 10/96)

When the Board creates a category for any discipline of allied (Revised 10/96) professional and when it is necessary to comply with statutes and regulations of the Commonwealth, the President of the Medical Staff shall appoint a Allied Professional Staff Committee (Revised 10/96) which will be responsible for evaluating and recommending policies and procedures pertaining to the scope and circumstances of the practice of allied professionals.
ARTICLE VII – ORGANIZATION AND OPERATION OF THE MEDICAL STAFF

Section 1 - General

Part 1 - Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the first day of July and ends on the thirtieth day of June of the following year.

Part 2 - Dues and Assessments

All persons appointed to the Medical Staff are personally responsible for paying annual Medical Staff dues and assessments as established by the Medical Staff for each Medical Staff membership category. Any funds collected through dues or assessments and any other funds received by the Medical Staff shall be placed in such accounts or directories as approved by the Medical Staff. Disbursement shall be according to policy adopted by the Medical Staff.

Members who have not paid their dues or assessments will be given a second notice after sixty (60) days and will have their membership and clinical privileges suspended if dues are not paid within six (6) months of the original due date. Suspensions will be removed upon payment of dues.

Section 2 - Officers of the Medical Staff

Part 1 - Officers

The officers of the Medical Staff shall be the President, Vice-President, and Treasurer.

(Revised 10/94)

Part 2 - Election of Officers

a. Qualifications - Officers must be members in good standing of the Active Medical Staff at the time of nomination and election and must remain members during their term in office. Each officer should possess the ability and Medical Staff experience required to fill the office and a willingness to devote the time and effort needed to fulfill the responsibilities of the office.

b. Nomination - Nominations for officers of the Medical Staff shall be presented by the Nominating Committee for action at the Annual Medical Staff meeting every year. The Nominating Committee's slate of nominees, which shall include one (1) or more nominees for each office, shall be published at least twenty (20) days preceding the Annual Meeting. Write-in nominations are permitted so long as they are submitted in writing to the Chairman of the Nominating Committee (added 11/06) at least seven (7) days prior to the elections. Write-in nominations shall be published prior to the elections. Nominations may also be made from the floor at the time of elections. This nominating procedure will be followed in all Medical Staff elections unless an exception is either specifically noted in these Bylaws or approved by two-thirds
(2/3) vote of the Medical Staff.

c. **Election** - Officers shall be elected at the Annual Medical Staff meeting every year by a majority vote of those Medical Staff members eligible to vote and present at such meeting. The vote shall be by written secret ballot. If there are three or more candidates for an office in any election and no candidate receives a majority vote, there shall be successive balloting with the name of the candidate receiving the fewest votes omitted from each successive ballot until a majority vote is obtained by one candidate.

d. **Term** - Each officer shall hold office for a one (1) year term commencing on the day of his election unless he shall sooner die, resign, or be removed from office. All officers may be re-elected except the President of the Medical Staff may not hold that office for more than two (2) consecutive terms. A person who has served nine (9) or more months of an unexpired term shall be deemed to have served a term.

e. **Disqualification and Removal** - Failure of an officer to maintain his status as a member of the Active Medical Staff shall immediately disqualify that person from holding such office and shall be deemed to create a vacancy therein. The Medical Staff may, by a two-thirds (2/3) vote at a meeting in which a quorum has been established, remove any officer of the Medical Staff for conduct detrimental to the interests of the Medical Staff or because he is suffering from a physical or mental infirmity that renders him incapable of fulfilling the duties of his office, providing that notice of the meeting at which such action takes place shall have been given in writing to such officer by certified mail and its signed receipt returned at least ten (10) days prior to the date of such meeting. The officer in question shall be afforded the opportunity to speak in his own behalf prior to the taking of any vote on his removal. Any such removal from office shall not entitle such officer to the procedural rights afforded by Article XII and shall not affect his Medical Staff membership status or clinical privileges.

f. **Vacancies** - When the office of the President of the Medical Staff is vacated prematurely, the Vice-President shall act as President of the Medical Staff until the vacancy is filled. If the Vice-President is unable to act as President for any reason, the authority and duties of the President will be temporarily assumed by the Immediate Past President of the Medical Staff, the Secretary, the Treasurer, or the next available senior member (as determined by tenure on the Executive Committee and in the event of a tie, by years of Medical Staff membership) of the Executive Committee in that order of succession, until the next regular Medical Staff meeting at which time any prematurely vacated offices shall be filled by vote of the membership following the nominating procedures set forth above in Part 2.b. of Section 2 of this Article, except that the report of the Nominating Committee shall be published at least seven (7) days prior to the meeting.

**Part 3 - Duties of Officers**

a. **President of the Medical Staff** - The President of the Medical Staff shall serve as the chief administrative officer of the Medical Staff and, as such, shall:

   1. act on behalf of the Medical Staff in cooperation with the Chief Executive
Officer in matters of mutual concern involving the Hospital;

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

3. serve as Chairman of the Executive Committee;

4. appoint, in consultation with the Executive Committee, committee chairmen and members, to all standing, special, and multi-disciplinary Medical Staff committees, except as otherwise specified in these Bylaws;

5. serve as an ex officio member, without vote, of all Medical Staff committees, unless otherwise required in these Bylaws;

6. present the activities, opinions, policies, concerns, needs and grievances of the Medical Staff to the Chief Executive Officer and to the Board;

7. report the policies and decisions of the Board to the Medical Staff;

8. be the spokesman for the Medical Staff in its external professional and public relations; and

9. serve on liaison committees with the Board and administration as well as outside licensing and accrediting agencies.

b. Vice-President - The Vice-President shall:

1. assume all the duties and have all the authority of the President in his absence or disability;

2. succeed the President when he fails to serve for any reason;

3. serve as a member and Vice Chairman of the Executive Committee; and

4. perform such other duties as may be assigned by the President, Executive Committee of the Medical Staff.

c. Treasurer - The Treasurer shall:

1. collect and be custodian of Medical Staff dues and funds, and make disbursements authorized by the Medical Staff, the Executive Committee or their designees;

2. issue a report at each Annual Meeting of the Medical Staff, specifying the amount and location of all fund balances and itemizing all receipts and disbursements occurring since the previous meeting.
Section 3 - Meetings of the Medical Staff

Part 1 - Annual Medical Staff Meeting

The Annual Medical Staff Meeting shall be held in the month of May or June (added 11/06). At this meeting, the President of the Medical Staff and committee chairmen may present annual reports. Elections shall be held for officers and the vacant positions on the Executive Committee to be filled by vote of the Medical Staff. The Treasurer shall present a financial report and Medical Staff dues shall be established for the ensuing year. Voting rights at the Annual Meeting and at all other Medical Staff meetings shall be determined by Medical Staff membership category.

Part 2 - Medical Staff Meetings

The Medical Staff shall meet at least four (4) (Rev. 3/05) times annually, for the purpose of reviewing and evaluating departmental and committee reports and recommendations and to act on any other matters placed on the agenda by the President. The May meeting shall be the Annual Meeting.

Part 3 - Special Medical Staff Meetings

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the Executive Committee, the Board of Trustees or a petition signed by not less than 10% of the members of the Active Medical Staff. In the event it is necessary for the Medical Staff to act on a question without being able to meet, the voting members may be presented with the question by mail, and their votes returned to the President by mail. An affirmative vote by a majority of the eligible voters shall be binding.

Part 4 - Notice of Meetings

The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

a. Regular Meetings - A written notice stating the place, day and hour of regular meetings of the Medical Staff shall be posted in the Medical Staff Lounge.

b. Special Meetings - Written notice for special meetings shall be posted in the Medical Staff Room at least two (2) business days before the date of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Part 5 - Quorum

A quorum is defined as those present at a meeting. (Rev. 10/01)

Part 6 - Agenda
The agenda at any regular or special meeting of the Medical Staff shall be determined by the President, employing the following outlines:

a. Regular

1. Call to order;

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

3. Report of the Chief Executive Officer;

4. Report of the Vice President, Medical Affairs and/or Medical Staff officers;

5. Unfinished business;

6. Communications;

7. Reports of departments;

8. Reports of standing and special committees;

9. New business;

10. Discussion and recommendations for improvement of the professional work of the Hospital;

11. Adjournment.

b. Special:

1. Reading of the notice calling the meeting;

2. Transaction of the business for which meeting was called;

3. Adjournment.

All actions of the Executive Committee shall be included in its report to the Medical Staff at any regular meeting or at any special meeting called for the purpose of reviewing the actions of the Executive Committee.

Part 7 - Place of Meetings

The President may designate the date, time of the day and place for any regular or special
meeting unless specified otherwise by either the Executive Committee or the Medical Staff.

**Part 8 – Conflict Management Process** (Added 02/12)

A special meeting of the Medical Staff may be called by a petition signed by not less than one fourth of the voting staff to discuss any conflict with regard to (1) proposed amendments to these Medical Staff By-Laws; (2) proposed amendments to the Medical Staff Rules and Regulations; (3) proposed amendments to an existing policy that is under the authority of the Executive Committee; or (4) a new policy proposed by the Executive Committee. The agenda for that meeting will be limited to the amendment(s) or policy at issue.

**Section 4 - Department and Committee Meetings**

**Part 1 - Department Meetings**

Each department shall meet at least four (4) times per year. When a department meets 12 (twelve) or more times, the attendance requirement for an individual in that department shall be set at a maximum of 12 (twelve) meetings per year. (Revised 5/01)

**Part 2 - Committee Meetings**

All committees shall meet at least quarterly, unless otherwise specified in these Bylaws, at a time set by the chairman of the committee unless specified by a resolution of the committee. The agenda for the meeting and its general conduct shall be established by the chairman.

**Part 3 - Special Department and Committee Meetings**

a. A special meeting of any department or committee may be called by or at the request of the department or committee chairman, by the President, or by petition signed by not less than one-third (1/3) of the members of the department or committee involved, but not less than two (2) members. Written or oral notice stating the place, day, hour and purpose of any special meeting shall be given to each member of the department or committee not less than forty-eight (48) hours before the time of such meeting. No business shall be transacted at any special meeting except that business stated in the notice calling the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's written or oral notice of such meeting.

b. In the event that it is necessary for a department or committee to act on a question without being able to meet, the voting members of the concerned department or committee may be presented with the question, in writing by the chairman, and their written vote returned to the chairman of the department or committee. A majority of the eligible voters shall prevail.

**Part 4 - Quorum**

A quorum is defined as those present at a meeting. (Rev. 10/01)
Part 5 - Rights of Ex Officio Members

Ex officio committee members shall have all the rights and privileges of regular members unless otherwise restricted by these Bylaws.

Part 6 - Minutes

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of the members and of the recommendations made. The minutes shall be signed by the presiding officer, and copies thereof shall be promptly forwarded to the Executive Committee, unless otherwise specified for certain committees in Article IX. Each department and each committee shall maintain a permanent file of the minutes of each of its meetings.

Section 5 - Provisions Common to All Meetings

Part 1 - Notice of Meetings

Written notice specifying date, time and location of all meetings of the Medical Staff, of departments and of committees shall be published in the Hospital's schedule of meetings and/or posted on the bulletin board in the Medical Staff Lounge at least two (2) days prior to a given meeting. No further notification of meetings is required unless otherwise stated in these Bylaws.

Part 2 - Attendance Requirements

a. Members of the Active Staff are expected to attend all meetings of: the Medical Staff; the department to which they have been assigned; and committees to which they are either appointed or elected. Excepting specific meetings from which they have been excused, members are required to attend at least fifty percent (50%) of the remainder of all such applicable meetings of the Medical Staff and fifty percent (50%) of the meetings of their department and committees, during any given Medical Staff year. Meeting attendance can be in person, via teleconference, skype, go to meeting or other similar modalities. The aforementioned methods of attendance will be documented as attendance of the meeting. Attestation of reading the meeting minutes will also be considered as meeting attendance. (Added 4/12) Any member who is compelled to be absent from a given meeting, may submit the reason for his absence to the appropriate presiding officer or their designee (added 4/12) prior to or within ten (10) days following that meeting. In any event, the presiding officer, on a basis of information available to him, may decide that such an absence is valid and declare a member to be excused from attending that meeting. Either the presiding officer or the member in question may request the Executive Committee to judge the validity of the absence. The name of any individual so excused, shall be recorded in the minutes of the applicable meeting. Failure of any member of the Medical Staff to comply with the aforementioned requirements shall constitute grounds for action leading to corrective measures as specified in Article XI of these Bylaws. The attendance record of each member shall be maintained for meetings of the Medical Staff, departments and committees. Such records shall be reviewed by the Credentials Committee at the time of the member's reappointment. If the Credentials Committee determines at the time of reappointment that a member has not
complied with the meeting attendance requirements, the Committee may recommend that the member be placed on probation for one (1) year. If the member has not met the meeting attendance requirements during the probationary period, the Committee may recommend termination of the member’s Medical Staff membership and clinical privileges.

b. Any member of the Medical Staff whose clinical work is questioned will be requested to discuss such clinical work at a meeting of a department, a committee or of the Executive Committee. The member shall be so notified, and shall be expected to attend the specified meeting. The chairman of the department or committee or the Chairman of the Executive Committee shall give such a member fifteen (15) days advance written notice of the time and place of the meeting at which his attendance is expected. If the individual makes a timely request for postponement supported by an adequate showing that his absence or his inability to be prepared is unavoidable, the presentation may be postponed by the chairman of the department or committee or the Chairman of the Executive Committee, but for no longer than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

c. If the individual does not request a postponement and fails to appear, the chairman of the applicable department or committee shall notify the Executive Committee of the failure of an individual to attend any meeting to which he was given notice that attendance was mandatory. Unless excused by the Executive Committee upon showing of good cause, such failure may result in an automatic suspension of all or such portion of the individual's privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved.

d. Members of the Courtesy, Consulting, Affiliate and Honorary Staffs are encouraged to attend and participate in department and Medical Staff meetings, but shall not be required to do so as a condition of continued staff appointment, unless their clinical work is scheduled for discussion.

Part 3 - Rules of Order

Wherever they do not conflict with these Bylaws, the currently revised Sturgis Rules of Order shall govern all meetings of the Medical Staff and the Executive Committee. When required or requested, a parliamentarian shall be appointed by the presiding officer. (Revised 6/92)

Part 4 – Voting

Any individual who attends a meeting in more than one capacity shall only be entitled to one vote. The right to vote at all meetings shall be determined by the individual's Medical Staff membership category and as otherwise specified in these Bylaws.

ARTICLE VIII - CLINICAL DEPARTMENTS AND SECTIONS

Section 1 - Departments and Services

Part 1 - Creation and Elimination
In order that the clinical work of the Hospital may be carried out effectively and efficiently and in order to properly administer medical practice in the Hospital, the Medical Staff shall be divided into clinical departments.

Upon recommendation of the Executive Committee and the approval of the Board, sections of departments may be established, and existing ones may be eliminated, rearranged, combined or separated. New departments may be established and existing ones may be eliminated, rearranged, combined or separated upon recommendation of the Executive Committee and with the approval of the Medical Staff and the Board.

Part 2 - List of Departments

The Medical Staff shall be divided into the following departments:

a. Anesthesiology – to include pain management. (added 3/98)

b. Family Medicine (rev. 11/06)

c. Medicine - to include allergy and immunology, infectious diseases, endocrinology and metabolism, hematology, oncology, cardiovascular diseases, pulmonary diseases, nephrology, gastroenterology, rheumatology, neurology, dermatology, physical medicine, internal medicine, geriatric medicine, occupational medicine. (Revised 6/91) and Radiation Oncology (Rev. 02/12).

d. Obstetrics and Gynecology

e. Pathology

f. Pediatrics

g. Behavioral Medicine (Revised 12/95)

h. Radiology - to include nuclear medicine.

i. Surgery - to include the following sections: general surgery, plastic and reconstructive surgery, neurological surgery, urology, cardiothoracic surgery, vascular surgery, otorhinolaryngology/head and neck surgery (revised 4/99), oral surgery, colo-rectal surgery, surgical podiatry (added 6/98), surgical oncology (added 6/98), ophthalmology, traumatology (added 6/98), and bariatric surgery (added 4/14).

j. Emergency Medicine

k. Orthopaedic Surgery (added 11/06) – to include the following sections: general orthopaedics, hand surgery, orthopaedic trauma, spine surgery, and sports medicine

l. Pain Medicine and Palliative Care (added 7/10)
Section 2 - Organization and Operation of Medical Staff Department

Each department shall be organized as a unit of the Medical Staff and shall have a duly appointed chairman who shall be responsible for the overall supervision of the clinical work within the department.

Section 3 - Functions of Departments

Part 1 - Criteria and Rules and Regulations

Each department by majority vote shall establish in writing its own criteria for the delineation and assignment of clinical privileges, its own rules and regulations and requirement for holding a departmental office consistent with the policies of the Medical Staff, the Board, The Joint Commission and other regulatory bodies, both private and public. They shall become effective when approved by the Executive Committee and the Board.

Part 2 - Medical Care Evaluation

At the request of a majority of a committee composed of the Vice President for Medical and Academic Affairs, Chief of the Clinical Department, and the Quality Improvement Departmental Team Chairman, or the affected individual, outside consultants may be used for additional peer quality review. The Chairman of the Committee would be the Vice President for Medical and Academic Affairs. The expense of the outside consultant will be borne by the party requesting the outside consultant. (Added 4/94)

Each department shall establish effective mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated privileges in the department, such evaluation to include both inpatient and outpatient services. The mechanisms adopted should include procedures for: the collection of pertinent information; assessment of the information and identification of problems in patient care using objective criteria approved by the department; recommending action to resolve problems; evaluating effectiveness of actions taken; and reporting quality assurance activities.

Each department shall hold monthly meetings to review and analyze on a peer-group basis the clinical work of the department. Specific reviews may be suggested by the Quality Assurance Committee or required by the Executive Committee. Written reports shall be maintained reflecting the conclusions of all evaluations performed and stating all actions taken.

The chairman of each clinical department will appoint a QI Team Leader whose appointment is subject to approval by the departmental membership. The Team Leader may appoint additional departmental members to serve on the departmental QI Team. (Added 2/94)

Part 3 - Proctoring

All initial appointees to the Active Staff shall be subject to a period of proctoring, during
which time the proctor (either the chairman of the department or his designee) will observe the clinical performance of the appointee. In the event the chairman of the department is subject to proctoring, the chairman shall be proctored according to procedures established and approved by the department and approved by the Executive Committee.

Each department shall develop proctoring protocols and reporting requirements for review and approval by the Executive Committee.

**Part 4 - Reports**

In discharging these functions, each department shall report periodically, but at least quarterly, to the Executive Committee detailing its analysis of patient care.

**Section 4 - Department Chairmen** (Rev. 12/13)

**Part 1 - Qualifications**

The chairman of each department, at the time of his appointment, shall be a member of either the Active Staff or be eligible for such appointment and shall be certified by an appropriate specialty board or be (added 1/09) qualified by training, experience, and administrative ability for the position.

**Part 2 - Selection**

The chairman of each department shall be appointed by the President & CEO of the hospital or his designee following consultation with the Medical Executive Committee or respective department.

**Part 3 - Term**

Department chairmen may be appointed for a term determined by the President & CEO of the hospital, such term to be consistent with both the membership requirements and reappointment policies set forth in these Bylaws. There is no limit on the number of terms.

**Part 4 - Vice Chairman**

A vice chairman may be appointed for a term determined by the President & CEO of the hospital with no limit on the number of terms. Such appointment shall be made by the President & CEO of the hospital or his designee following consultation with the Medical Executive Committee.

**Part 5 - Removal**

A chairman or vice chairman may be removed at any time by the President & CEO of the hospital or his designee with or without cause following consultation with the Medical Executive Committee.
Part 6 - Departmental Secretary

Each department may elect a Secretary who shall be responsible for maintaining meeting minutes and other departmental records.

Section 5 - Function of Departmental Chairmen

Each chairman shall:

a. be responsible to the Executive Committee for the organization of and the general administration of the department and for all professional and administrative activities of the department within the scope of these Bylaws;

b. provide guidance to the Executive Committee on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding the quality of patient care in the department;

c. maintain continuing review of the professional performance of all individuals with clinical privileges in the department, including the operation of the department's proctoring system, and report and recommend thereon to the Credentials Committee;

d. be responsible for enforcement within the department of these Bylaws and the rules and regulations of the Medical Staff and of the department;

e. be responsible for implementation within the department of actions taken by the Executive Committee;

f. transmit to the Credentials Committee recommendations concerning appointment, reappointment, delineation of clinical privileges, and medical staff category for all individuals in and applicants to the department;

g. be responsible for the establishment, implementation, and effectiveness of any teaching, education, and research program in the department;

h. be responsible for the general administration of the department and work in cooperation with the administration as necessary concerning matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

i. assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization (added 1/09),

j. assist the administration in the preparation of annual reports and budget planning pertaining to the department as may be requested by the Executive Committee, the Chief Executive Officer or the Board;
k. assign such duties to the vice chairman and other members of the department as deemed appropriate;

l. establish sections within the department subject to the approval of the Executive Committee and the Board.

Section 6 - Assignment to Departments

The Executive Committee shall make the recommendations for departmental assignment of Medical Staff members and approved allied professional staff members based upon the advice received from the specific department(s) through the Credentials Committee.

Any member of the Medical Staff may have privileges in one or more departments on the basis of his training and experience. Clinical privileges requested from a department other than the member's assigned department shall be processed by the same procedures the department follows in the credentialing of its assigned members. Such a member shall be subject to all of the rules of each department which has granted him clinical privileges.

Section 7 - Exclusive Contractual Arrangements

The President of the Hospital shall provide the Medical Staff, through the Executive Committee, an opportunity to review tentative decisions by the Hospital Administration to execute an exclusive contract in a previously open department or service, to terminate an exclusive contract in a particular department or service or to modify an existing exclusive contract in a particular department or service that would affect existing clinical privileges before the Board makes a final decision.

The President of the Hospital shall inform the President of the Medical Staff in a reasonable time and manner of any plans to renew an existing exclusive contract.
ARTICLE IX - COMMITTEES OF THE MEDICAL STAFF

Section 1 - Appointment

Part 1 - Chairman

The appointment of all committee chairmen, unless otherwise provided for in these Bylaws, will be made by the President no later than ten (10) days after the end of the Medical Staff year for a term of one (1) year with no limit on the number of terms. A member's eligibility to serve as a committee chairman shall be determined by the rights granted by the respective Medical Staff membership category. Physician trustees will not be eligible to serve as medical staff committee chairmen effective July 1, 1992. (Revised 2/92)

Part 2 - Members

a. Members of each standing committee, except as otherwise provided for in these Bylaws, shall be appointed annually by the President, not more than ten (10) days after the end of the Medical Staff year, with no limitation on the number of terms they may serve. The President's appointments shall be approved by the Executive Committee. Eligibility for appointment shall be determined according to Medical Staff membership category unless specifically stated otherwise in these Bylaws. All appointed members may be removed and vacancies filled by the President subject to the approval of the Executive Committee. Elected committee members may be removed and vacancies filled according to election procedures set forth in these Bylaws. Unless otherwise specified in these Bylaws, the involvement of Hospital personnel and other nonpractitioners in committee meetings shall be recommended by the Chief Executive Officer and appointed by the President.

b. The President shall be a member of the Executive Committee. He shall be an ex officio member, without vote, on all other standing Medical Staff committees.

c. If an elected committee member is unable to serve, another Medical Staff member shall be elected by the Executive Committee to fill the position until the original member returns to the Committee or until the expiration of the term of the original member.

d. Unless otherwise stated in these Bylaws, all committee members shall have voting privileges.

Part 3 - Attendance

The attendance requirements set forth in Part 2, Section 5 of Article VII shall apply to committee members.

Part 4 - Meetings
The time and place of committee meetings shall be determined by a majority vote of the voting members. Unless otherwise specified in these Bylaws, committees shall meet at least ten (10) times annually.

**Part 5 - Voting Rights and Quorum**

Voting rights are limited to members of the Medical Staff on a committee. Except where stated otherwise, only Medical Staff members shall be counted in determining a quorum. Committee actions shall be decided by a majority vote.

**Part 6 - Subcommittees**

A committee of the Medical Staff may establish a subcommittee(s) so long as the duties, composition and meeting schedule of any proposed subcommittee is approved by the Executive Committee. Subcommittee members shall be appointed by the President of the Medical Staff. Unless specifically stated otherwise in these Bylaws, all subcommittee members must be members of the parent committee. The parent committee shall appoint the chairman of a subcommittee, such chairman to be a member of the parent committee.

All subcommittees shall report on a regular basis to the respective parent committee which is responsible for overseeing the activity of its subcommittees.

**Section 2 - Committee Records and Reports**

Unless otherwise specified in these Bylaws, each Committee shall maintain a permanent record of its proceedings, findings and actions and shall report its activities to the Executive Committee.

**Section 3 - Creation of Standing Committees**

The Executive Committee may, with the approval of the Medical Staff, establish a Medical Staff committee and may in the same manner, dissolve or rearrange an established Medical Staff committee's structure, duties or composition. The duties, structure and composition of proposed committees shall be specified when presented to the Medical Staff for approval. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Executive Committee.
Section 4 - Standing Committees of the Medical Staff

The following standing committees are organized by the Medical Staff to carry out its functions and the responsibilities delegated to the Medical Staff by the Board of Trustees:

Bylaws Committee
Code Review Committee (Added 5/02)
Continuing Medical Education Committee
Credentials Committee
Emergency Management Committee (Rev. 1/06)
Executive Committee
G.I. Endoscopy Committee
Infection Control Committee
Library Committee
Allied Professional Staff Committee (Revised 10/96)
Graduate Medical Education Committee (Revised 10/96)
Medical Care Evaluation Committee (Added 4/10)
Medical Records Committee
Medical Staff Finance Committee (Added 8/03)
Medical Staff Health Committee
Nominating Committee
Nutrition Committee
Operating Room Committee
  Laser Sub-Committee
Patient Education Advisory Committee
Pharmacy and Therapeutics Committee
Quality Improvement Committee
Radiation Safety and Isotope Committee
Transfusion Committee
Cancer Committee (Rev. 04/12)

Part 1 - Bylaws Committee

a. Composition - The Bylaws Committee shall consist of five (5) or more members of the Medical Staff appointed by the President with the approval of the Executive Committee.

b. Duties - The Bylaws Committee shall:

1. review the Bylaws of the Medical Staff at least annually and recommend revisions, if indicated, to the Executive Committee;

2. receive and consider recommendations for changes in these Bylaws referred by the Board, the Executive Committee, a Medical Staff department or the Medical Staff; and

3. coordinate the activities associated with the review and revision of the Rules and Regulations of the Medical Staff and departments.
4. In order to ensure that these publications comply with and do not contradict policy set forth in the Medical Staff By-Laws, the By-Laws Committee has the responsibility to review the following: a. substantive changes in forms used by Medical Staff; b. Medical Staff and hospital policy manuals. (Added 9/93)

c. Meetings, Records and Reports - The Bylaws Committee shall meet as often as necessary, but at least annually.

Part 2 – Code Review Committee (Added 5/02)

a. Composition – The Code Review committee shall be composed of at least five members of the Medical Staff to include: cardiology, emergency medicine, anesthesia, internal medicine and residency program director. Representatives from the departments of pharmacy, respiratory therapy, risk management and nursing (manager, supervisor and educator) will also be invited to participate in the Committee’s activities.

b. Duties – The Code Review Committee is responsible for: Review of all code blue records and critique forms at least on a quarterly basis to identify opportunities for improvement. Compile outcomes data of codes; determine if ACLS protocols were followed; develop the Administrative Policy and Procedure for “Code Blue” and revise as needed. Ensure implementation of all change of ACLS protocol as issued; and develop recommendations and education relative to the follow-up of code issues (which are divided into personnel, equipment, medications, or miscellaneous) or provide quality medical care in codes.

c. Meetings, Records and Reports – The Code Review Committee shall meet a minimum of four (4) times per year. All minutes will be forwarded to the Senior Vice President of Medical and Academic Affairs and the Director of Quality Resources.

Part 3 - Continuing Medical Education Committee (Added 8/90)

a. Composition - The Continuing Medical Education Committee shall be composed of one member of each of the medical staff departments. The Vice President for Medical and Academic Affairs and the Assistant Vice President, Medical Education are also members of the Committee.

b. Duties - The Continuing Medical Education Committee is responsible for evaluating, planning and approving the continuing medical education activities at St. Luke's Hospital. The Committee is also responsible for leadership in determining the future of continuing medical education.

c. Meetings, Records and Reports - The Continuing Medical Education Committee shall meet a minimum of six (6) times per year. (Revised 4/94)

d. Appointment and Term of Office - Effective in fiscal year 1993, one-third of the membership of the Continuing Medical Education Committee shall be appointed for one year, one-third shall be appointed for a term of two years, and one-third shall be appointed for a term of three years. Thereafter, persons who leave the committee will be replaced by new members who will have appointments for three years. Members whose appointments have expired will be eligible for
Part 4 - Credentials Committee

a. Composition - The Credentials Committee shall consist of at least five (5) Active members including the Immediate Past President. Department chairmen are not eligible to serve on the Committee.

b. Duties - The Credentials Committee functions as an investigative and advisory body and does not have policy making authority. The duties of the Credentials Committee shall be to:

1. review the credentials of all applicants, to arrange for the interview of applicants and conduct such investigations as may be necessary and to make recommendations for Medical Staff membership and delineation of clinical privileges in accordance with procedures set forth in these Bylaws;

2. make a report to the Executive Committee on each applicant for Medical Staff membership and clinical privileges, including specific considerations of the recommendations from the department(s) in which such applicant requests privileges;

3. review questions regarding the ethics and professional and clinical competence of persons who are currently members of the Medical Staff and make recommendations to the Executive Committee for the granting, reduction or withdrawal of promotions, privileges, reappointments and changes in the assignment of members to the various departments; and

4. evaluate reports that are referred by the Executive Committee;

5. review all applicants for allied professional staff categories as detailed in Article VI of these Bylaws.

c. Meetings, Records and Reports - The Credentials Committee shall meet as often as necessary to accomplish its duties but at least two (2) times a year.

d. General Considerations -

1. Conflict of Interest - In any instance where a member of the Credentials Committee is in direct economic competition or has a conflict of interest in any financial or business matter involving an applicant or a member of the Medical Staff which comes before the Credentials Committee, that member of the Credentials Committee shall not participate in the discussion or voting on the matter and shall leave the meeting during that time, although questions concerning the matter may be asked and answered before leaving.

2. All members of the Credentials Committee shall faithfully comply with the stipulations of Article X of these Bylaws concerning the confidentiality of credentialing materials and discussions.
Part 5 – Emergency Management Committee (Rev. 1/06)

a. Composition - The Emergency Management (Rev. 1/06) Committee shall be composed of at least three (3) members of the Medical Staff. Hospital personnel who have job responsibilities related to the Committee's duties will participate in the Committee's activities.

b. Duties - The primary responsibility of the Emergency Management (Rev. 1/06) Committee is to plan for the appropriate responses to both internal and external disasters. Specifically, the Committee is responsible for developing and implementing an emergency preparedness program which:

(1) is designed to safeguard patients and continue essential patient care at the time of a disaster including provisions for all key personnel to rehearse fire and other types of disaster drills during the year; and

(2) provides for the reception, care and evacuation of mass casualties, such plan to be coordinated with the Hospital's inpatient and outpatient services and to identify the Hospital's role in community-wide disaster plans; and

(3) is implemented, evaluated and documented semiannually.

c. Meetings, Records and Reports - The Committee shall meet as often as necessary but at least quarterly. The Committee shall report to the Executive Committee and the Hospital's Chief Executive Officer.

Part 6 - Executive Committee

a. Composition –(Revised 4/94)

1. The Executive Committee shall consist of the following:

a. The Chiefs of medicine, surgery, obstetrics and gynecology, pediatrics, Family Medicine (rev. 11/06), radiology, pathology, anesthesiology, behavioral medicine (Revised 12/95), emergency medicine and orthopaedic surgery (added 9/06),

b. One elected member from each of the departments of medicine, obstetrics and gynecology and surgery.

c. The President of the Medical Staff.

d. The Vice President of the Medical Staff.

e. The Past President of the Medical Staff (optional).

f. The Chairman of the By-Laws Committee.
g. The Chairman of the Credentials Committee.

h. The Hospital's PMS/HMSS representative.

i. Nine at-large members to be elected by the active medical staff by secret ballot for a term of three years. These members shall be selected to represent as wide a cross section of the staff as possible without a sacrifice of the quality of representation.

j. The President of the Medical Staff shall also serve as Chairman of the Executive Committee, and the Vice President of the Medical Staff shall also serve as Vice Chairman of the Executive Committee.

k. The Vice President, Medical and Academic Affairs as an ex-officio member without voting privileges.

l. The Chief Executive Officer shall be invited to attend meetings of the Executive Committee and shall be provided with a copy of the agenda. In the event the Executive Committee goes into executive session, the CEO shall be informed of the items that will be under discussion, and shall have the opportunity to discuss the issues with the Executive Committee both prior to and following the executive session. Other members of the administrative staff may attend meetings for specific purposes, on the request of the CEO and approval of the Chairman. During executive sessions, no formal votes will be taken on matters effecting the appointment, clinical privileges or peer review of any applicant or individual appointed to the medical staff.

The Network Medical Executive Committee (MEC) of St. Luke’s Medical Staff will include (Rev 11/06):

m. The Vice President, Medical Affairs of St. Luke’s Allentown Campus as an ex-officio member,

n. Three members of the Medical Staff whose practice is primarily at the St. Luke’s Allentown Campus. Those members may be nominated for positions on the Medical Executive Committee by their chief of service or the vice president of medical affairs of St. Luke’s Allentown Campus. Their selection for the medical executive committee will be by vote of the Medical Council of St. Luke’s Allentown Campus.

b. **Duties** - The duties of the Executive Committee shall be to:

1. represent and act on behalf of the Medical Staff in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws or specific policy established by the Medical Staff;

2. present to the Medical Staff at its next regular meeting, all actions taken which create, change or implement policy;

3. coordinate the activities and general policies of the various departments;
4. receive and act upon committee and departmental reports as approved by the respective committee or department, and make recommendations concerning them to the Medical Staff, Chief Executive Officer and the Board, as appropriate;

5. implement policies of the Medical Staff which are not the responsibility of the departments;

6. provide leadership for the Medical Staff and provide liaison within the Medical Staff and with the Chief Executive Officer and the Board on behalf of the Medical Staff;

7. recommend action to the Chief Executive Officer on medical-administrative and Hospital management matters;

8. ensure that the Medical Staff is kept abreast of the requirements of The Joint Commission (Rev. 6/08) and informed of the accreditation status of the Hospital;

9. evaluate the recommendations of the Credentials Committee and make recommendations to the Board relative to: Medical Staff membership, Medical Staff category, department assignment, and clinical privileges for practitioners; the delineation of clinical functions for allied professional staff; and the reappointment of practitioners and allied professional staff; and;

10. take reasonable steps to: ensure proper professional and ethical conduct of Medical Staff members; maintain good working relations among members and resolve differences between members; enforce these Bylaws and their Rules and Regulations; and make recommendations to the Board on actions described in Article X;

11. consider questions concerning the clinical competence, patient care and treatment or case management of any individual member of the Medical Staff and recommend appropriate action;

12. act on behalf of the Medical Staff relative to hearing and appeal procedures set forth in Article XII;

13. be responsible to the Board for the general quality of medical care rendered to patients in the Hospital;

14. determine minimum continuing education requirements for members of the Medical Staff;

15. review the Medical Staff Bylaws and related rules and regulations, policies, documents and forms at least annually and recommend changes as necessary and desirable; and

16. evaluate future trends in medical practice and make recommendations to the Board relative to the objectives and mission of the Hospital.
A subcommittee of the Executive Committee shall be responsible for medical staff matters specific to each satellite campus of St. Luke’s Hospital. The composition of the subcommittee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Executive Committee. (added 4/00)

c. **Meetings, Records and Reports** - The Executive Committee shall hold at least ten (10) monthly meetings and maintain a permanent record of its actions and proceedings. Recommended action of the Executive Committee will be reported to the Medical Staff and the Board or the Chief Executive Officer, as appropriate. Unless otherwise specified in these Bylaws, meetings of the Executive Committee will be governed by the current edition of Sturgis Rules of Order. (Revised 6/92)

1. Attendance: Attendance of each elected member of the Executive Committee shall be mandatory unless excused by the president. Failure to attend two unexcused meetings per year shall be construed as resignation from the Executive Committee and shall call for a special election by the medical staff. (Added 6/91)

d. **General Considerations** –

1. **Conflict of Interest** - In any instance where a member of the Executive Committee has a conflict of interest in any financial or business matter involving another member of the Medical Staff which comes before the Executive Committee, or in any instance where a member of the Executive Committee brings a complaint against a member, that Executive Committee member shall not participate in the discussion or voting on the matter and shall leave the meeting during that time, although questions concerning the matter may be asked and answered before leaving.

2. **Medical Staff Approval** - All actions taken between meetings of the Medical Staff by either the officers of the Medical Staff or the Executive Committee which either establish, revise, rescind or implement Medical Staff policy is subject to the review and approval of the Medical Staff. All such actions shall be reported in writing to the membership of the Medical Staff at least seven (7) days prior to the next regularly scheduled meeting of the Medical Staff unless it is sooner considered at a duly scheduled special meeting. The membership of the Medical Staff has the authority to either revise or rescind any action taken by an officer of the Medical Staff or the Executive Committee.

**Part 7 - G.I. Endoscopy Committee** (Added 2/94)

a. **Composition** - The Committee shall be composed of at least five (5) members of the Medical Staff to include representatives of the following departments utilizing the G.I. Laboratory: medicine, surgery, and radiology. The following shall also participate in the committee's activities: nursing director of the peri-operative division and nurse manager of the G.I. Laboratory.
b. **Duties** - The duties of the G.I. Endoscopy Committee shall be to: 1) address quality issues including complications that occur in the G.I. Lab and quality issues with equipment; 2) develop and recommend criteria for credentialing; 3) review problems as they arise; 4) address work relation issues; 5) to plan for growth and development of the G.I. Lab (Master Facility Plan); 6) improve intra-departmental services/relationships; 7) determine capital budget needs; 8) address scheduling problems; and 9) review new procedures and develop protocols. The Committee will report to the Quality Improvement Committee of the Medical Staff.

c. **Meetings, Records and Reports** - The G.I. Endoscopy Committee shall meet at least ten (10) times per year.

**Part 8 - Infection Control Committee**

a. **Composition** - The Infection Control Committee shall consist of a Medical Staff member from the Departments of Family Medicine (rev. 11/06), Medicine, Obstetrics/Gynecology, Pathology, Pediatrics and Surgery. The following Hospital representatives shall participate in the Committee’s activities: the administration, the nursing service, the microbiology section of the laboratory, the Infection Control Nurse, Engineering, Pharmacy, Environmental Services, Dietary, Sterile Supply and the Chief Resident. Qualified allied professional staff may be appointed to the Committee. A Medical Staff member shall serve as chairman.

b. **Duties** - The Infection Control Committee shall be responsible for the surveillance of inadvertent infection potentials, the review and analysis of actual infections, the promotion of preventive and corrective programs designed to minimize infection hazards, and the general supervision of the Hospital’s infection control program.

The Committee shall participate in:

1. determining the type of surveillance and reporting systems to be used;

2. developing standard criteria for reporting all types of infections, including respiratory, gastrointestinal, surgical wound, skin, urinary tract, septicemias and those related to the use of intravascular catheters;

3. the periodic review of infections within the Hospital with a determination as to whether an infection is nosocomial;

4. the origin, supervision, review and action relative to the review of required cultures of personnel or of the environment, except as otherwise required by local, state or federal authorities;

5. the review and evaluation of all aseptic, isolation and sanitation techniques employed in the Hospital;

6. the monitoring of the use of antibiotics and in joint studies of antibiotic usage with the Pharmacy and Therapeutics Committee;
7. the development of policies which define the specific indications for isolation requirements relative to the medical condition involved;

8. corrective action plans to control reported infections and infection potentials among patients and Hospital personnel;

9. the offering of educational programs in infection control for all Hospital personnel; and

10. the review of other situations as requested by the Executive Committee, other Medical Staff or Hospital Committees, and the Hospital's administration.

The Chairman of the Committee shall have the authority to institute control measures or studies when it is reasonably believed that there may be danger to patients or personnel.

A subcommittee of the Infection Control Committee shall be responsible for infection control matters specific to each satellite campus of St. Luke’s Hospital. The composition of the subcommittee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Infection Control Committee. (added 4/00)

c. Meetings, Records and Reports - The Infection Control Committee shall meet a minimum of six (6) times per year, shall maintain permanent records of its findings, proceedings and actions, and shall make a report to the Executive Committee following each meeting, such reports to then be forwarded to the Medical Staff, the Vice President, Nursing and the CEO. (Revised 4/95)

Part 9 - Library Committee

a. Composition - The Library Committee shall consist of at least three (3) members of the Medical Staff.

b. Duties - The Library Committee shall make recommendations on the operation of the Medical Library and shall recommend purchase or deletion of periodicals, books, textbooks and other educational materials, such as audio-visual aids and attend to all functions necessary for the operation of the Medical Library.

c. Meetings, Records and Reports - The Committee shall meet as often as necessary to discharge its duties.

Part 10 - Allied Professional Staff Committee (Revised 10/96)

An Allied Professional Staff Committee shall be organized by the Executive Committee and approved by the Medical Staff when it is necessary to comply with statutes and regulations of the Commonwealth.
Part 11 - Graduate Medical Education Committee (Revised 10/96)

a. Composition - The Graduate Medical Education Committee (Revised 10/96) shall be composed of at least eight (8) members of the Medical Staff who have an interest in medical education and who hold positions in teaching programs or positions that contribute to educational programs. A representative of the Hospital's administration and a representative of the Board of Trustees shall also be appointed to the Committee.

b. Duties - The Medical Education Committee shall:

1. serve as a forum for the exchange of information about the teaching programs with those who are heading teaching programs and for those who contribute to the teaching programs;

2. act as an educational planning unit responsible for recommending action to enhance the Hospital's teaching programs including the consideration of issues such as outside affiliations and the funding of educational programs;

3. promote the posture of Saint Luke's Hospital as a teaching institution; and

4. assist in complying with the requirements of the Accreditation Council for Graduate Medical Education.

c. Meetings, Records and Reports - The Committee shall meet at least twice annually.

A subcommittee of the Graduate Medical Education Committee shall be responsible for graduate medical education matters specific to each satellite campus of St. Luke’s Hospital. The composition of the sub-committee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Graduate Medical Education Committee. (added 4/00)

Part 12 - Medical Care Evaluation Committee (Added 4/10)

a. Composition - This is a committee of the Medical Staff and shall consist of three or more practitioners (MD or DO) who will carry out the functions of utilization management as delineated in the Network UR Plan and as outlined below. The committee may designate as member(s) an outside professional group approved for this purpose by CMS.

b. Duties - 1) To ensure appropriate utilization of resources related to provision of care for patients; 2) To assist in the promotion of quality care through the analysis and review of clinical practices throughout the hospital; 3) To serve as a resource to clinical departments, administration and medical staff by making recommendations and sharing information based on
utilization data; and 4) To address problems of over-and underutilization and inefficient scheduling.

c. **Meetings and Reports:** The committee shall meet at least four (4) times per year and shall report to the Medical Executive Committee

**Part 13 - Medical Records Committee**

a. **Composition** - The Medical Records Committee shall be composed of at least three (3) Medical Staff members. Ex officio members without vote shall include representatives of the Medical Records Department and the Nursing Service.

b. **Duties** - The Medical Record Committee will perform the medical record review function in cooperation with the Nursing Service, the Medical Record Department, the administration and other departments and services as appropriate. This responsibility will include an evaluation of medical records to determine that such records:

1. properly describe the diagnosis, condition and progress of the patient, the tests and therapy provided, the results thereof, the identification of responsibility for all such actions taken, and the condition of the patient at discharge;

2. are clinically pertinent and sufficiently complete at all times so that they may facilitate continuity of care and communications among all those providing patient care services in the Hospital;

3. meet standards of patient care usefulness and historical validity;

4. are adequate in form and content to permit patient care audit and other quality assurance activities to be performed;

5. assure that safe transfer of physician responsibility will take place if necessary; and

6. are adequate as medico-legal documents. The Committee shall also review Medical Staff and Hospital policies, rules and regulations relating to medical records completion, forms, formats, filing, indexing, the use of microfilming, if appropriate, storage and availability, and recommend methods of enforcement thereof and changes therein.

It shall also be the duty of the Committee to report to the appropriate department chairman the names of any Medical Staff members who are persistently or frequently delinquent in the completion of their records.

c. **Meetings, Records and Reports** - The Medical Record Committee shall meet a minimum of four (4) times per year. (Revised 4/10)
Part 14 - Medical Staff Finance Committee (Added 8/03)

a. **Composition** - The Committee shall be composed of the current president of the medical staff, the president elect of the medical staff, the immediate past president of the medical staff, the medical staff treasurer and at least two members of the active medical staff.

b. **Duties** – The Committee is responsible to evaluating and advising the Medical Executive Committee concerning requests for medical staff funds and overseeing the disbursement of the funds after approval by the Medical Executive Committee and the Medical Staff.

c. **Meetings, Records and Reports** – The Committee shall meet as often as necessary to accomplish its purpose and reports directly to the Medical Executive Committee.

Part 15 - Medical Staff Health Committee (Revised 8/92)

a. **Composition** - The Committee shall be composed of five (5) Medical Staff members who shall select their own chairman. Members are appointed annually with no limit on the number of terms.

b. **Duties** - The Committee shall be responsible for the operation of the Medical Staff Health Program according to the protocol approved by the Medical Staff.

c. **Meetings, Records and Reports** - Meetings of the Committee and Intervention Teams shall be held as often as necessary to discharge the Committee's responsibilities. Records and reports of Committee activities shall be held in confidence.

Part 16 - Nominating Committee

Part 16 - Nominating Committee

a. **Composition** - The Nominating Committee shall be composed of the immediate past president, the current president and the president elect of the Medical Staff and at least an equal number of members of the active medical staff. The Nominating Committee will present a slate of nominees for the three active staff positions on the Nominating Committee at the Annual Medical Staff meeting with the physicians elected to serve on the Nominating Committee the following year. The Past President shall serve as Chairman. (Revised 12/92) Members of the Nominating Committee elected by the medical staff will be limited to two one-year terms. (added 4/99)

b. **Duties** - The Nominating Committee publish, at least twenty (20) days preceding the Annual Meeting, a slate of one (1) or more nominees for each of the vacant offices of the Medical Staff, vacant at-large positions on the Executive Committee and the Medical Staff's representatives to the PMS and AMA Medical Staff sections. The Committee shall also nominate a member(s) to be elected by a majority vote of the Medical Staff to fill any Hospital Board position previously held by a member of the Medical Staff. The Committee may also adopt procedures as needed, but not inconsistent with these Bylaws, to govern Medical Staff elections.

c. **Meetings, Records and Reports** - The Nominating Committee shall meet as often as
necessary to accomplish its purpose and shall make its reports to the Medical Staff.

**Part 17 - Nutrition Committee**

a. **Composition** - The Nutrition Committee shall be composed of at least five (5) members of the Medical Staff. Hospital personnel who have job responsibilities related to the Committee's duties may be invited to attend meetings.

b. **Duties** - The Nutrition Committee is responsible for providing advice, recommendations and/or guidance to the medial staff and all clinical services regarding the nutrition care of patients (Rev. 1/06). This shall include both enteral and parenteral nutrition support.

Periodically review and approve the Clinical Standards of Care, Diet (Nutrition Care) Manual, Performance Improvement, and all pertinent protocols regarding the provision of nutritional care of patients at St. Luke’s Hospital and Health Network (Added 1/06).

Annually review the enteral formulary (Added 1/06).

Review and advise on the educational activities of staff delivering nutrition care to patients, and on the status of patient and public teaching materials prior to review by the Patient Education Committee (Added 1/06).

c. **Meetings, Records and Reports** - The Committee shall meet at least twice annually.

**Part 18 - Operating Room Committee**

a. **Composition** - The Operating Room Committee shall be composed of at least four (4) members of the Medical Staff including representatives of the Departments of Surgery, Ob-Gyn, and Anesthesiology. The Hospital's Nurse Manager of the Surgical Suite and the Nurse Manager of the PAC/Ambulatory Surgery Unit shall attend committee meetings. The Committee membership shall be rotated.

b. **Duties** - The duties of the Operating Room Committee shall be to: (1) renew and recommend policies and procedures concerning the overall functioning of the Surgical Suites (main operating) and the system by which practitioners may schedule surgical procedures; (2) make recommendations, after approval by the appropriate department, to the Hospital concerning staffing requirements for the Surgical Suite; and (3) correlate the activities of the Surgical Suite and other supportive services and, when necessary, make recommendations to the Hospital's administration or the Executive Committee concerning recommended changes beyond the authority of the Committee.

c. **Meetings, Records and Reports** – The Operating Room Committee shall meet quarterly or more often as necessary to fulfill its responsibilities.
Part 18A - Laser Sub-Committee

a. **Composition** - The Laser Sub-Committee shall be composed of up to 10 members of the Medical Staff to include the Chairman of the Department of Surgery, an anesthesiologist and up to (8) physician users in various surgical disciplines. The following shall also be represented on the Committee: the Hospital's Safety Officer, a nursing supervisor, three (3) nurse specialists, a representative of biomedical engineering, and a representative of the administration. (Revised 2/92)

b. **Duties** - It is the responsibility of the Laser Sub-Committee to:
   1. evaluate the purchase of appropriate laser equipment and oversee the Hospital's Laser Program;
   2. establish, maintain and update: the Laser Protocol and Procedures Manual, a credentialing process for physician users and nurse specialists, appropriate safety measures and anesthesia guidelines; and
   3. promote education and training for those involved in the use of lasers.

c. **Meetings, Records and Reports** - The Committee shall meet at least two times annually. The Committee shall report to the Operating Room Committee and in cases involving clinical privileges in the Laser Program, the Committee shall also report to the Credentials Committee.

Part 19 - Patient Education Advisory Committee

a. **Composition** - The Committee shall be composed of at least eight (8) members of the Medical Staff. Representatives of Hospital departments or services who have expertise and responsibilities in the area of patient and public education will be requested to participate in the Committee's activities.

b. **Duties** - The Committee is responsible for monitoring and coordinating the comprehensive delivery of patient education services as an integral part of effective patient care. The Committee will evaluate program accountability, quality assessment, effective utilization of resources and potential generation of revenue through patient education services. The Committee will also strategically plan for the implementation of new patient and public education programs.

The Committee shall review and comment on all activities and programs of the Hospital and affiliated organizations when such activities and programs are intended, either directly or indirectly, to promote the public's understanding and favorable image of the Hospital and its affiliated organizations.

c. **Meetings, Records and Reports** - The Committee shall meet a minimum of six (6) times per year. (Revised 4/95)
Part 20 - Pharmacy and Therapeutics Committee

a. **Composition** - The Pharmacy and Therapeutics Committee shall consist of at least five (5) members of the Medical Staff. The director of the Hospital's Pharmacy shall serve as a member and Secretary of the Committee. Other Hospital personnel shall be involved in Committee activities as necessary and required.

b. **Duties** - The duties of the Pharmacy and Therapeutics Committee shall be to examine and survey all drug utilization policies and practices within the Hospital, including ambulatory services, in order to assure optimum clinical results and a minimum potential for hazard and to assure that quality is not compromised due to economic considerations. The Committee shall assist the Hospital's pharmacist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs, chemicals, biologicals and pharmaceutical preparations used in the Hospital. Such products shall meet the standards of quality of the U.S. Pharmacopeia, National Formulary, New and Non-official Drugs, Accepted Dental Remedies and other accepted national standards. It shall also perform the following specific functions:

1. serve as an advisory group to the Medical Staff and the Hospital's pharmacist in all matters pertaining to the use of available drugs;

2. review the appropriateness of empiric, prophylactic and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;

3. develop and review periodically a formulary for use in the Hospital, the selection of items to be included in the formulary to be based on their therapeutic merits, safety and cost;

4. prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

5. evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

6. establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs in conjunction with the Institutional Review Board;

7. review all cases of suspected and significant untoward drug reactions;

8. review antibiotic usage in the Hospital as a joint effort with the Infection Control Committee as to the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of antibiotics:

   --for all types of antibiotics used in the Hospital; and

   --for all areas of patient care services.
a. screening mechanisms may be used to identify problems in the use of a specific antibiotic, or category of antibiotics, for more intensive evaluation.

b. clinically valid criteria are used in the screening process and in the more intensive evaluation of known or suspected problems in antibiotic usage.

c. written reports of conclusions, recommendations, actions taken, and the results of actions taken are maintained and reported at least quarterly, and the Infection Control Committee is informed or consulted as appropriate.

9. make recommendations concerning drugs for which automatic stop orders are necessary; and

10. assist in the planning of suitable educational programs for the Hospital's professional staff relative to appropriate drug use.

c. Meetings, Records and Reports - The Pharmacy and Therapeutics Committee shall meet at least 10 times per year.

A subcommittee of the Pharmacy and Therapeutics Committee shall be responsible for pharmacy and therapeutic matters specific to each satellite campus of St. Luke’s Hospital. The composition of the sub-committee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Pharmacy and Therapeutics Committee.

(part 2)

Part 21 - Quality Improvement Committee (Revised 6/06)

a. Composition - The Quality Improvement Committee shall be composed of: the chairman or a designee of each Medical Staff department and the Quality Improvement Team chairman of each department, the hospital’s Chief Operating Officer (added 6/06), two residents appointed by the SLH Resident Organization (added 6/06), and the Vice President for Medical and Academic Affairs. The President of the Medical Staff will appoint two at-large members to the Committee – one from the medical service line and one from the surgical service line (Added 6/06). Other Medical Staff representatives and members of the hospital's administrative staff may be invited to participate in Committee activities as determined to be necessary by the Committee. The chairman of the committee shall be the Vice President for Medical and Academic Affairs.

b. Duties – The Medical Staff's Quality Improvement Committee (Rev. 6/06) will include the following functions: (1) monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with clinical privileges or duties; (2) monitor the monthly quality review activities of Medical Staff departments; (3) coordinate all Medical Staff quality review activities. (Rev. 6/06)

c. Meetings, Records and Reports - The Quality Improvement Committee shall meet a minimum of (added 6/06) four times per year. (revised 11/99) The Vice President for Medical and
Academic Affairs, as the Committee's chairman, shall report Quality Improvement activities and actions of the Medical Staff Quality Improvement Committee to both the Medical Staff's Executive Committee and the Quality and Education Committee of the Board of Trustees. (Rev. 6/06)

Each campus may have a representative on the Medical Staff QI Committee to present quality issues and request reviews from the other campuses.

d. Report Sequence (Added 1/97)

1. Each department with subsections may establish a Sectional Quality Assurance/Quality Improvement Committee. The chief of the department will appoint the chairman of the sectional QA/QI Committee, subject to approval by the section. (Outside consultants were already dealt with under Departments, Part 2, Medical Care Evaluation, Part 29, of the By-Laws and do not need to be repeated here.)

2. The Sectional QA/QI Committee will report its recommendations and evaluations to the Departmental QA/QI Committee whose chairman will also be appointed by the department chief, subject to approval by the department.

3. The Departmental QA/QI Committee will report its evaluations and recommendations to the Medical Staff QA/QI Committee.

4. Medical Staff QA/QI Committee, listed as in total for Part 22 of the By-Laws.

5. The Medical Staff QI Committee reports its evaluations and findings to the: 1) Medical Staff Executive Committee; 2) Quality and Medical Education Committee (Rev. 6/06) which in turn reports to the Board of Trustees, as does the Executive Committee.

e. Protocol for the Trauma Performance Improvement Process (Added 6/68)
TRAUMA PERFORMANCE IMPROVEMENT

Identified Patient Care Problems

Referred to:

Further Review Required?

Close Case

Further Review Required?

Identified Systems

Trauma Committee

“TrIM” Conference

Refer directly to Hosp. Dept. Head, Chief of Service or Dept. Chair

Decision rendered by TD after review of response

Further Action Required

Y

N

Re-Evaluation

Prospective, Focused Review

Trend Data

Report all findings through Medical Staff QI and/or Quality Council

Board of Director

Action: Counseling +/- or Educ. Session +/- or New Policy +/- or Policy Revision as per TD

Decision rendered by

Further Action Required?

Refer to Trauma Surgeon Staff Meeting

Decision rendered by

Refer to Trauma Steering Committee

Legend:
TD=Trauma Director
TS=Trauma Surgeon
TC=Trauma Coordinator
AF=Audit Filters
Comp=Complications
TrIM=Trauma Interdepartmental Mortality & Morbidity Conference
f. Intense Analysis will be performed for Sentinel Events as defined by The Joint Commission (Rev. 6/08) criteria as well as other adverse clinical events which have directly impacted or have had the potential to impact patient safety and quality. Intense analysis is performed to identify root causes of an event and to develop actions for performance improvement.

Intense Analysis reports will be made to the Medical Staff QI Committee, the Network Performance Improvement Council and to the Quality and Medical Education Committee of the Board of Trustees as appropriate to assure that performance improvements are appropriate and completed as planned.

g. Integrated Clinical Care Peer Review – In performing peer review the Medical Staff Quality Improvement Committee can exchange information with all clinical departments which could include Nursing, Respiratory, Physician Extenders, Pharmacy, and others.

h. Measurements of Key Clinical Outcomes – Measurements of mortality, CMS Demonstration Project, Unexpected Complications, and other Quality Demonstration projects will be reviewed by the Medical Staff QI Committee. The Department QI committees will be responsible for reviewing all cases of mortality. The committee will also review Failure to Rescue Cases.

i. Anyone, including a patient and family, resident, nurse, physician extender, or others, can request a case review. This request should be addressed to either the Vice President for Medical Affairs or the Senior Nurse Executive & Vice President with feedback returning to the referring person once a review has been completed.

**Part 22 - Radiation Safety and Isotope Committee**

a. **Composition** - The Radiation Safety and Isotope Committee shall be composed of at least three (3) members of the Medical Staff including physicians experienced in nuclear medicine, diagnostic and/or therapeutic radiology, hematology, pathology and general surgery as well as a person experienced in the assay of radio-isotopes and protection against ionizing radiations. Other members of the Committee shall include the Radiation Safety Officer, Chief Technician - Nuclear Medicine, VP - Administration and Chief Technician - Cardiology.

b. **Duties** - The Radiation Safety and Isotope Committee is responsible for planning, establishing and evaluating procedures related to the use of X-ray equipment and all radioactive isotopes throughout the Hospital and off site facilities. Plans and maintains radiation accident emergency procedures for its immediate catchment areas. The Committee also evaluates dosimetry reports on personnel relative to radiation exposure. (Revised 12/91)

c. **Meetings, Records and Reports** - The Radiation Safety and Isotope Committee will meet as often as necessary to discharge its responsibilities, but at least quarterly.
Part 23 – Transfusion Committee

a. **Composition** - The Transfusion Committee shall be composed of at least five (5) Medical Staff members representative of those specialties which are involved in the use of blood.

b. **Duties** - The Committee shall be responsible for:

1. reviewing blood transfusion for proper utilization, including the use of whole blood versus component blood elements;

2. evaluate and report on each actual or suspected transfusion reaction;

3. developing policies and procedures relative to the distribution, handling, use and administration of blood and blood components;

4. reviewing the adequacy of transfusion services in meeting patient needs; and

5. reviewing the amount of blood and blood products requested, the amount used and the amount of wastage.

c. **Meetings, Records and Reports** - The Transfusion Committee shall meet at least quarterly. A subcommittee of the Transfusion Committee shall be responsible for transfusion matters specific to each satellite campus of St. Luke’s Hospital. The composition of the subcommittee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Transfusion Committee. (added 4/00)

Part 24 - Cancer Committee (Rev. 5/13)

a. **Composition** - The Cancer Committee membership shall be multidisciplinary representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services. Coordinators who are responsible for specific areas of program activity are designated from the membership.

Required physician members include: Diagnostic Radiology, Pathology, Surgery, Medical Oncology, Radiation Oncology, Cancer Liaison Physician, and a physician member of the palliative care team. Invited colleagues include specialty physicians representing the major cancer experience seen at our health network.

Other required members include: Cancer Program Administrator, Oncology Nurse, Social Worker, Cancer Registrar (CTR), Performance Improvement, Clinical Research, Pharmacist, Registered Dietician, Hospice, Rehabilitation, and Genetics Counselor. Additional invited colleagues include Communication & Marketing, Community Education, and a representative from the American Cancer Society.
b. Duties – The Cancer Committee shall be responsible for:

1. monitoring and assessing all cancer program activities at St. Luke’s Health Network and identifying changes that are needed to effectively improve cancer-related activities

2. designating one coordinator for each of the six areas of cancer program activity: cancer conference, cancer registry quality, quality improvement, community outreach, clinical research, and psychosocial services.

3. developing and evaluating at least 1 clinical and 1 programmatic goal for the endeavors related to cancer care and evaluate each goal twice annually.

4. establishing, monitoring and evaluating the cancer conference frequency, format, multidisciplinary attendance, and case discussion requirements for cancer conferences on an annual basis

5. establishing and implementing a plan to evaluate the quality of cancer registry data and activity on an annual basis which includes monitoring case finding, accuracy of data, abstracting timeliness, follow-up and data reporting

6. performing a study to assess whether patients within the program are evaluated and treated according to evidence-based national treatment guidelines

7. ensuring that at least 1 cancer prevention program and 1 cancer screening program is providing to meet the needs of the community

8. ensuring that cancer pathology reports include the scientifically validated data elements outlined in the College of American Pathology (CAP) protocols

9. providing a formal mechanism to educate patients about cancer-related clinical trials

10. reviewing the percentage of cases accrued to cancer-related clinical trials each year

11. monitoring the effectiveness of community outreach activities on an annual basis through review of the community outreach activity summary

12. offering a cancer-related educational activity yearly that focuses on the use of American Joint Committee on Cancer (AJCC) staging in the clinical practice

13. developing and analyzing three (3) studies that measure quality of care and outcomes for patients with cancer

14. implementing two (2) improvements that directly affect patient care

15. establishing subcommittees or workgroups as needed to fulfill cancer program goals

16. making recommendations to the Chief Executive Officer concerning personnel, facilities, equipment and space relative to the Hospital’s cancer program

17. developing and maintaining the policies and procedures necessary to operate an effective hospital cancer program

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c. Meetings, Records and Reports – The Cancer Committee shall meet at least once each calendar quarter and maintain compliance with eligibility requirements and standards as outlined in the most current Commission on Cancer Program Standards.

Section 5 - Special Committees

Special committees may be created and dissolved by the President with the approval of the Executive Committee, such approval to include a written description of the Committee's composition and duties. The chairman and members of each special committee shall be appointed by the President, unless specifically stated otherwise by the Executive Committee. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee. The Executive Committee shall review special committees, at least on an annual basis, to determine the need for their continuation. Special committees include the following:

Part 1 - Institutional Review Board

a. Composition - The Institutional Review Board shall be composed of qualified Medical Staff members and others as required by Federal regulations and as deemed appropriate by the Executive Committee.

b. Duties - The Institutional Review Board shall be responsible for reviewing new proposals and modifications of research projects which involve patients in experimentation, new procedures, drug evaluation or other investigative studies, such evaluation to consider: the risks and benefits to patients; the knowledge to be gained; the rights of patients and the adequacy of informed consent; local community attitudes and ethical standards; and institutional policies, applicable law and standards of professional practice. The Institutional Review shall perform duties required by Federal regulations and shall function according to such regulations.

c. Meetings, Records and Reports - The Institutional Review Board shall meet as often as necessary to discharge its duties, maintain a permanent record of its proceedings, findings and actions, and report its activities to the Executive Committee and the Chief Executive Officer.

Part 2 - Institutional Ethics Committee (Moved to Special Cmte 1/20/06)

a. Composition - The Committee shall be composed of at least five (5) Medical Staff members, representatives of the Hospital's administration, nursing staff, social service, pastoral care and legal services as well as representatives of the community in general. An alternate shall be designated for each member, such alternate to attend meetings that the member is unable to attend. The membership of the Committee shall be recommended by the President of the Medical Staff and approved by the Executive Committee at its first meeting following the Annual Meeting of the Medical Staff.

Affected parties and others who can offer additional expertise may be invited to participate in Committee activities.

b. Duties - The Committee is established to address ethical issues associated with the care
of patients and shall:

1. serve as an educational resource for patients, families, physicians, other health care professionals and the community concerning ethical issues associated with the care of patients;

2. serve in a guidance/resource capacity for patients, families, physicians and other health care professionals involved in decisions concerning initiation, withholding or withdrawing treatment;

3. develop, recommend and review institutional policies regarding withholding or withdrawal of life sustaining measures;

4. communicate the Committee's duties and activities to Hospital personnel, physicians, other health care professionals and the community;

5. recommend policies and procedures to guide the Committee in the fulfillment of its responsibilities.

A subcommittee of the Institutional Ethics Consultation Committee shall be responsible for ethics matters specific to each satellite campus of St. Luke’s Hospital. The composition of the sub-committee shall be determined by the members of the medical staff for whom the primary hospital site is the satellite campus and be approved by the president of the medical staff. The subcommittee shall report its activities to the network Institutional Ethics Consultation Committee. (added 4/00)

c. **Meetings, Records and Reports** - The Committee shall meet at least quarterly and shall conduct its meetings in accordance with policies and procedures approved by the Medical Staff. Minutes of Committee meetings shall be submitted to the Executive Committee. All Committee records and minutes will be maintained in accordance with the Hospital's policy on confidentiality of patient and medical information.

**Part 3 - Perinatal Ethics Consultation Committee** (Description updated & moved to Special Cmte 12/09)

a. **Composition** - The Committee shall be composed of at least four (4) members of the Medical Staff to include representatives of the following specialties: Family Medicine (rev. 11/06), Neonatology, Ob/Gyn and Pediatrics. Other members shall include the following: maternal/child nurse, administrator, social worker, and pastoral care representative. An alternate of each may be permitted to attend and enter the process (added 12/09) at meetings in the absence of a member. Should such a position eventuate in the Network, a designated Ethicist shall be added to the Committee. (added 12/09) The term of office and staggered terms shall be determined according to guidelines developed by the Committee and approved by the Executive Committee.

A quorum of any meeting shall be determined as consisting of two physician members, or their alternates, and two of the non-physician members or their alternates. (Rev. 12/09)

b. **Duties** - The Committee shall (Rev. 12/09):
1. Serve as a concurrent, ad hoc interventional resource for the consideration of unresolved specific perinatal or neonatal clinical patient issues with ethical implications. The steps include:

a. Notification of the Chairperson of the Committee (the Section Chief of Maternal and Fetal Medicine, or his/her CoChairperson, the Section Chief of Neonatology, or their respective alternates. This physician shall formally consult on the patient issue.

b. After consultation, the Chairperson shall convene a quorum of the Committee, in person or by conference call, within 24 hours of the consultation.

c. The patient and her designee(s) shall be included in this concurrent discussion.

d. The ultimate purpose of the hearing, discussion and team decision making shall be to provide non-binding guidance to the patient and family, with ethical implications.

2. Serve as a routinely scheduled, educational resource for Physicians, Nursing, Ancillary personnel, and potentially parents and the community concerning ethical matters involving seriously ill gravidas, fetuses and neonates (Revised 6/96); This shall include:

a. At least once yearly, holding an organizational meeting to consider process, statistics, prior case reporting, and recommendations for educational experiences. Record shall be kept per recommendations made by the Committee.

b. At least once yearly, holding a meeting with the Department of Obstetrics and Gynecology, its Physicians, and Nursing Staffs, with Neonatal/Pediatric invitation. This shall have specific perinatal ethical subject matter.

3. Continually review and recommend institutional policies relevant to seriously ill gravidas, fetuses and neonates; and

4. Recommend procedures to make hospital personnel, physicians and patients or families informed of the existence and functions of the Perinatal Ethics Consultation Committee and the procedures for referral of cases to the Committee; and

5. Conduct prospective, concurrent and retrospective case review. As a resource for education and policy development, participation in such review is to be limited to health care provider members of the Committee (Revised 6/96).

Section 6 - Hospital Committees

Representatives of the Medical Staff shall be appointed to serve on Hospital committees which consider issues and recommend policy related to the general quality of patient care, use of resources, including personnel, for treatment and the facilities and equipment necessary for quality patient care.
The Executive Committee shall receive reports on the activities of all such Hospital committees.
ARTICLE X - APPOINTMENT TO THE MEDICAL STAFF

Section 1 - Requirements for Appointment

Part 1 - Eligibility, Qualifications, Basic Responsibilities and Conditions and Duration

All persons practicing medicine or dentistry in Saint Luke's Hospital, unless specifically exempted by these Bylaws, must first have been granted membership on the Medical Staff according to procedures and requirements set forth in Article V of these Bylaws.

Section 2 - Conditions of Initial Appointment

All initial appointments to the Medical Staff, except for Consulting, Affiliate and Honorary memberships, shall be to the Provisional Staff (Revised 7/97), and as such, all initial clinical privileges shall be provisional for a period of twelve (12) months from the date of the appointment. Provisional (Revised 7/97) status may be longer if approved by the Executive Committee, but not longer than an additional six (6) months. At the end of such period, the Provisional (Revised 7/97) Staff member must either be appointed to another Medical Staff category or have membership and privileges terminated. During the term of this provisional appointment, the Provisional (Revised 7/97) Staff member shall be evaluated by the chairman of the department or departments in which clinical privileges are held and by the relevant committees of the Medical Staff as to the practitioner's clinical competence and general behavior and conduct in the Hospital. Clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted. Appointment to the Active or Courtesy Staff after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article XI of these Bylaws.

Section 3 - Application for Initial Appointment and Clinical Privileges

Part 1 - Application Form

Applications for appointment to the Medical Staff shall be submitted on forms prescribed by the Board after consultation with the Executive Committee. The application forms shall be requested in writing to the Hospital's Chief Executive Officer or his designee. An application form shall be provided to the applicant within ten (10) days of the receipt of a written request. The application shall require detailed information concerning the applicant's professional qualifications and character including:

a. references from at least three (3) practitioners who have had extensive experience in observing and working with the applicant during the prior two (2) years and from the directors of all postgraduate training programs in which the applicant participated. All references must specifically relate to the applicant's present professional competence, ethical character and ability to relate to other practitioners in a satisfactory manner including clinical judgment, interpersonal skills, communication skills, and professionalism. (added 11/06).

b. information as to whether the applicant's medical staff appointment or clinical
privileges have ever been denied, revoked, suspended, reduced, not renewed or voluntarily withdrawn to avoid disciplinary action at any other hospital or health care facility;

c. a listing of all hospitals where the applicant has held appointment and/or privileges during the previous ten (10) years;

d. information as to whether membership in local, state, or national medical societies or his license to practice any profession in any state, or his federal license to prescribe and administer controlled substances has ever been suspended, modified, terminated or denied. The submitted application shall include a copy of all of the applicant's current licenses to practice, as well as his current federal narcotics licenses if issued, and a current passport size photo of the applicant;

e. evidence of a current license to practice in Pennsylvania and any pending investigation, sanction or restriction relative to his medical license in both Pennsylvania and in any other state;

f. information relative to board certification status with the appropriate national specialty board, if applicable;

g. information as to whether the applicant currently has professional liability insurance coverage in force, the name of the insurance company, the amount and classification of such coverage and coverage exclusions in the policy;

h. information from the practitioner's professional liability insurance carrier concerning the applicant's malpractice experience including a record of all claims, suits and settlements over the prior five (5) years;

i. a consent to release necessary information from applicant's present and past malpractice insurance carriers and a consent to release necessary information from other third parties and a full waiver and release of liability to the third parties providing the information;

j. a request for the specific clinical privileges and membership category desired by the applicant;

k. information on the applicant's physical or mental health;

l. information as to whether the applicant has ever been named as a defendant in a criminal action and the details of any such instance;

m. information on the citizenship and visa status of the applicant;

n. Information as to whether the applicant has ever been convicted of a felony; and

o. such other information as the Board or Executive Committee may require.
Applicants must have actively practiced in an accredited hospital at least eighteen (18) of the previous twenty-four (24) months including postgraduate training. Missionary service, military service or other service of similar experience may be considered to satisfy this requirement.

**Part 2 - Terms of Application**

Every application for appointment shall be signed by the applicant and shall contain the applicant's:

a. specific acknowledgment of the obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the applicant has responsibility;

b. agreement to abide by these and subsequent Bylaws and rules and regulations of the Medical Staff as shall be in force for the duration of membership on the Medical Staff;

c. agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the Medical Staff;

d. acknowledgment that the current Bylaws and rules and regulations of the Medical Staff have been received and read and agreement to be bound by the terms in all matters relating to consideration of the application whether or not appointment to the Medical Staff is granted;

e. agreement to appear for personal interviews in regard to the application;

f. agreement to abide by generally recognized principles of professional ethics; and

g. agreement to refrain from fee splitting or other inducements relating to patient referral;

h. agreement to not deceive a patient as to the identity of any other practitioner performing surgery, providing treatment or services;

i. agreement to only delegate the responsibility for the diagnosis and treatment of patients to qualified practitioners;

j. agreement to exhaust the administrative remedies offered by these Bylaws before taking legal action when an adverse ruling is made concerning appointment to the Medical Staff, medical staff status or clinical privileges; and

k. understanding that false, incorrect, or misleading information provided by applicant shall be grounds for rejection of the application or for termination of membership in the event that membership is granted prior to discovery of any misrepresentation.
Part 3 - Release and Immunity from Liability

The following are express conditions applicable to any applicant or member of the Medical Staff. These statements shall be included on the application form, and by applying for appointment to the Medical Staff and for clinical privileges the applicant or member expressly accepts these conditions during the processing and consideration of his application, whether or not appointment to the Medical Staff and clinical privileges is granted as well as for the duration of membership:

a. To the fullest extent permitted by law, the applicant or member extends immunity and release from liability to the Medical Staff, the Board, their authorized representatives and any third party providing information from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures involving the applicant or member, either performed, made or received in good faith, by the Medical Staff, the Board and their authorized representatives, specifically including but not limited to members of its Medical Staff by or from any third party concerning activities relating to but not limited to: (Revised 4/92)

1. applications for appointment or clinical privileges, including temporary privileges;

2. periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

3. proceedings for suspension of clinical privileges, revocation of medical staff membership or any other disciplinary sanction;

4. summary suspension;

5. hearings and appellate reviews;

6. medical care evaluation;

7. utilization reviews;

8. other hospital, department or committee activities conducted under hospital auspices relating to the quality of patient care or the professional conduct of a practitioner; and concerning matters relating to an applicant's or member's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on the individual's competence or the quality of patient care, or the orderly operation of this or any other hospital or health care facility, including otherwise privileged or confidential information.

b. Any act or communication with respect to any applicant or member made in good faith and at the request of an authorized representative of the Medical Staff or the Board or any other hospital or health care facility, for the purposes set forth in a, above, shall be privileged to the fullest extent permitted by law and shall extend to members of the Medical Staff, the Board and
their authorized representatives and to any third parties who supply information to any of the foregoing authorized to receive, release or act upon same.

c. The Medical Staff, the Board and their designated representatives are specifically authorized to: (1) consult with the management and members of the medical staffs of other hospitals, health care facilities or institutions with which the applicant or member has been associated, and with others who may have information bearing on his competence, character and ethical qualifications; and (2) inspect all records and documents that may be material to an evaluation of either the applicant's or member's professional qualifications, clinical competence and moral and ethical character.

d. The applicant or member specifically releases from any liability, the Medical Staff, the Board and their designated representatives, and persons who provide information, for statements made or acts performed in good faith in evaluating the applicant or the member for any of the purposes or reasons set forth in these Bylaws.

e. The applicant or member specifically authorizes the Medical Staff, the Board and their designated representatives to release requested information to other hospitals and health care facilities for the purpose of evaluating the practitioner's professional qualifications, clinical competence and moral and ethical character.

Part 4 - Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. The absence of requested information shall constitute an incomplete application which shall not be processed until such time as the applicant fulfills his responsibility to provide the requested information or cause it to be provided. He shall have the burden and shall bear the expense of providing evidence that all the statements made and information given on the application are factual and true.

Section 4 - Basis for Determining Clinical Privileges

Each practitioner appointed to the Medical Staff shall be entitled to exercise only those clinical privileges granted by the Board. The clinical privileges recommended to the Board shall be based upon the requirements set forth in Article V of these Bylaws along with other relevant information, including an appraisal of the applicant's or member's qualifications by the department in which such privileges are sought.

Section 5 - Procedure for Initial Appointment

Part 1 - Processing of Application

a. The completed application form for appointment to the Medical Staff shall be submitted by the applicant to the Hospital's Chief Executive Officer or his designee along with payment of
such processing fees as may be established by the Board. The date of receipt of the application in the office of the Chief Executive Officer shall be recorded. After collecting references and other information and documents deemed pertinent or required by these Bylaws, the Chief Executive Officer or his designee shall immediately transmit the application and all supporting materials to the Credentials Committee for evaluation. If the application and the collection of required supporting material is not completed within sixty (60) days of the receipt of a completed application form, the applicant shall be notified of the reason for the delay by the Chief Executive Officer with a copy of such notification to the Chairman of the Executive Committee.

b. Upon receipt of the completed application for appointment to the Medical Staff, the Credentials Committee shall:

1. inform the chairman of each department in which the applicant seeks clinical privileges of the pending application;

2. notify Medical Staff members of the application by either announcing it at a Medical Staff meeting and/or by posting the name of the applicant in the Medical Staff Lounge so that each member of the Medical Staff may have an opportunity to either submit to the committee, in writing, information bearing on the applicant's qualifications for appointment or to appear in person before the Credentials Committee to discuss in confidence any concerns the member may have about the applicant.

c. The chairman of each department in which the applicant seeks clinical privileges shall be provided the application and requested to provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the Credentials Committees report.

d. The Credentials Committee shall examine each application form, supporting information requested and any other pertinent information available to determine whether the applicant: (1) is eligible for membership; (2) meets all of the qualifications for membership and the clinical privileges requested; and (3) is capable of fulfilling the basic responsibilities of Medical Staff membership as set forth in Article V.

e. As part of this process, either the Credentials Committee or the Executive Committee may at any time require an impartial physical or mental examination of the applicant and shall require that the results be made available for consideration.

f. The Credentials Committee and/or the appropriate department chairman shall have the right to require the applicant to meet with the Committee or the chairman to discuss any aspect of his application, his qualifications and his requested clinical privileges.

Part 2 - Credentials Committee Reports

The following procedures apply to the processing of the report of the Credentials
Committee:

a. Not later than sixty (60) days from receipt of the completed application from the Chief Executive Officer, the Credentials Committee shall make a written report with recommendations.

b. If the recommendation of the Credentials Committee is delayed longer than sixty (60) days following receipt of the completed application and supporting material, the Chairman of the Executive Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer explaining the delay. In such case, the Credentials Committee shall follow with another report to the Executive Committee within thirty (30) days either recommending appointment or rejection of the applicant or providing an explanation for any further delay.

c. When the deliberations of the Credentials Committee are concluded, a report shall be submitted to the Executive Committee with all supporting information and specific recommendations.

Part 3 - Executive Committee Action on the Application

a. Consideration - The Executive Committee shall act on an application within sixty (60) days of receipt of the Credentials Committee report or notify the applicant and the Chief Executive Officer of the reason for the delay.

b. Favorable Recommendation - When the recommendation of the Executive Committee is favorable to the applicant, the Chairman of the Executive Committee shall promptly forward the application, together with all supporting documentation, to the Medical Administration and Medical Education Committee of the Board which shall submit its report to the Board within sixty (60) days of receipt of the Executive Committee report. All recommendations to appoint must also recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.

c. Defer Action - When the recommendation of the Executive Committee is to defer the application for further consideration it must be followed up within thirty (30) days by a subsequent recommendation for appointment, for rejection of the application or provide an explanation for any further delay.

d. When the Executive Committee has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Executive Committee shall either:

1. remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee, prior to the Executive Committee's final recommendation; or

2. set forth in its report and recommendation to the Board the specific reasons for the Executive Committee's disagreement with the Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or Credentials Committee's reports.
e. **Adverse Recommendation** - When the recommendation of the Executive Committee is adverse to the applicant in respect to either appointment to the Medical Staff or clinical privileges requested, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant by certified mail, return receipt requested, such notice to inform the applicant of his rights under Article XII of these Bylaws. The Chief Executive Officer shall then hold the application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Article XII. At the time the applicant has been deemed to have waived his right to a hearing, the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting documentation to the Quality Medical Education Committee (rev. 1/09) of the Board which, in turn, shall report its recommendation to the Board. Otherwise, the hearing and appeal procedures set forth in Article XII shall be followed.

f. **Contrary Board Action** - In the event the Board's action is contrary to the Executive Committee's recommendation, the Board shall not finalize its action without conference with the Executive Committee.

g. **Department Assignment** - The Executive Committee shall recommend initial department assignments for all applicants for Medical Staff membership and for all allied professional staff granted clinical privileges.

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**Part 4 - Privilege Notification (Added 1/09)**

The process to disseminate all granting, modification or restriction decisions relative to privileges for medical staff and allied professional staff members is as follows:

a. to all hospital staff by e-mail broadcast of all new medical staff and allied professional staff appointed to the staff.

b. through the hospital intranet for privileges granted to all medical staff and allied professional staff members, and,

c. a listing of all new medical staff and allied professional staff members in the *Medical Staff Newsletter*.

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**Section 6 - Procedure for Temporary Clinical Privileges**

**Part 1 - Temporary Privileges for Applicants**

Upon receipt of an application for Medical Staff appointment from an appropriately licensed practitioner, the Chief Executive Officer may, upon the basis of information then available which may reasonably be relied upon as to the competence, character and ethical standing of the applicant, and after receiving a written concurrence from the President, the chairman of the appropriate department, and the chairman of the Credentials Committee, grant temporary admitting and clinical privileges to the applicant for a period not to exceed thirty (30) days. Such privileges may be extended for up to an additional one hundred twenty (120) days (Rev. 11/06) according to the procedures of this Part but not to exceed the time needed to reach final decision on the application by the Board. In exercising such privileges, the applicant shall act under the supervision of the chairman or his designee of the department in which primary privileges were requested.
The following items must be verified prior to the issuance of temporary privileges: current license, relevant training or experience, current competence, ability to perform the privileges requested, other criteria required by the organized medical staff by-laws, a query and evaluation of the NPDB information, a complete application, no current or previously successful challenge to licensure or registration, and no subjection to involuntary limitation, reduction, denial or loss of clinical privileges (added 11/06).

**Part 2 - Temporary Privileges for Non-Applicants**

Temporary admitting and clinical privileges for care of a specific patient or patients may be granted by the Chief Executive Officer with the concurrence of the President, the chairman of the appropriate department, and the chairman of the Credentials Committee to a practitioner who is not an applicant for appointment, in the same manner and upon the same condition as set forth in Part 1 of this Section, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment agreeing to be bound by the policies of the Hospital, these Bylaws, and the rules and regulations of the Medical Staff then in force in all matters relating to temporary clinical privileges. Such privileges shall be restricted to the specific patients during a specific admission for which they are granted.

**Part 3 - Special Requirements**

Special requirements of supervision and reporting may be imposed by the chairman of the department concerned on any individual granted temporary clinical privileges.

**Part 4 - Locum Tenens**

The Chief Executive Officer may grant a practitioner serving as a locum tenens for a member of the Medical Staff temporary admitting and clinical privileges to attend patients of that member for a period not to exceed thirty (30) days without applying for appointment to the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in Part 1 of this Section, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment of having received and read copies of the policies of the Hospital, these Bylaws and the rules and regulations of the Medical Staff then in force and agreement to be bound by the terms thereof in all matters relating to the temporary clinical privileges.

**Part 5 - Termination of Temporary Clinical Privileges**

a. **Termination** - The Chief Executive Officer or a designee, may at any time, with the concurrence of the President terminate an individual's temporary clinical privileges for failure to comply with any special conditions imposed or for a breach of these Bylaws or Medical Staff rules and regulations. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed and such termination shall be immediately effective.
b. **Reassignment of Patients** - The appropriate department chairman or, in the absence of the chairman, the President, shall assign to a member of the Medical Staff responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

c. **Limitations of Temporary Privileges** - The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Neither the granting, denial or termination of such temporary privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

d. **Immediate Termination of Temporary Privileges** - Temporary privileges shall be terminated immediately if the Executive Committee recommends unfavorably in respect to the applicant's appointment to the Medical Staff or if the Executive Committee's recommendation shall be to grant permanent privileges which differ from the temporary privileges previously granted.

**Section 7 - Emergency Clinical Privileges**

**Part 1 - Emergency Privileges for Non-members**

In an emergency involving a particular patient, a practitioner who is not currently a member of the Medical Staff may be permitted by the Hospital if there are no qualified members of the Medical Staff immediately available to exercise clinical privileges to act in such emergency, within the scope of his license, using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.

**Part 2 - Emergency Privileges for Members**

In the case of emergency, a member of the Medical Staff is permitted by the Hospital if there are no qualified members of the Medical Staff immediately available to exercise clinical privileges not specifically assigned to him, but within the scope of his license, so that he may act in such emergency.

**Part 3 - Termination of Emergency Privileges**

When the emergency situation no longer exists, such practitioner must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the patient shall be assigned to a qualified member of the Medical Staff by the appropriate department chairman or the President, giving consideration wherever possible to the wishes of the patient.

**Part 4 - Definition of "Emergency"**

For the purposes of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.
Part 5 - Reports

Physicians who treat patients under the provisions of either Parts 1 or 2 above must report the occurrence to the Vice President for Medical Affairs.

Part 6 – Disaster Credentialing Policy (Rev. 4/13)

When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners (“volunteers”). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

a. Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

1. A volunteer’s identity must be verified through a valid government-issued photo identification (i.e., driver’s license or passport).

2. A volunteer’s license may be verified in any of the following ways: (a) current Hospital picture ID card that clearly identifies the individual’s professional designation; (b) current license to practice; (c) primary source verification of the license; (d) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; (e) verification by a current Hospital employee or medical staff member who possesses personal knowledge regarding the individual’s ability to act as a volunteer during a disaster.

b. Primary source verification of a volunteer’s license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

c. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (1) the reason primary source verification could not be performed in the required time frame; (2) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (3) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

d. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.
Section 8 - Procedure for Reappointment

Part 1 - Completion of Reappointment Form

a. Any member of the Medical Staff who, at the designated time of processing the reappointment to the Medical Staff, wishes to be considered for a change in the Medical Staff category or in clinical privileges, or who does not desire reappointment, shall so indicate on the appropriate form submitted to the Executive Committee. All members of the Medical Staff, who do not indicate otherwise, shall be considered for reappointment to the same category of the Medical Staff with the same clinical privileges they then hold unless the Executive Committee acts otherwise, after considering the recommendation of the Credentials Committee. Reappointment to the Medical Staff shall be for a period of not more than two (2) years.

Any practitioner who desires a change in clinical privileges or Medical Staff status during the term of appointment shall follow the reappointment procedures set forth in this Section.

b. Each member who wishes to be reappointed shall be responsible for reviewing the initial application form, copy to be provided by the Hospital upon request and stating on the reappointment form any material changes in the information given there. The submission of false or misleading information will be grounds for terminating a member's membership and clinical privileges according to procedures set forth in Articles XI and XII. The Medical Staff reappointment form shall be developed by the Executive Committee in consultation with the Credentials Committee and approved by the Board.

Part 2 - Factors to be Considered

Each recommendation concerning reappointment of a member of the Medical Staff or a change in Medical Staff category, where applicable, shall be based upon, but not necessarily limited to, any or all of the following factors:

a. professional ethics, demonstrated competence and clinical judgment in the treatment of patients and relevant recent training and such other specific data concerning the member's ethics, character and qualifications as may relate to his ability to provide good patient care;

b. the following six areas of General Competencies will be considered at the time of initial appointment and reappointment: patient care – practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life; medical/clinical knowledge – practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others; practice-based learning and improvement – practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices; interpersonal and communication skills – practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams; professionalism – practitioners are expected to demonstrate behaviors that reflect a commitment to continuous...
professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society; and systems-based practice – practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care (added 11/06).

c. attendance at Medical Staff, department and committee meetings and cooperative participation in Medical Staff affairs;

d. compliance with these Bylaws and related rules and regulations;

e. behavior and cooperation with Hospital personnel, fellow practitioners and others, use of the Hospital's facilities for patients, and general attitude toward patients, the Hospital and the public;

f. physical or mental capacity to effectively treat patients;

g. satisfactory completion of such continuing education requirements as may be imposed by law, applicable accreditation agencies or the rules and regulations of the Medical Staff;

h. professional liability insurance coverage, claims, suits or settlements;

i. review of records of patients treated in this or others hospitals;

j. sanctions of any kind imposed or pending by any other health care institution or organization or licensing or regulatory agency or any request by same to withdraw an application or to voluntarily resign; and

k. demonstrated compliance with the responsibilities of Medical Staff membership set forth in Section 4 of Article V of these Bylaws.

Part 3 - Department Procedures

a. At least sixty (60) days prior to the expiration of a practitioners reappointment, the Medical Staff Office (Rev. 12/09) shall provide each Medical Staff/Allied Professional Staff (Added 12/09) member with a reappointment form for Medical Staff/Allied Professional Staff (Added 12/09) membership and clinical privileges. This form must be completed and returned to the Medical Staff Office at least within thirty (30) days. Failure to return the form within the stated time frame without good reason shall cause automatic suspension of clinical privileges. In such instances the member in question is entitled to the fair hearing proceedings described in Article XII.

b. The completed reappointment forms shall be promptly forwarded to the Credentials Committee which shall transmit to the chairman of each department a current list of those members being evaluated for reappointment in that department, together with the clinical privileges each then holds, accompanied by the applications of those members who have applied for a change in clinical
privileges or for a change in Medical Staff category.

c. Within a period of thirty (30) days thereafter, the chairman of the department shall transmit to the Credentials Committee the list of those members of the department recommended for reappointment in the same Medical Staff category with the same clinical privileges they then hold. In addition, the chairman shall submit individual recommendations, and the reasons therefor, for any changes recommended in Medical Staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not.

d. Recommendations for changes by the department chairman shall be based upon, but not necessarily limited to, any or all of the relevant factors listed in Part 2 of this Section. If a change in staff status or privilege(s) is being recommended by the department chairman, the physician should be so informed prior to the recommendation going to the Credentials Committee. The physician will be invited to attend the Credentials Committee meeting in a timely fashion to discuss the recommendation if he/she disagrees with the chairman’s recommendation. (Added 5/02)

Part 4 - Credentials Committee Procedures

a. The Credentials Committee, after receiving recommendations from the chairman of each department, shall review all pertinent information available and make recommendations for staff reappointment, for change in Medical Staff category, and for granting of clinical privileges for the ensuing two years.

b. The Credentials Committee or the Executive Committee may require that a person currently seeking reappointment undergo an impartial physical and/or mental examination either as part of the reapplication process or during the appointment year to aid it in determining whether clinical privileges should be granted or continued and make results available for the committee's consideration. Failure of the person seeking reappointment to undergo such an examination within reasonable time after being requested to do so in writing shall constitute a voluntary relinquishment of Medical Staff membership and clinical privileges until the request is satisfied.

c. The Credentials Committee shall submit its report and recommendations for reappointment to the Executive Committee in time for the Executive Committee to prepare a timely report for consideration at the Board's May meeting.

d. When the Executive Committee's recommendation for reappointment is favorable, those names shall be transmitted by the President to the Board through the Quality Medical Education Committee (rev. 1/09) of the Board for its consideration. Where non-reappointment, non-promotion of an eligible current staff member, or a limitation in clinical privileges is recommended, the reason or reasons shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff member has exercised or has been deemed to have waived his right to a hearing as provided in Article XII.

e. When the Executive Committee has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Executive Committee shall either:
1. remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee, prior to the Executive Committee's final recommendation; or

2. set forth in its report and recommendation to the Board the specific reasons for the Executive Committee's disagreement with the Credentials Committee's recommendation, supported by reference to particular aspects of the individual's record or Credentials Committee's reports.

   f. When action is delayed on the application for reappointment the member shall be entitled to continue to exercise clinical privileges currently in force, unless a suspension has been enacted according to procedures set forth in these Bylaws.

   Part 5 - Meeting with Affected Individual

   If the Executive Committee is considering an adverse recommendation on a member's request for reappointment, the member shall be invited to meet with the Executive Committee prior to any final recommendation by the Executive Committee.

   As part of its proceedings and report, the Executive Committee shall indicate whether an informal meeting has occurred with a member whose Medical Staff status or clinical privileges may be adversely changed. This meeting shall not constitute a hearing and none of the procedural rules provided by these Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept.

   Part 6 - Procedure Thereafter

   Any decision by the Executive Committee to recommend: a denial of reappointment; a denial of a requested change in staff category or clinical privileges; or a reduction in clinical privileges shall entitle the affected individual to the procedural rights provided in Article XII. The President of the Medical Staff shall then promptly notify the individual of the decision by certified mail, return receipt requested. A recommendation shall not be forwarded to the Quality Medical Education Committee of the Board and then to the Board until the individual has exercised, or has been deemed to have waived the right to a hearing as provided in Article XII, after which the Board shall be given the Committee's final recommendation and shall act on it. Thereafter all relevant provisions of Part 3, Section 5 of this Article shall apply.

Section 9 - Confidentiality of Peer Review Credentialing Documents and Material

   Part 1 - Peer Review Credentialing Documents and Material

   For the purpose of this Part and these Bylaws, the phrase "peer review credentialing documents and material" means all written or otherwise recorded information related to:
a. processing applications for Medical Staff membership and the granting of clinical privileges;

b. reappointment of Medical Staff members;

c. corrective action taken against a member of the Medical Staff; and

d. any and all other material and information maintained in the Credentials file which may lead to an adverse action against a member of the Medical Staff.

Any information concerning the qualifications, clinical competence, performance, conduct, or mental or physical health of either an applicant for Medical Staff membership, a Medical Staff member seeking reappointment or a Medical Staff member who is the object of a corrective action, shall be classified as peer review credentialing documents and material, regardless of its source or the circumstances causing its submission to either the Board or any of its individual members, the Administration, or the Medical Staff or any of its individual members.

Part 2 - Content, Examination and Removal of the Credentials File

The content, examination, removal and storage of the credentials file of an individual member shall be governed by policy adopted by the Medical Staff and approved by the Board.

Section 10 - Membership, Clinical Privileges and Contractual Relationship with the Hospital

For the purpose of these Bylaws, a "medico-administrative officer" is a practitioner employed by the Hospital in a position which involves administrative duties related to clinical activities and may also include direct patient care.

All practitioners, including medico-administrative officers, who have contractual or employment relationships with the Hospital must be members of the Medical Staff. Termination from a group with an exclusive contract leads to automatic loss of hospital privileges for the individual with the exception of members of the honorary, emeritus or affiliate staff. (Added 6/96)

The Medical Staff membership and the clinical privileges of any practitioner employed by the Hospital cannot be modified, suspended or terminated without compliance with the due process procedures set forth in these Bylaws unless the practitioner waives such rights in his contractual agreement with the Hospital.

Section 11 – Collegial, Educational, and/or Informal Proceedings (added 11/99)

a. These By-laws specifically encourage voluntary informal collegial and educational efforts to address questions or concerns relating to an individual’s practice and conduct where there is a reasonable likelihood that such steps may correct a problem before it
requires formal investigation. The goal of these efforts is to arrive at responsive actions by the individual.

b. All efforts of Medical Staff leaders (Medical Staff officers, department chiefs and committee chairs) and Hospital management in this regard are intended to be part of the Hospital and the Medical Staff performance improvement and professional/peer review activities.

c. These efforts may include, but not be limited to:

1. educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2. following up on any questions or concerns raised about the clinical practice and/or conduct of staff members and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

3. sharing summary comparative quality, utilization, and other relevant information in order to assist individuals to conform their practices to appropriate norms.

4. providing the affected individual an opportunity to respond in writing to any written communications, and the response shall be maintained in the individual’s file along with the original communication.

d. Collegial efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders depending on the circumstances. Collegial efforts shall be considered to be confidential peer review activities, but shall not in and of themselves give rise to any hearing rights.

ARTICLE XI - CORRECTIVE ACTION

Section 1 – Procedure for Actions Involving Clinical Competence, Professional Ethics, Unacceptable Conduct or Infraction of Hospital or Medical Staff Bylaws or Rules

Part 1 - Grounds for Action

Whenever the Chairman of the Board, the Chief Executive Officer, any Medical Staff officer, department chairman or committee chairman, or any member or group of members of the Medical Staff has cause to question a Medical Staff member's:

a. clinical competence;

b. care or treatment of a patient or patients or management of a case;

c. known or suspected violation of these Bylaws or Medical Staff rules or regulations;
d. professional ethics;

e. behavior or conduct with patients in the Hospital; or

f. ability to work harmoniously with others in the Hospital,

a written request for a review of the matter shall be addressed to the Executive Committee making specific reference to the activity or conduct which gave rise to the request. The Chairman of the Executive Committee shall promptly notify the Chief Executive Officer and shall keep him informed of its actions in connection therewith. The practitioner in question shall be notified at the same time that a written request for a review has been received. (Revised 11/91) The Department Chairman and the Vice President for Medical and Academic Affairs will also be informed as to the grounds for action. The department chairman will submit a review of the matter. This will be forwarded to a Review Committee. The President of the Staff will appoint the members of the Review Committee consisting of at least three members of the active staff who may also be members of the Executive Committee including a representative of the affected member’s department. The Vice President of Medical and Academic Affairs shall be a member of this committee. The chief of the member’s department will be excluded from being part of this committee. The committee shall not include relatives, partners or associates of the affected individual. Should the chairman of the Executive Committee believe that it is important for the development of a meaningful report to name a representative to the committee who is in direct competition with the physician being investigated, such a person must refrain from voting on any recommendation of the committee. Outside consultants also can be used in the formation of this report. (added 11/99)

The purpose of this Review Committee is to review the basis of the action and prepare a factual report to the Executive Committee. The physician will be given the opportunity to take a leave of absence from exercising privileges that may be in question. A voluntary interim relinquishment of the clinical privileges would not be considered an admission of fault or guilt by the physician. (Added 11/99)

Part 2 - Investigative Procedure

The Executive Committee shall meet within thirty (30) (revised 11/99) days after receiving the request and if, in the opinion of the Executive Committee:

a. the request for a review contains sufficient information to warrant a recommendation, the Executive Committee will make a recommendation, but only after offering the member involved an opportunity to meet with the Committee. (Revised 11/91)

b. the request for a review at that point does not contain information sufficient to warrant a recommendation, the Executive Committee may either conduct a discussion with the physician concerned, seek further information or clarification from other sources, or by formal resolution, determine to commence an investigation. (Revised 11/91)

c. if an investigation is begun, the committee shall conduct the investigation or request the
President to appoint an Investigating Committee. The Investigating Committee, if appointed, shall consist of at least three (3) members of the Active Medical Staff, or members of the Executive Committee, including a representative of the affected member's department. This Committee shall not include relatives, partners or associates of the affected individual, persons in direct economic competition with the affected member. (Revised 11/99) The Investigating Committee shall have available to it the full Medical Staff and its resources and the Hospital to aid it in its work as well as the authority to use outside consultants as required. The individual involved shall have an opportunity to meet with the Investigating Committee before it makes its report. Before this meeting the individual shall be provided the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided by these Bylaws with respect to hearings shall apply. If a practitioner does not elect to meet with the Committee, the practitioner shall be notified in writing that the Committee will proceed with its investigation which may result in a recommendation adverse to the practitioner. A summary of this interview shall be made by the Investigating Committee and submitted with its report. The report of the Investigating Committee shall be submitted to the Executive Committee which may accept, modify or reject the recommendation of the Investigating Committee. (Revised 11/91)

At any time during the investigation the clinical privileges of the person being investigated may be suspended according to procedures set forth in Section 3 of this Article.

Part 3 - Procedure Thereafter

a. At the conclusion of its investigation, the Executive Committee or the Investigating Committee, whichever is appropriate, shall prepare a report which may recommend: (1) issuance of a written warning or reprimand, (2) imposition of terms of probation, (3) imposition of a requirement for consultation, (4) a reduction of clinical privileges, (5) suspension of clinical privileges for a term, (6) revocation of staff appointment, (7) no further action indicated or (8) a letter of apology and/or exoneration.

b. If any recommendation of the Executive Committee includes any of the following conditions, the affected individual shall be entitled to the procedural rights provided in Article XII:

1. a written warning, a letter of reprimand, or a period of probation;

2. a reduction or termination of clinical privileges;

3. a requirement for consultation;

4. a suspension of clinical privileges for a period in excess of fourteen (14) days; or

5. suspension or revocation of the individual’s Medical Staff membership. In such instances, the recommendation shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested, such notification
to advise the practitioner of the right to a hearing as provided in Article XII of these Bylaws. The Chief Executive Officer shall hold the recommendation until after the individual has exercised, or has been deemed to have waived, the right to a hearing as provided in Article XII. At the time the individual has waived or has been deemed to have waived his right to a hearing as defined in the Bylaws, the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting documentation to the Board.

Suspension and restrictions shall not be considered a final action until adoption as such by the Board of Trustees following exhaustion of hearing and appeal rights.

c. If the action of the Executive Committee is less severe than that described in the above paragraph (Section 2, Part 3b), the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made to the Board through the President and the action shall stand unless modified by the Board. In the event the Board determines to consider modification of the action of the Executive Committee, the Executive Committee shall be notified of the Board's tentative action. If requested by the Executive Committee, the matter shall be reviewed by the Quality Medical Education (rev. 1/09) Committee of the Board prior to final action by the Board.

d. If the Board's final action includes any of the conditions contained in Part 3b of this Section, it shall so notify the individual, through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article XII.

Section 2 - Precautionary Suspension of Clinical Privileges (Revised 6/93)

Part I - Grounds for Precautionary Suspension (Revised 6/93)

a. Any two (2) of the following individuals - the Chief Executive Officer, the Senior Vice President, Medical/Academic Affairs, the Vice President, Medical Affairs, Allentown Campus, the President of the Medical Staff and the chairman of a clinical department or the executive committees of either the Board or the Medical Staff, may summarily suspend all or any portion of the clinical privileges of a member of the Medical Staff whenever such action must be taken immediately in the best interest of patient care or safety in the Hospital, or for the continued effective operation of the Hospital. Such precautionary suspension shall be deemed an interim precautionary 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 review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension. (Revised 6/93)

b. The Practitioner shall be the first to be notified, by the Senior Vice President, Medical/Academic Affairs, the Vice President, Medical Affairs, Allentown Campus, the President of the Medical Staff, regarding the imposition of the precautionary suspension. (Revised 9/93) The physician will be given the opportunity to take a leave of absence from exercising those
same privileges. A voluntary interim relinquishment of the clinical privileges will not be considered an admission of fault or guilt by the physician. (Added 11/99)

c. Such precautionary suspension or leave of absence shall become effective immediately upon imposition; it shall immediately be documented in writing by the party imposing the suspension and shall remain in effect until modified. (Added 11/99)

d. The precautionary suspension or restrictions shall not be considered a final action until adopted as such by the board of trustees following exhaustion of hearing and appeal rights. (Added 9/98)

Part 2 - Investigative Procedure

The individuals who exercise the authority granted under Part 1 of this Section to suspend summarily a member of the Medical Staff shall immediately report this action in writing to the Chairman of the Executive Committee. (Revised 11/99)

The Chairman of the Executive Committee will immediately appoint a Review Committee consisting of at least 3 members of the Active Medical Staff who may be members of the Executive Committee, including a representative of the affected member’s department. The Chief of the member’s department will be excluded from being a part of this Committee. The Committee shall not include relatives, partners or associates of the affected individual. Should the Chairman of the Executive Committee believe that it is important to the investigation to name a representative to the Committee who is in direct competition with the physician being investigated, such person must refrain from voting on any recommendation of the Committee. (Added 11/99)

The Review Committee will have available to it the full Medical Staff and its resources. The individual involved shall have an opportunity to meet with the Review Committee before it makes its report. Prior to this meeting, the individual shall be provided with the factual evidence supporting the requested review and shall have the opportunity to discuss, explain and refute it. Should the involved practitioner choose not to meet with the Committee, the Committee shall proceed with its review in any event. (Added 11/99)

The Executive Committee will convene within 14 days to hear the report of the Review Committee. The Executive Committee may then proceed according to the procedures set forth in Parts 2 and 3 of Section 1 of this Article. The precautionary suspension or voluntary leave of absence shall remain in effect unless modified by the Executive Committee or by those individuals who imposed the suspension. (Added 11/99)

Part 3 - Care of Suspended Individual's Patients

Immediately upon the imposition of a precautionary suspension, the Chairman of the department in question shall, after consulting with the patient or the patient's family, assign to another member or other members of the Medical Staff responsibility for care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. If the suspended practitioner is a member of a group practice, preference shall be given
to assigning the patient to another member of the group, if acceptable to the patient. It shall be the
duty of the chairman of the involved department to cooperate with the party imposing and enforcing
the precautionary suspensions. (Revised 6/93)

Section 3 - Other Actions

Part 1 - Failure to Comply with these Bylaws
and the Medical Staff Rules and Regulations

Admitting and specified clinical privileges of members of the Medical Staff may be
temporarily suspended for failure to comply with these Bylaws and the Rules and Regulations of
the Medical Staff. Repeated or extended failure to comply may result in appropriate disciplinary
action as stated in the Rules and Regulations or as provided in Section 2 of this Article.

Part 2 - Action by State Licensing Agency

Action by the appropriate state licensing agency revoking or suspending an individual's
professional license, shall result in automatic relinquishment of Medical Staff membership and
termination of clinical privileges as of that date. If the individual's license is restored, he may
reapply for appointment to the Medical Staff as provided in Article X.

Part 3 - Failure to Attend Meetings or
Satisfy Continuing Education Requirements

Failure to attend meetings or failure to complete mandated continuing education as required
by these Bylaws and related rules and regulations shall be considered a voluntary relinquishment of
Medical Staff membership and shall be sufficient grounds for refusing to reappoint the individual
concerned. Such failures shall be documented and specifically considered by the Credentials
Committee when making its recommendations for reappointment.

Part 4 - Loss of Liability Insurance Coverage

As in the case of loss of state licensure, revocation, suspension, or a reduction in amount
from what is mandated by these Bylaws and/or rules and regulations of a member's liability
insurance coverage will automatically result in immediate loss of Medical Staff membership and
clinical privileges as of that date. Once the liability coverage is restored to the satisfaction of the
Executive Committee and the Board, the individual shall be eligible to reapply for staff
appointment and the application shall be processed in the same manner as if it were an initial
application. However, in a case where the Executive Committee determines that loss or reduction
of liability insurance was beyond control of the individual and not related to any culpability on his
part, it may recommend to the Board that his membership be reinstated as soon as adequate
insurance coverage is secured.
Section 4 - Procedure for Leave of Absence

Persons appointed to the Medical Staff may, for good cause be granted leaves of absence by the Board for a definitely stated period of time. Requests for leaves of absence shall be made to the Executive Committee and shall state the beginning and ending dates of the requested leave. The Executive Committee shall transmit a recommendation for action by the Board.

At least sixty (60) days prior to the expiration of the leave of absence, the Vice President of Medical Affairs shall notify the member of the scheduled expiration date in the event the member elects to request an extension.
ARTICLE XII - HEARING AND APPEAL PROCEDURE

Section 1 - Definitions

For the purposes of this Article, the following terms shall have the meaning and definition assigned to them in this Section except as otherwise expressly provided in these Bylaws:

a. "Adverse recommendation or decision" means a finding by the Executive Committee or the Board (after a favorable recommendation to the Board) which is against the interests of the petitioner.

b. "Hearing" means a recorded adversarial meeting before a hearing panel in which the petitioner and the Executive Committee or the Board may:

1. be present;

2. be represented by an attorney and/or a physician;

3. call, examine and cross-examine witnesses;

4. present any relevant evidence of the sort which responsible persons are accustomed to rely upon in the conduct of serious affairs regardless of its admissibility in a court of law.

c. "Appropriate Notifying Officer" means the President of the Medical Staff in those instances where the adverse decision emanates from the Medical Staff and the Chief Executive Officer in those instances where the adverse decision emanates from the Board in lieu of a favorable recommendation by the Medical Staff.

d. "Hearing panel" means a body appointed by the President of the Medical Staff, or the Chief Executive Officer as appropriate.

The Medical Staff hearing panel shall be composed of not less than three (3) nor more than five (5) members, (Revised 6/91) a majority of whom shall be Active physician members of the Medical Staff who have not actively participated in the consideration of the matter involved at any previous level and who are not relatives or who do not have any direct economic competition with the affected individual or any other financial or business conflict of interest. Such appointment shall include designation of the chairman, who shall be a member of the Active Medical Staff.

A Governing Body hearing panel shall be composed of not less than five (5) members, to include three (3) lay Board members and two (2) representatives from the Medical Staff, none of whom shall be a relative or be in direct economic competition with the affected individual or have any other financial or business conflict of interest.

e. "Appellate Review Panel" means a body appointed by the Chairman of the Governing Body and shall be composed of not less than three (3) Board members.
f. "Petitioner" means a practitioner seeking membership, or a member of the Medical Staff who is entitled to a formal hearing whenever an adverse recommendation, based on grounds, has been made:

1. denial of initial Medical Staff appointment;
2. denial of requested advancement in Medical Staff category;
3. denial of Medical Staff reappointment;
4. revocation of Medical Staff appointment;
5. denial of requested initial clinical privileges;
6. denial of requested increased clinical privileges;
7. decrease of clinical privileges;
8. suspension of total clinical privileges for a period of more than fourteen (14) days;
9. change in Medical Staff category not mandated in Article V;
10. any individual limitation or restriction of privileges;
11. any written warning or reprimand;
12. any individual requirement for special or additional training or education in order to retain all or part of previously granted clinical privileges.

Section 2 - The Hearing

Part 1 - Request for Hearing

Whenever a practitioner receives an official notice of an adverse recommendation, including the reasons for the action, such individual shall have thirty (30) days following receipt of such notice to request, in writing to the appropriate notifying officer, a hearing before the appropriate hearing panel. The official notice to the affected physician shall state the reasons for the adverse recommendation as well as reference to patient records and/or information supporting the recommendation. Each practitioner will be notified in writing by the Chief Executive Officer of the right to a hearing and/or appeal or to meet with a reviewing body as provided in these Bylaws, such notice to be made in a timely fashion. In the event the affected individual does not request a hearing in this manner, the right to such hearing shall be deemed waived and such action shall thereupon become effective immediately upon final action by the Board. In cases where the right to a hearing has been waived, the practitioner shall be notified in writing that the process will proceed
and may result in an action adverse to the practitioner.

In the event a hearing is properly requested, a formal hearing must be held, and recommendations made, before the Board enters a final decision.

**Part 2 - Time and Place for Hearing**

The appropriate notifying officer shall schedule the hearing before the appropriate hearing panel and shall give notice to the person who requested the hearing of its time, place and date, at least thirty (30) days prior to such hearing date. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned but not later than sixty (60) days after the receipt of the request for a hearing. (Revised 6/91)

**Part 3 - List of Witnesses**

Upon a written request, by either the Hearing Panel or the person requesting the hearing, for a list of witnesses, the names and addresses of the individuals who will give testimony or evidence, so far as is then reasonably known, shall be furnished within ten (10) days and the names and addresses of additional witnesses as soon as procured.

**Part 4 - Failure to Appear**

Failure, without good cause, of the person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary waiver of the right to a hearing and acceptance of the recommendations or actions pending which shall then become effective immediately upon final action by the Board.

**Part 5 - Postponements and Extensions**

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone but such extensions shall be permitted only by the Hearing Panel or its chairman acting upon its behalf on a showing of good cause. In no event shall a postponement be permitted that would cause the hearing to take more than two months, without the concurrence of the hospital CEO and the President of the Medical Staff, upon recommendation of the Chairman and a majority of the hearing panel. (Revised 6/91)

**Part 6 - Deliberations and Recommendation of the Hearing Panel**

Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Hearing Officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver written copies of such report to the appropriate notifying officer and the affected practitioner.
Part 7 - Disposition of Hearing Panel Report

Upon its receipt, the appropriate notifying officer shall send a copy of the report and recommendation by certified mail, return receipt requested, to the person who requested the hearing. If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, the report of the Hearing Panel shall be delivered by the President of the Medical Staff to the Executive Committee for whatever modification, if any, it may wish to make to its original recommendation which then shall be transmitted to the Board. If it has been conducted by reason of an action of the Board or its committee, the report of the Hearing Panel shall be delivered to the Board or that committee by the Chief Executive Officer.

Section 3 - Hearing Procedure

Part 1 - Representation

The person requesting the hearing shall be entitled to be represented at the hearing by an attorney and/or a physician of his choice who may examine the witnesses and present his case or assist the person in examining witnesses or presenting his case. The person requesting the hearing shall inform the appropriate notifying officer in writing of the names of such representative ten (10) days prior to the date of the hearing. The President of the Medical Staff acting for the Executive Committee or the Chief Executive Officer acting for the Board, whichever is appropriate, shall appoint a representative to present its recommendations and to examine witnesses.

Part 2 - The Hearing Officer

The appropriate notifying officer may appoint an attorney as Hearing Officer. The Hearing Officer must not act as a prosecuting officer nor as an advocate for the Board or the Executive Committee, but rather shall advise the Chairman of the Hearing Panel on matters pertaining to procedure, admissibility of evidence, and other legal considerations relating to the hearing, deliberation and report of the Panel, but shall not be entitled to vote on its recommendation.

Part 3 - The Presiding Officer

The Chairman of the Hearing Panel shall preside at all sessions, shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. (Added 6/91) The Presiding Officer shall also assure that decorum is maintained throughout the hearing, shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence.
Part 4 - Pre-Hearing Discovery (Added 6/91)

a. There is no right to pre-hearing discovery. The individual requesting the hearing shall be entitled, upon specific request, to the following subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

1. copies of or reasonable access to all relevant patient medical records, at his or her expense;
2. reports of experts, if any relied upon by the Executive Committee;
3. copies of redacted relevant committee minutes (such provision does not constitute a waiver of the Pennsylvania Peer Review Protection Act);
4. copies of any other documents relied upon by the Executive Committee or Board, or otherwise reasonably relevant.

b. Prior to the hearing, on dates set by the hearing officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits and copies thereof. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Hearing Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

c. Neither the Medical Executive Committee nor counsel for the hospital and Medical Executive Committee, nor the physician or the physician's attorney, shall contact individuals who are on the witness list of the other party about the hearing unless that contact is agreed upon between counsel for both sides or otherwise approved by the hearing officer. (Added 11/91)

Part 5 - Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a certified court reporter. The cost of such reporter shall be borne by the Hospital. The Hearing Panel shall require that oral evidence be taken on oath or affirmation administered by any person designated by such body and entitled to administer oaths in this state.

Part 6 - Rights of Both Sides

At a hearing, both sides shall have the following rights: to call and examine witnesses to the extent available; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to rebut any evidence; to file a closing brief; and to receive a written copy of the final report. If the person requesting the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination.
Part 7 - Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the Chairman of the Hearing Panel if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed following the close of the hearing and shall set the time period for filing same. The affected individual shall be permitted to file a closing brief. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. Depositions may be used in lieu of oral testimony in cases where the Hearing Panel believes the health of a witness or the distance a witness must travel precludes the presence of the witness at a hearing.

Part 8 - Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Part 9 - Basis of Decision

The decision of the Hearing Panel shall be based on the evidence produced at the hearing.

Part 10 - Adjournment and Conclusion

The Chairman may adjourn the hearing and reconvene the same, without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed and the Hearing Panel shall thereupon, outside the presence of any other person, conduct its deliberations. After reaching its decision and subsequent consultation with the Hearing Officer, it shall submit its written report as indicated in Parts 6 and 7, Section 2 of this Article.

Section 4 - Appeal

Part 1 - Time for Appeal

Within fifteen (15) days after the affected individual is officially notified by the appropriate notifying officer of a final adverse recommendation, an appellate review may be requested in writing and delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within thirty (30) days as provided herein, the affected individual shall be deemed to have accepted the
recommendation involved and it shall thereupon become final and effective upon final action by the Board.

**Part 2 - Grounds for Appeal**

The grounds for appeal from a final adverse recommendation shall be that:

a. there was substantial failure on the part of the Executive Committee or Hearing Panel to comply with the Bylaws of the Hospital or the Medical Staff in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or

b. the recommendation was made arbitrarily, capriciously or with prejudice; or

c. the recommendation of the Executive Committee or Hearing Panel was not supported by the evidence; or

d. new evidence has become known or obtainable subsequent to the hearing.

**Part 3 - Time, Place and Notice**

Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than thirty (30) days, nor more than 40 days, from the date or receipt of the request for appellate review; provided, however, that when a request for appellate review is from a member who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

**Part 4 - Nature of Appellate Review**

The Chairman of the Board shall appoint an Appellate Review Panel composed of not less than three (3) Board members to consider the record upon which the recommendation before it was made. In the case of an appeal based on new evidence only, the Appellate Review Panel may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Each party shall have the right to present a written statement in support of his position on appeal. The Appellate Review Panel shall allow each party or its representative to appear personally and make oral argument. The Appellate Review Panel shall recommend final action to the Board. The Board may affirm, modify or reverse the recommendation of the Appellate Review Panel or, in its discretion, refer the matter for further review and recommendation either to an Appellate Review Panel or the Quality Medical Education Committee of the Board as outlined in Part 5 of this Section.
Part 5 - Decision of the Board

The Board shall consider the report and recommendations of the Appellate Review Panel. In the event the Board's contemplated decision is contrary to the recommendation of the Executive Committee, the matter will be referred to the Quality Medical Education (rev. 1/09) Committee of the Board for review and recommendation prior to a final decision of the Board.

Within forty-five (45) days after the conclusion of the proceedings before the Appellate Review Panel, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual in person or by certified mail.

Part 6 - Further Review

Except where the matter is referred for further action and recommendation in accordance with Parts 4 and 5 of this Section, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. However, if the matter is referred for further action and recommendation, such recommendations shall be made promptly to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

Part 7 - Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Board, the Executive Committee or a Hearing Panel, or a combination of acts of such bodies. However, nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of a practitioner to apply for reappointment or an increase in clinical privileges after the expiration of one (1) year from the date of such Board decision unless the Board provides for a lesser waiting period in its written decision.

Section 5 – Procedure for Independent Allied Health Professionals, Advanced Practice Nurses and Physician Assistants

Allied Health Professionals (AHP) shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. Any and all rights to which AHP’s are entitled are set forth in this Policy.

1. Notice of Adverse Recommendation and Hearing Rights:

   (a) In the event a recommendation is made by the Executive Committee that an AHP’s privileges be restricted for a period of more than 30 days, terminated or
not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(b) The rights and procedures in this Policy will also apply if the Board, without a prior adverse recommendation from the Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated or not renewed. In this instance, all references in this Policy to the Executive Committee will be interpreted as a reference to the Board.

(c) The AHP may request a hearing by submitting the request in writing, directed to the Vice President of Medical and Academic Affairs, within 30 days after receipt of written notice of the adverse recommendation.

(d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

2. Hearing Committee:

(a) If a request for a hearing is timely made, the Vice President of Medical and Academic Affairs, in consultation with the President of the Medical Staff, will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, AHPs, management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the AHP, or any competitors of the affected individual.

(b) The Vice President of Medical and Academic Affairs will appoint one of the Hearing Committee members to serve as Chair or may appoint a Presiding Officer. The role of the Hearing Committee Chair or the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Hearing Committee Chair or the Presiding Officer will maintain decorum throughout the hearing.

(c) As an alternative to a Hearing Committee, the President, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer will preferably be an attorney. The Hearing Officer may not be in direct economic competition with the individual
requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Policy to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

3. Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(c) At the hearing, a representative of the Executive Committee will first present the reasons for the recommendation. The AHP will be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The AHP and the Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The AHP will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Executive Committee was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(g) The AHP and the Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

4. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information,
to the President/CEO. The President/CEO will send a copy of the written report and recommendation by special notice to the AHP and the Executive Committee.

(b) Within ten days after notice of such recommendation, the AHP or the Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy and/or other applicable bylaws or policies and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.

(d) The request for an appeal will be delivered to the President/CEO by special notice.

(e) If a written request for appeal is not timely submitted, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the President/CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

5. Appellate Review:

(a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(b) The AHP and the Executive Committee will each have the right to present a written statement on appeal.

(c) At the sole discretion of the Appellate Review Committee, the AHP and a representative of the Executive Committee may also appear personally to discuss their position.

(d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities.
(e) The AHP will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Executive Committee.
ARTICLE XIII - MEDICAL STAFF REPRESENTATION-BOARD OF TRUSTEES

Four (4) members of the Medical Staff shall be appointed to the Hospital's Board of Trustees in accordance with the terms and conditions set forth in Article IV, Section 3, paragraph b of the Hospital's Bylaws.

The Medical Staff shall elect at least one (1) nominee for any vacant Board position previously held by a member of the Medical Staff.

The election of the Medical Staff's recommended nominee(s) shall be held at a meeting of the Medical Staff.
ARTICLE XIV - RULES AND REGULATIONS OF THE MEDICAL STAFF

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these Bylaws. There will be a set of general rules and regulations which shall set standards of practice and operation that are required of all Medical Staff members. Subject to the approval of the Executive Committee, each department may, by majority vote, formulate and modify its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such departmental rules and regulations shall not be inconsistent with these Bylaws or the general Medical Staff rules and regulations. General rules and regulations may be amended, repealed or added by a two-thirds (2/3) vote of the Medical Staff at any regular meeting without notice or at any special meeting with notice. Rules and regulations and any amendments thereto shall become effective when approved by the Board.

All rules and regulations shall have the same force and effect as the Bylaws when approved according to procedures set forth in this Article.

The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the medical staff. Notice of all provisionally adopted amendments shall be provided to each member of the medical staff as soon as possible. The medical staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the medical staff and the Medical Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented. An urgent amendment is defined as those amendments that cannot be reasonably be processed through the present system of by-law governance and in a timely enough manor in accordance with law or regulations. (Added 02/12)

Among medical staff documents. If there is a conflict between the policies and the rules and regulations, the rules and regulations prevail. If there is a conflict between the by-laws and the rules and regulations, the by-laws shall prevail. (Added 02/12)
ARTICLE XV - AMENDMENTS

All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred by the Executive Committee to the appropriate Medical Staff committee for review and recommendation. The Executive Committee shall present a recommendation at a regular meeting of the Medical Staff, but no later than ninety (90) days from the receipt of the referral, or at a special meeting called for such purpose, the scheduling of such special meeting to be no sooner than thirty (30) days after the amendment has been proposed. Any proposed amendment to the medical staff Bylaws shall be published to the medical staff at least twenty-one (21) days prior to the next medical staff meeting. To be adopted, an amendment must receive two-thirds (2/3) of the votes cast by the voting staff who are present at the time of such vote and who do vote. At the discretion of the president of the medical staff, amendments can be distributed for an electronic vote between meetings. To be adopted an amendment must receive two-thirds (2/3) of the votes cast within a 21 day time frame of publication. (Added 4/10) Amendments so adopted shall be effective when approved by the Board. (Revised 2/92)

The Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent unless disapproved by the Medical Staff or the Board at their next regular meeting respectively. After adoption, such amendments shall, as soon as practicable, be sent to each member of the Medical Staff and the Chief Executive Officer.

Neither the Board nor the Medical Staff may unilaterally amend these Bylaws.
ARTICLE XVII - ADOPTION

These Bylaws are adopted and made effective January 23, 1989, superseding and replacing all previous Bylaws of the Medical Staff; henceforth, all activities and actions of the Medical Staff and its members, and of the Board and its members and its administrative staff shall comply with the requirements of these Bylaws, provided that allied professional staff who have been approved to perform clinical functions shall be unaffected by the adoption of these Bylaws (current clinical functions may continue to be exercised) until such time as the provisions of Article VI are fully implemented.

The present rules and regulations of the Medical Staff are hereby readopted and placed into effect pursuant to these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

ADOPTED BY THE MEDICAL STAFF ON SEPTEMBER 27, 1988

Signed: Edward M. Salgado, M.D.
President of the Medical Staff

Signed: Joseph B. Lennert, M.D.
Secretary of the Medical Staff

APPROVED BY THE BOARD ON JANUARY 23, 1989

Signed: Paul J. Franz, Jr.
Chairman of the Board of Trustees

Signed: Donna L. Fields
Secretary of the Board of Trustees

Amendments to April 28, 2014 included.