ST. LUKE'S UNIVERSITY HEALTH NETWORK

MEDICAL STAFF BYLAWS

OF

St. Luke's Hospital – Bethlehem

ARTICLE 1

GENERAL

The Board of Trustees (the "Board") of St. Luke's Hospital Bethlehem campus (the "Hospital") has appointed an organized medical staff ("Medical Staff") composed of practitioners for the purposes of delineating clinical privileges and obligations of those practitioner's services in the Hospital. These Medical Staff Bylaws (the "Bylaws") set forth the Medical Staff's organization and government, and shall be in conformity with the policies of the Hospital Board, and shall become effective upon approval by the Hospital Board. Nothing in these Bylaws shall be deemed to restrict or modify the powers vested in the Board under the Hospital's Bylaws or under law.

1.A. PREAMBLE

All Medical Staff members commit to working cooperatively and professionally with each other and Hospital employees and management to promote safe, appropriate patient care. Medical Staff Leaders will strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety.

1.B. TIME LIMITS

Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. The Medical Staff will strive to be fair under the circumstances and to comply with the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 et seq. ("HCQIA").

1.C. DELEGATION OF FUNCTIONS

Functions assigned to an identified individual or committee may be delegated to one or more designees.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the Peer Review Committees, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a written policy; or

(c) as authorized, in writing, by the President and by legal counsel to the Hospital

Any breach of confidentiality may result in appropriate sanctions. The physician will be notified in writing when this occurs.

1.D.2. Peer Review Protection:

All professional review activity will be performed by or on behalf of Peer Review Committees, including, but not limited to:

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

(b) all Departments;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, Medical Staff Leaders, and experts or consultants retained to assist in professional review activities. All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential

1.E. MEDICAL STAFF DUES

1.E.1 Dues.

Medical Staff dues shall be as recommended by the MEC and may vary by category.

1.E.2 Payment.

Dues shall be payable every two years upon request in conjunction with the respective reappointment date. Failure to pay dues when requested, at least 1 month prior to the reappointment month shall result in ineligibility to apply for Medical Staff reappointment.

1.E.3. Signatories.

Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff, Vice President, and Treasurer.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff are eligible to apply for appointment to one of the following categories:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of members who are involved in at least twelve (12) patient contacts per twelve (12) months or who are employed or engaged by the hospital in medico-administrative positions.

2.A.2. Prerogatives:

Active Staff members:

(a) may vote in all general and special meetings of the Medical Staff, and applicable Department, and committee meetings; and

(b) may hold office, serve as Department Chairman, and serve on committees.

2.A.3. Responsibilities:

Active Staff members must:

(a) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call, care for unassigned patients, and evaluation of members during the initial focused professional performance evaluation ("FPPE") period, as described in the Rules and Regulations;

(b) actively participate in the peer review and performance improvement process;

(c) accept consultations when requested;

(d) attend applicable meetings;

(e) pay application fees and dues; and

(f) perform assigned duties.

2.B. 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, 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.

2.C. 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 hospital's service area, who are recognized by the Medical Staff for their outstanding reputations, their noteworthy contributions to the health and medical sciences, and 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, vote at Medical Staff meetings, or hold office. Honorary Staff 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.

2.D. AFFILIATE STAFF

2.D.1 Composition.

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 outpatients.

2.D.2. Responsibilities.

Affiliate Staff members: (1) may, but are not required to, attend meetings of the Medical Staff and departments without vote; (2) shall have no staff committee responsibilities, but may be assigned to special committees; (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, and make medical record entries, but not write orders or perform consults; (5) may order services through the Hospital's diagnostic facilities and the infusion center; (6) shall not be granted clinical inpatient privileges and shall not admit or treat patients at the Hospital; and (7) shall pay Medical Staff dues of $50 (or other amount as determined by the MEC).

2.D.3. Transfer to Another Category.

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

2.E. AMBULATORY STAFF

The Ambulatory Staff will be members who are employed to provide services at emergency / urgent care departments, affiliated outpatient facilities, and clinics operated under a Network 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 Network-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 State license may be considered for appointment to this category with approval of their residency program director.

2.F. ACTIVE ASSOCIATE STAFF

2.F.1 Composition.

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 twelve (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 (or other amount as determined by the MEC).

2.F.2. Responsibilities.

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 or management of inpatient care except to provide consultations for their patients when requested to do so by a hospitalist or other active medical staff member.

ARTICLE 3

OFFICERS

3.A. OFFICERS

The officers of the Medical Staff shall consist of the President of the Medical Staff, the Vice President, and the Treasurer

3.B. ELIGIBILITY CRITERIA

Only those members of the Active or Active Associate Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff or member of the MEC. They must:

(1) be appointed in good standing to the Active or Active Associate Staff, and have served on the Active or Active Associate Staff for at least two (2) years (applicable following the initial five years of operation of the Hospital);

(2) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) not presently be serving as medical staff officers, Board Members or department chairman at any other non- Network hospital and shall not so serve during their terms of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have demonstrated an ability to work well with others;

(6) have no active conflicts of interest at the time of serving

Preference shall be given to candidates that have:

(1) experience in a leadership position, or other involvement in performance improvement functions for at least two (2) years; and

(2) have attended continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) communicate on policies and report on the activities of the Medical Staff to the President, VPMA and the Board;

(c) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and the MEC;

(d) chair the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;

(e) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(f) recommend Medical Staff representatives to Hospital committees; and

(g) perform all functions authorized in these Bylaws and all applicable policies, including collegial intervention under Article 11.A.

3.C.2. Vice President:

The Vice President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;

(b) serve on the MEC;

(c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC; and

(d) become President of the Medical Staff upon completion of his/her term.

3.C.3. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.C.4 Treasurer:

The Treasurer of the Medical Staff shall:

(a) Collect and be custodian of Medical Staff dues and funds, and make disbursements authorized by the Medical Staff, the Executive Committee or their designees;

(b) 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.

3.D. NOMINATIONS

Nominations for officers of the Medical Staff shall be presented by the Nominating Committee for action at the Annual Medical Staff meeting every two (2) years. 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 applicable Annual Meeting. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least ten (10) days prior to the elections. Write-in nominations shall be published prior to the elections. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.A, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted

3.E. ELECTION

Candidates receiving a majority of votes cast shall be elected, subject to Board confirmation. A written ballot may be requested. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes. Secret ballots shall not be permitted

3.F. TERM OF OFFICE

Officers shall serve for a term of two (2) years or until a successor is elected, unless removed earlier.

3.G. REMOVAL

3.G.1. Process:

Removal of an elected officer or a member of the MEC may be effectuated by a two-thirds vote of the MEC; or by the Board for:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff;

(d) an infirmity that renders the individual incapable of fulfilling the duties of the office;

(e) failure of an officer to maintain his status as a member of the Active or Active Associate Medical Staff shall immediately disqualify that individual and be cause for immediate removal from office; or

(f) no reasons if determined by the MEC or Board

3.G.2. Notice:

Except for a removal pursuant to 3.F.(1)(f) above, at least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC or the Board prior to a vote on removal.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

STAFF DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff may be organized into departments (each a "Department") when the Medical Staff duties and functions become too complex to be handled by the staff as a whole, as determined by the MEC.

Subject to the approval of the Board, the MEC may create new Departments, eliminate Departments, or otherwise reorganize the Department structure.

4.B. ASSIGNMENT TO DEPARTMENT

Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical Department. Assignment to a particular Department does not preclude an individual from seeking and being granted clinical privileges typically associated with another Department. An individual may request a change in Department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The Departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, and (ii) to monitor the practice of all those with clinical privileges in a given department. Each Department shall assure emergency call coverage for all patients consistent with Hospital policy.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRMAN

Each Department Chairman shall:

(1) be an Active Staff member;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(3) satisfy the eligibility criteria in Section 3.A.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRMAN

Appointment and removal of Department Chairman shall be as follows:

(1) Department Chairman shall be appointed by the CEO of the Network or designee following consultation with the Medical Executive Committee or department.

(2) Any Department Chairman may be removed pursuant to the terms of applicable contracts, or if no contract exists, by 2/3rds vote of the MEC, or by the Board. Grounds for removal shall include, but not be limited to:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(e) no reasons if determined by the MEC or Board

3) A Department 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 MEC.

4.F. DUTIES OF DEPARTMENT CHAIRMAN

Each Department Chairman is accountable for the following:

(1) all clinically related activities of the Department;

(2) all administratively related activities of the Department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the Department;

(5) evaluating requests for clinical privileges for each member of the Department;

(6) assessing and recommending off-site sources for needed patient care services not provided by the Department or the Hospital;

(7) the integration of the Department into the primary functions of the Hospital;

(8) the coordination and integration of interdepartmental and intradepartmental services;

(9) the development and implementation of policies and procedures that guide and support the provision of services;

(10) recommendations for a sufficient number of qualified and competent persons to provide care or service;

(11) determination of the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services;

(12) continuous assessment and improvement of the quality of care, treatment, and services provided;

(13) maintenance of quality monitoring programs, as appropriate;

(14) the orientation and continuing education of all persons in the Department;

(15) recommendations for space and other resources needed by the Department; and

(16) performing all functions authorized in these Bylaws, including collegial intervention under Article 11.A.

(17) be responsible to the MEC 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.

(18) provide guidance to the MEC on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding the quality of patient care in the Department and take responsibility for the implementation of these policies.

(19) 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.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. Medical Executive Committee (MEC)

5.A.1. Composition:

(a) The MEC shall be composed of the officers of the Medical Staff, the VPMA, and other members of the Active or Active Associate Staff recommended by the President of the Medical Staff and appointed by the MEC (but not to exceed 10), broadly reflecting the specialty mix of the Medical Staff. Terms shall be staggered by the MEC so as to provide reasonable continuity. Terms are for three (3) years or until a successor is elected.

(b) The President of the Medical Staff will chair the MEC.

(c) The Hospital President and CNO shall be *ex officio* members of the MEC, without vote.

5.A.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment;

(4) delineation of clinical privileges for each eligible applicant;

(5) participation of the Medical Staff in Hospital performance improvement activities;

(6) the mechanism by which Medical Staff appointment may be terminated; and

(7) hearing procedures;

(c) consulting with the President on quality related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, Departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to promote uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) reviewing or delegating to the Bylaws Committee the responsibility to review, at least every three (3) years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) performing such other functions as are assigned to it by these Bylaws, the Board or applicable policies.

Any change to these duties shall be delineated in an amendment to these Bylaws in accordance with Article 16.

5.A.3. Meetings:

The MEC shall meet as often as necessary to fulfill its responsibilities (but at least ten (10) times a year) and maintain a permanent record of its proceedings and actions.

5.B. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(2) the Hospital's and individual practitioners' performance on quality metrics, including but not limited to The Joint Commission (“TJC”) standards and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(4) the utilization of blood and blood components, including review of significant transfusion reactions;

(5) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(6) education of patients and families;

(7) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(8) accurate, timely, and legible completion of medical records;

(9) the use of developed criteria for autopsies;

(10) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(11) nosocomial infections and the potential for infection;

(12) unnecessary procedures or treatment; and

(13) appropriate resource utilization.

(14) radiation safety

5.C. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

All committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.A of these Bylaws. Committee chairs and members shall be appointed for initial terms of one (1) year, but may be

reappointed for additional terms. The President of the Medical Staff and the President (or their respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise stated.

5.D. CREATION OF STANDING COMMITTEES

The MEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. The MEC may create a Committee Manual. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the MEC.

5.E. SPECIAL TASK FORCES

Special task forces may be created and their members and chairs appointed by the President of the Medical Staff and report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is July 1 to June 30.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least once a year, and more often, if decided by a majority of no less than twenty-five percent (25%) the Medical Executive Committee

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Board, or by a petition signed by not less than twenty-five percent (25%) of voting staff. No business shall be transacted at a special meeting other than that stated in the special meeting notice.

6.B.3. Conflict Management Process:

A special meeting of the Medical Staff may be called by a petition signed by not less than 25% of the Voting Staff to discuss any conflict with regard to:

(1) proposed amendments to these Medical Staff Bylaws;

(2) proposed amendments to the Medical Staff Rules and Regulations;

(3) proposed amendments to an existing policy that is under the authority of the MEC; or

(4) a new policy proposed by the MEC.

The agenda for that meeting will be limited to the amendment(s) or policy at issue.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Committee Manual, each Department and committee shall meet at least bi-annually, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any Department or committee may be called by or at the request of the presiding officer, the President of the Medical Staff, or by a petition signed by not less than 25% of the voting staff members of the Department, or committee, but in no case by fewer than two (2) members. No business shall be transacted at a special meeting other than that stated in the special meeting notice.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of Departments and committees at least seven (7) days in advance of the meetings. Notice may also be provided by posting in a designated location at least seven (7) days prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a Department, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Posting may not be the sole mechanism used for providing notice.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, Department, or committee, those members present, including remotely, and eligible to vote at the meeting shall constitute a quorum. For meetings of the MEC and the Credentials Committee, the presence of at least 50% of the total Committee shall constitute a quorum. Once a quorum is present at a meeting, the failure to maintain a quorum throughout the meeting shall not inhibit any subsequent action from being taken at that meeting.

(b) Recommendations and actions of the Medical Staff, Departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present and eligible to vote.

(c) The voting members of the Medical Staff, a Department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the presiding officer by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated. Failure to vote shall be considered an affirmative vote in favor of the question raised.

(d) Voting by secret ballot shall not be permitted.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, Department, or committee, and shall include such agenda in the notice of the meeting.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff, Department, or committee custom shall prevail at all meetings, and the Department Chairman or committee chair shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, Departments, and committees shall be prepared and shall include a record of the attendance of members and, the recommendations made, and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, Departments, and committees shall be transmitted to the MEC, President, and VPMA. The Board shall be kept apprised of the recommendations of the Medical Staff and, its Departments, and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital for at least seven (7) years

6.D.6. Requirements:

(a) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable Department and committee meetings each year.

(b) At a minimum, however, each Active Staff member is expected to attend at least 25% of meetings of the general Medical Staff, as well as at least 25% of the applicable Department and Committee meetings in each year. It is not necessary to prepare excuses for missed meetings because excuses shall not be considered when compliance with this attendance requirement is reviewed. Failure to meet the attendance requirement shall result in the member's automatic relinquishment of voting rights for the ensuing year and other potential sanctions.

(c) Members of more than one Network Medical Staff can count their attendance from their primary hospital toward fulfilling the attendance requirements at any of the other Network hospital Medical Staff of which they are a member.

ARTICLE 7

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

7.A. QUALIFICATIONS

7.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, or clinical privileges, the applicant must, as applicable:

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

(b) have a current, unrestricted DEA registration, and applicable State CDS registration;

(c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital; provided that this requirement does not apply to Honorary Staff under Article 2.C;

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

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

(f) have never been, and are currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;

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

(j) demonstrate recent clinical activity in their primary area of practice within the last two (2) years; provided that this requirement may not apply to certain Medical Staff categories defined in Article 2;

(k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges, 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;

(l) be board certified in their primary area of practice at the Hospital (except for those categories of membership defined in Article III for which board certification is not required). Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five (5) years will be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training or within the time period set by the applicable board.

(m) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, 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 to the primary practicing specialty board certification expiration, the applicant will be allowed two (2) more documented tries to recertify within a period of five (5) years; and

(3) not enrolling in the recertification exam immediately prior to the certification expiration date or those two (2) exams scheduled immediately after will be considered as a failed recertification exam(s);

(n) be allowed to submit an application pursuant to the Hospital's Medical Staff Conflict of Interest Policy, and, at the hospital campus(es) where applicable, invited to sign a letter agreement required by the Hospital (the "Letter Agreement") ; and

(o) Comply with the Hospital's Medical Staff Conflict of Interest Policy

7.A.2. Waiver of Threshold Eligibility Criteria:

(a) Waivers of threshold eligibility criteria will not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment or clinical privileges will not be processed unless the Board has granted the requested waiver.

(b) A request for a waiver will only be considered if the applicant provides information sufficient to demonstrate that his/her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.

(c) The Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant Department Chairman, and the best interests of the Hospital and the communities it serves. The Credentials Committee will forward its recommendation, including the basis for such, to the MEC.

(d) The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

(e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

(f) Notwithstanding anything to the contrary herein, a waiver of the Hospital's Medical Staff Conflict of Interest Policy shall only be granted as set forth in such policy.

7.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

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

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams;

(f) recognition of the importance of, and willingness to support the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care; and

(g) participation in Hospital and Medical Staff initiatives related to quality of care, patient safety, resource utilization, and compliance;

(g) if applicable under Article 7.A.1, compliance with the terms of the Letter Agreement signed prior to the provision of the initial application

7.A.4. No Entitlement to Appointment:

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

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

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

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

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

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

7.A.5. Nondiscrimination:

No one will be denied appointment on the basis of gender, race, creed, national origin, or other factor prohibited by law.

7.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

7.B.1. Basic Responsibilities and Requirements:

As a condition of Medical Staff membership, every applicant and member specifically agree to the following:

(a) to provide continuous and timely care;

(b) to abide by the Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

(c) to participate in Medical Staff affairs through committee service, participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) be available for call and follow-up care (which may be provided by the physician on call or by a mutually agreed-upon designee) for emergency and other patients, without regard to the patient's ability to pay, and satisfy applicable response time requirements as defined by the Hospital or applicable law;

(e) comply with benchmarking criteria, clinical pathways, and Network initiatives to achieve top decile performance with core measures and other publicly reported data;

(f) use electronic medical records and other technologies as implemented;

(g) not enter into a contract or compensation or financial relationship with another entity that would, in the discretion of the Board, result in a potential conflict of interest with the Board's commitment to the community;

(h) comply with all regulatory and accreditation requirements;

(i) be fiscally responsible in utilization of Hospital resources for care and treatment of patients;

(j) work harmoniously with others, using interpersonal and communication skills to facilitate positive professional relationships with patients, families, and other members of the health care team;

(k) comply with Network safety initiatives;

(l) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two (2) Medical Staff Leaders (or one Medical Staff Leader and the President or VPMA) are concerned about his/her ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations will be determined by the Medical Staff Leaders and the Hospital;

(m) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(n) to cooperate in supplying sufficient information to allow continuing assessment of current competence;

(o) to seek consultation whenever necessary;

(p) to complete in a timely manner all medical and other required records;

(q) to perform all services and to act in a cooperative and professional manner;

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

(s) to satisfy continuing medical education requirements.

7.B.2. Burden of Providing Information:

(a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) The Hospital shall be permitted to rely on the accuracy of any statements made and information submitted by Applicants. Applicants have the burden of providing evidence

that all the statements made and information given on the application are accurate and complete

(c) An application will be complete when all questions on the application form have been answered to the Hospital's satisfaction, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Notification of any change in status or any change in the information provided on the application form will be given to the VPMA or the President of the Medical Staff. This information will be provided with or without request, at the time the change occurs. Failure to provide this information will deem the applicant ineligible for staff membership or clinical privileges. Failure to provide this information as a member will result in automatic relinquishment.

7.B.3. Initial Focused Professional Performance Evaluation (FPPE) Period:

(a) Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

(b) During the FPPE period, the exercise of clinical privileges will be evaluated by the Department Chairman or by a physician(s) designated by the Chair of the Credentials Committee. This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed will be determined by the Credentials Committee.

(c) The duration of the FPPE period for initial appointment and privileges will be typically eight months or as recommended by the Credentials Committee. The duration of the FPPE period for all other initial grants of privileges will be as recommended by the Credentials Committee.

(d) During the FPPE period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the Department Chairman or by other designated physicians.

(e) A newly appointed member will automatically relinquish his or her appointment and privileges at the end of the FPPE period if he or she fails, during the FPPE period, to:

(1) participate in the required number of cases;

(2) cooperate with the monitoring and review conditions; or

(3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two (2) years.

(f) If a member who has been granted additional clinical privileges fails, during the FPPE period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges will be automatically relinquished at the end of the provisional period.

(g) When, based on the evaluation performed during the FPPE period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

7.C. APPLICATION

7.C.1. Information:

Applications for appointment and reappointment will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of these Bylaws. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment as stated in these Bylaws.

7.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The VPMA and President of the Medical Staff will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

7.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the Hospital, Medical Staff Leaders, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

The applicant agrees that the hearing and appeal procedures set forth in these Bylaws will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees

(f) Authorization to Share Information within the Network:

The applicant specifically authorizes the Hospital and its affiliates to share information pertaining to the applicant's clinical competence or professional conduct.

ARTICLE 8

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

8.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

8.A.1. Application:

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

(b) Applications will be provided only to those who are selected by the process established by the Board to satisfy specific mission-related criteria, and who complete and sign an appointment eligibility and/or agreement as required. Others who inquire will be sent a standard letter explaining that no application will be provided. Prospective applicants who have signed agreements when applicable will be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents who have unrestricted licenses or are in the final six (6) months of their training and who have signed employment agreements with the Network. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

8.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office and accompanied by the application fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

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

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

(e) An interview(s) with the applicant may be conducted by one of or a combination of any of the following: the Department Chairman, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, VPMA, or the President.

8.A.3. Department Chairman Procedure:

The Chairman in each Department in which the applicant has requested clinical privileges will review the application and all supporting materials.

8.A.4. Credentials Committee Procedure:

(a) The Credentials Committee will consider review the application and make a recommendation.

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

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee will review the health status information to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require a physical or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination will be made available to the Committee. Failure to undergo an examination within a reasonable time after a written request from the Credentials Committee will be considered a voluntary withdrawal of the application.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health, or clinical issues. The Credentials Committee may also recommend

that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of the applicant's compliance with any conditions.

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

8.A.5. MEC Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MEC will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the MEC is to appoint, the recommendation will be forwarded to the Board.

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

8.A.6. Board Action:

(a) The Board may delegate to a committee, consisting of at least two (2) Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

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

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

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

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

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

(1) grant appointment and clinical privileges as recommended; or

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

(3) disagree with or modify the recommendation.

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

(d) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

8.A.7. Time Periods for Processing:

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

ARTICLE 9

CLINICAL PRIVILEGES

9.A. CLINICAL PRIVILEGES

9.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria.

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

(d) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

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

(7) the Hospital's available resources and personnel;

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

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

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(e) Requests for increased privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

9.A.2. Privilege Waivers:

(a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. This only applies to requests for privileges within the individual's primary specialty.

(b) In limited circumstances, the Hospital may consider a waiver of the requirement that privileges are granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.

(d) The following factors, among others, may be considered in deciding whether to grant a waiver:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(3) the expectations of Medical Staff members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) an undue burden to other members who serve on the call roster in the relevant specialty; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(e) If the Board grants a waiver related to privileges, it will specify the effective date. The Board may revoke a waiver at any time if the circumstances underlying the waiver change.

(f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

9.A.3. Resignation of Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least thirty (30) days from the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the President will act on the request.

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

(a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the privilege have been adopted.

(b) The individual seeking to perform the new procedure will submit a report to the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations.

(d) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

9.A.5. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) The individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals. The Credentials Committee will then conduct additional research and consult with experts, as necessary.

(c) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations.

(d) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

9.A.6. Physicians in Training:

Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the MEC or its designee, and the Graduate Medical Education Committee. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

9.A.7. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chairman, the Credentials Committee, and the MEC.

(b) Individuals applying for telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in these Bylaws, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.

(c) Qualified applicants may be granted telemedicine privileges but will not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

(d) Applications for telemedicine privileges will be processed in accordance with the provisions of these Bylaws in the same manner as for any other applicant, except that the Hospital may use the credentialing information provided by the applicant's primary hospital if that hospital is a Medicare-participating hospital and provides a list of all privileges granted to the practitioner, as well as a signed attestation that the information is complete, accurate, and up-to-date.

(e) Telemedicine privileges, if granted, will be for a period of not more than two (2) years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.

(f) Individuals granted telemedicine privileges will be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations, and peer review activities.

9.B. TEMPORARY CLINICAL PRIVILEGES

9.B.1. Granting of Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the President, upon recommendation of the President of the Medical Staff, to:

(1) applicants for initial appointment whose complete application is pending review by the MEC and Board, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary privileges, an applicant must have demonstrated ability to perform the privileges requested and have had no (1) current or previously successful challenges to licensure or registration or (2) involuntary restriction, reduction, denial, or termination of medical staff membership or clinical privileges at another health care facility;

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

(ii) when necessary to prevent a lack of services in a needed specialty area;

(iii) proctoring; or

(iv) locum tenens for a member of the Medical Staff.

(b) The following verified information will be considered prior to the granting of any temporary privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.

(c) The grant of temporary clinical privileges will not exceed one hundred twenty (120) days. For non-applicants the days need not be consecutive and may be renewed.

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

9.B.2. Termination of Temporary Clinical Privileges:

(a) The granting of temporary privileges is a courtesy and may be terminated for any reason by the President at any time, after consulting with the President of the Medical Staff, the chair of the Credentials Committee, or the Department Chairman. The individual may be afforded an opportunity to refrain from exercising privileges.

(b) The Department Chairman or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

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

9.C. EMERGENCY SITUATIONS

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

(2) In an emergency situation, a member or non-member may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, as determined by the Hospital, the patient will be assigned by the Department Chairman or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

9.D. DISASTER PRIVILEGES

(1) 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.

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

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

(b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) 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; or (v) identification 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.

(3) 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.

(4) 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: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) 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.

(5) 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.

ARTICLE 10

PROCEDURE FOR REAPPOINTMENT

10.A. ELIGIBILITY FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have:

(1) completed all medical records;

(2) completed all continuing medical education requirements;

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

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

(5) paid any applicable reappointment processing fee; and

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

10.B. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section 2.A.3 of these Bylaws will be considered, as will the following additional factors relevant to the member's previous term:

(1) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

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

(3) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(4) any focused professional practice evaluations;

(5) verified complaints received from patients or staff; and

(6) other reasonable indicators of continuing qualifications.

10.C. REAPPOINTMENT APPLICATION

Reappointment shall be handled as follows:

(1) Reappointment will be for a period of not more than two (2) years.

(2) An application for reappointment will be furnished to members at least sixty (60) days prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within thirty (30) days.

(3) Failure to return a completed application within thirty (30) days will result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least thirty (30) days prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(4) Except as provided in paragraph five (5), if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the member's appointment and clinical privileges will expire at the end of the then current term of appointment. However, if the inaction is due to circumstances beyond the applicant's control, and no issues have been raised about the application, the President and Board chair may grant conditional reappointment for a period not to exceed one hundred twenty (120) days to allow for Board action at its next meeting.

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

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

(7) If the Credentials Committee or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made. Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

10.D. CONDITIONAL REAPPOINTMENTS

Conditional reappointments shall be handled as follows:

(1) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement steps such as general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.

(2) A recommendation of a conditional reappointment or for reappointment for a period of less than two (2) years does not, in and of itself, entitle a member to request a hearing or appeal.

(3) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

ARTICLE 11

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVINGMEDICAL STAFF MEMBERS

11.A. COLLEGIAL INTERVENTION

These Bylaws encourage the use of progressive steps by Medical Staff Leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff Leaders and Hospital management, but is not mandatory.

(1) Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:

(a) advising colleagues of applicable policies, such as policies regarding appropriate behavior, quality issues, emergency call obligations, and the timely and adequate completion of medical records;

(b) Following up on any questions or concerns raised about the clinical practice and/or conduct of staff members and proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(2) The relevant Medical Staff Leader(s), in conjunction with the VPMA, may determine whether a matter should be handled in accordance with the code of conduct policy, practitioner health policy, peer review policy or other applicable policy, or should be referred to the MEC.

(3) The relevant Medical Staff Leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

(4) All ongoing and focused professional practice evaluations will be conducted in accordance with the Hospital's peer review policies and procedures. Matters that cannot be appropriately resolved to the Hospital's satisfaction through collegial intervention or through the peer review policy will be referred to the MEC.

11.B. INVESTIGATIONS

11.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the President of the Medical Staff, the Department Chairman, the chair of a standing committee, the VPMA, the President, or the chair of the Board:

(1) clinical competence or clinical practice, including patient care, treatment, or management;

(2) the known or suspected violation of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or

(3) conduct and professional ethics that are considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others as well as conduct with patients

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff member, the matter will be referred to the President of the Medical Staff, the VPMA, or the President.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the MEC.

(d) No action taken pursuant to this section will constitute an investigation.

11.B.2. Initiation of Investigation:

(a) The MEC will review the question, discuss the matter with the individual, if invited, and determine whether to conduct an investigation or direct that the question be handled pursuant to a policy. An investigation will commence only after a determination by the MEC.

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

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

11.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee will not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff.

(b) The President of the Medical Staff will appoint the members of the Investigating Committee consisting of at least three (3) members of the active staff who may also be members of the MEC, including a representative of the affected member's department. The VPMA (or his or her designee) shall be a member of this committee. The Chairman of the member's Department will be excluded from being part of this committee.

(c) The purpose of this Investigating Committee is to review the basis of the action and prepare a factual report to the MEC. The physician will be given the opportunity to take a leave of absence from exercising privileges that may be in question.

(d) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports, and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness, and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(f) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings apply.

(g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the MEC with its findings, conclusions, and recommendations. The Investigating Committee's report shall be confidential and shall not be shared with the subject of the investigation without the Hospital's prior approval.

11.B.4. Recommendation:

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

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring, or consultation;

(5) require additional training or education;

(6) recommend reduction of clinical privileges;

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

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

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

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

(c) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the President, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

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

11.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health or safety of any individual the Network CEO, the President, the President of the Medical Staff, the chairman of the relevant clinical Department, the VPMA, the Board chair, or the MEC is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges

(b) A precautionary suspension or restriction can be imposed at any time following a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, the person(s) considering the suspension will meet with the individual and review the concerns.

(c) Precautionary suspension or restriction will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

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

(e) Within three (3) business days of the imposition of a suspension or restriction, the individual will be provided a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).

11.C.2. MEC Procedure:

(a) The MEC will review the reasons for the precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time, not to exceed 14 days. As part of this review, the individual will be given an opportunity to meet with the MEC or a subgroup of the MEC to discuss the concerns. This meeting is not a hearing and the individual will not have the right to call and examine or cross-examine witnesses. The individual may be accompanied by counsel, who may advise the individual, but counsel will not be permitted to address the MEC. A stenographic reporter will be present to make a record of the meeting.

(b) The individual may propose ways other than precautionary suspension or restriction to protect patients, employees, or the orderly operation of the Hospital.

(c) After considering the reasons for the suspension or restriction and the individual's response, if any, the MEC will determine whether the precautionary suspension or restriction should be continued, modified, or terminated. The MEC will also determine whether to begin an investigation.

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

(e) Upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges.

11.D. AUTOMATIC RELINQUISHMENT

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

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

11.D.2. Action by Government Agency or Insurer;

Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the VPMA or President of the Medical Staff.

(b) An individual's appointment and clinical privileges will be automatically relinquished in the event of a violation of the threshold requirements set forth in Article 7.A.1, without right to hearing or appeal.

(c) Automatic relinquishment will take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.

(d) If the underlying matter leading to automatic relinquishment is resolved within ninety (90) days, the individual may request reinstatement. Failure to resolve the matter within ninety (90) days of the date of relinquishment will result in an automatic resignation from the Medical Staff, without the right to hearing or appeal.

(e) Requests for reinstatement will be reviewed by the relevant Department Chairman, chair of the Credentials Committee, the President of the Medical Staff, the VPMA, and the President. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

11.D.3. Failure to Provide Information:

Appointment and clinical privileges will be deemed to be relinquished upon the occurrence of:

(a) discovery of a misstatement or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and President to be

material and without good cause after considering any written or oral explanation provided by the individual;

(b) failure to notify the President of the Medical Staff or President of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and President to be material and without good cause after considering any written or oral explanation provided by the individual; or

(c) failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Credentials Committee, the Medical Executive Officer, the President, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

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

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a special conference.

(b) Special notice will be given at least three (3) days prior to the conference and will inform the individual that attendance at the conference is mandatory.

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

11.E. LEAVES OF ABSENCE

11.E.1. Initiation:

(a) A leave of absence of up to one (1) year must be requested in writing to the relevant Department Chairman, stating the beginning and ending dates of the leave and the reasons for the leave. Except in extraordinary circumstances, this request will be submitted at least thirty (30) days prior to the anticipated start of the leave.

(b) The VPMA will determine whether a request for a leave of absence will be granted, after consulting with the relevant Department Chairman. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff must report to the relevant Department Chairman anytime they are away from Medical Staff or patient care responsibilities for longer than thirty (30) days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the VPMA, in consultation with the relevant Department Chairman, may trigger an automatic medical leave of absence.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, or where reinstatement is denied for reasons other than professional competence or conduct, the determination will be final, with no recourse to a hearing and appeal.

11.E.2. Duties of Member on Leave:

During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). If completion of medical records is not a precondition of the leave of absence, then all medical records must be completed as soon as reasonably possible. The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

11.E.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant Department Chairman, the chair of the Credentials Committee, the President of the Medical Staff, the VPMA, and the President, and in accordance with the practitioner health policy, if applicable.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have

any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank (or any similar State database) is determined to be required, the individual will be entitled to request a hearing and appeal.

(c) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for appointment.

ARTICLE 12

HEARING AND APPEAL PROCEDURES

12.A. INITIATION OF HEARING

12.A.1. Grounds for Hearing:

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

(1) denial of initial appointment, reappointment, or requested clinical privileges;

(2) revocation of appointment to the Medical Staff or clinical privileges;

(3) suspension of clinical privileges for more than thirty (30) days (other than precautionary suspension);

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

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

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

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

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

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

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse or failure to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

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

(f) precautionary suspension or restriction;

(g) denial of a request for leave of absence, for an extension of a leave, or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(h) determination that an application is incomplete;

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

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, because of an exclusive contract, or Board policy determination pursuant to the Network's Medical Staff Development Plan or otherwise.

12.A.3. Notice of Recommendation:

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

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

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

(c) a copy of this Article.

12.A.4. Request for Hearing:

An individual has thirty (30) days following receipt of the notice to request a hearing, in writing, to the President of the Medical Staff and VPMA, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

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

(a) The President of the Medical Staff and VPMA will schedule the hearing and provide, by special notice, the following:

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

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

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

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

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

12.A.6. Witness List:

(a) At least ten (10) days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

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

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

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

(a) Hearing Panel:

The President of the Medical Staff and VPMA, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three (3) members, but not more than five (5) members, one of whom will be designated as chair.

(2) The Hearing Panel may include any combination of:

(i) Any member of the Medical Staff, or

(ii) physicians, or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(5) The Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing;

(iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter as determined by the President of the Medical Staff and VPMA; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The President of the Medical Staff and VPMA will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) 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;

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

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

(c) Objections:

Any objection to any member of the Hearing Panel, the Hearing Officer, or the Presiding Officer will be made in writing, within ten (10) days of receipt of notice, to the President. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff will be given a reasonable opportunity to comment. The President will rule on the objection and give notice to the parties. The President may request that the Presiding Officer make a recommendation as to the validity of the objection.

12.A.8. Counsel:

The Presiding Officer, and counsel for either party, may be an attorney at law who is licensed to practice, in good standing, in any state.

12.B. PRE-HEARING PROCEDURES

12.B.1. General Procedures:

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

12.B.2. Provision of Relevant Information:

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

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

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

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

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted, as determined by Hospital in its sole discretion); and

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

The provision of this information is not intended to waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten (10) days prior to the pre-hearing conference, unless modified by mutual written agreement of the parties, each party will provide the other party with its proposed exhibits.

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the

individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

12.B.3. Pre-Hearing Conference:

(a) The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference.

(b) All objections to documents or witnesses will be submitted in writing ten (10) days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. In addition:

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

(2) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

(3) It is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half (7.5) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

12.B.4. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing. Any disputes will be resolved by the Presiding Officer.

12.B.5. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.

12.B.6. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(a) the pre-hearing conference will be scheduled at least fourteen (14) days prior to the hearing;

(b) the parties will exchange witness lists and proposed documentary exhibits at least ten (10) days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five (5) days prior to the pre-hearing conference.

12.C. THE HEARING

12.C.1. Failure to Appear:

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

12.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken on oath or affirmation administered by any authorized person. The individual shall not be permitted to otherwise record the hearing.

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

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;

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

(6) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(7) Rebut any evidence; and

(8) Receive written copy of final report/record.

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

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

12.C.4. Order of Presentation:

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

12.C.5. Admissibility of Evidence:

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

12.C.6. Persons to Be Present:

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

12.C.7. Postponements and Extensions:

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

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

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

12.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

12.D.1. Basis of Hearing Panel Recommendation:

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

12.D.2. Deliberations and Recommendation of the Hearing Panel:

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

12.D.3. Disposition of Hearing Panel Report:

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

12.E. APPEAL PROCEDURE

12.E.1. Time for Appeal:

(a) Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten (10) days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

12.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with these Bylaws during the hearing, so as to deny a fair hearing; or

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

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

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

12.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the MEC and Hearing Panel any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten (10) days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

(d) The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel

proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

12.F. BOARD ACTION

12.F.1. Final Decision of the Board:

(a) The Board will take final action within thirty (30) days (unless it has good cause to delay action for a longer period) after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(b) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(c) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the President of the Medical Staff.

(d) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

12.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter. If the Board denies initial appointment, reappointment, or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five (5) years unless the Board provides otherwise.

ARTICLE 13

CONFLICTS OF INTEREST

13.A. Hospital Conflict of Interest Policy.

Compliance with the Hospital's Medical Staff Conflict of Interest Policy is a threshold requirement to Medical Staff membership, as provided in Article 3. Nothing in this Article 13 shall apply to issues raised under such policy.

13.B. Other Potential Conflicts.

When performing a function outlined in these Bylaws, applicable policies, Committee Manual, or the Rules and Regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

13.C. Notice of Potential Conflict

Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the Vice President if the President of the Medical Staff is the person with the potential conflict) or the applicable Department Chairman or committee chair. The President, the President of the of the Medical Staff and/or the applicable Department Chairman, or committee chair will make a final determination as to whether the provisions in this Article should be triggered.

13.D. Assessment of Conflict

The fact that a Department Chairman, committee chair, or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest. The fact that any Medical Staff member chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 14

EMPLOYEES

14.A. Employment Agreement Governs.

Except as provided below, the employment of an individual by the Hospital or an affiliate will be governed by the employment policies and manuals, and the terms of the individual's employment relationship or written contract. To the extent that the employment policies or manuals, or the terms of any applicable employment contract, conflict with these Bylaws, the employment policies, manuals, and descriptions and terms of the individual's employment relationship or written contract will control.

14.B. Processing of Applications.

A request for appointment, reappointment, or clinical privileges, submitted by an applicant or member who is employed by the Hospital or affiliate, will be processed in accordance with the terms of these Bylaws. A report regarding each practitioner's qualifications will be made to Administration or Human Resources (as appropriate) to assist in making employment decisions.

14.C. Concerns about Employees.

If a concern about an employed member's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with these Bylaws, after which a report will be provided to Human Resources.

ARTICLE 15

PHYSICIAN ASSISTANTS, ADVANCED PRACTICE REGISTERED NURSES AND OTHER ALLIED HEALTH PROFESSIONAL STAFF

15.A. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES.

Physician Assistants ("PAs") and Advanced Practice Registered Nurses ("APRNs") are not members of the Medical Staff, but will have applications for clinical privileges processed through the Medical Staff process. The MEC or Board may adopt policies governing the supervision and practice of PAs and APRNs and other Allied Health Professionals such as Psychologists and Medical Podiatrists.

15.B. DEFINITIONS.

15.B.1 "Dependent Allied Professional":

Means 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 supervision of a physician member; (2) are employed by a 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.

15.B.2: "Independent Allied Professional":

Means individuals other than licensed practitioners who: (1) are duly licensed by the appropriate licensing board of the State; (2) are authorized by State 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.

15.B.3: "Medical Associates":

Means 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 these Bylaws.

15.C. CATEGORIES FOR ALLIED PROFESSIONALS.

15.C.1: 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.

15.C.2: 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 Network and APS Affiliate includes APS members without the minimum amount of Network activity to be active members but who provide evidence of satisfactory activity from another acceptable healthcare facility.

15.D. 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 MEC and approved by the Board. Such clinical functions shall be recommended by the MEC 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.

15.E. RIGHTS AND RESPONSIBILITIES.

The MEC 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.

15.F CLINICAL EVALUATION AND ASSIGNMENT TO DEPARTMENT.

Each limited health professional with approved clinical functions shall be assigned to the Department recommended by the MEC 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 MEC and approved by the Board.

ARTICLE 16

AMENDMENTS

16.A. Proposal by Petition.

Amendments to these Bylaws may be proposed by a petition signed by no less than twenty-five percent (25%) of the Voting Staff or by the MEC. All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least fourteen (14) days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the Voting Staff at the meeting.

16.B. Proposal by MEC.

The MEC may present proposed amendments to the Voting Members by mail or electronic ballot, returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast within the twenty-one (21) day time frame from publication. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated. Failure to vote shall be considered an affirmative vote in favor of the amendment to the Bylaws, the Rules and Regulations, or in support of the MEC recommendations for amendments(s).

16.C Clarifying Changes.

The MEC shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression without presenting such amendments to the Medical Staff at large for prior vote; provided that the MEC provides a written update to the Medical Staff of such changes promptly.

16.D. Board Approval.

All amendments shall be effective only after approval by the Board.

16.E. Conference.

If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President within two (2) weeks after receipt of a request for same submitted by the President of the Medical Staff.

16.F. No Secret Ballots.

Secret ballots shall not be permitted in any Medical Staff vote taken under this Article.

ARTICLE 17

OTHER MEDICAL STAFF DOCUMENTS

17.A. Medical Staff Documents.

In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations (collectively known as "Medical Staff Documents") that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice.

17.B. Adoption.

Medical Staff Documents other than the Medical Staff Bylaws may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists

17.C Notice.

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

17.D. Emergency Amendments.

The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Documents 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 members shall have fourteen (14) days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth above shall be implemented.

17.E. Board Approval.

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

ARTICLE 18

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board.

Adopted by the Medical Staff on:

Date: October 5, 2015

Signed by: David M.Yen, M.D.

President of the Medical Staff

Approved by the Board:

Date: October 16, 2015

Signed by: Charles D. Saunders, M.D.

Chair, Board of Trustees

GLOSSARY

The following definitions apply to terms used in these Bylaws:

(a) **"ADMINISTRATION"** means the personnel employed by the Hospital, including the President, who are responsible for carrying out the day to day management of the Hospital s operations, under the authority of the Board.

(b) **"ADVERSELY AFFECTING"** privileges has the meaning defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 et seq. ("HCQIA"), that is, reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or appointment.

(c) **"ALLIED PROFESSIONAL"** 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.

(d) **"APPLICANT"** means any physician, dentist, oral surgeon, or podiatrist who has submitted an application for initial appointment or reappointment to the Medical Staff or for clinical privileges.

(e) **"BOARD"** means the Board of Trustees of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(f) **"BOARD CERTIFICATION"** is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual's area of clinical practice.

(g) **"CEO"** means the President and Chairman Executive Officer of the Network.

(h) **"CHIEF NURSING OFFICER" or "CNO**" means the individual appointed by the Hospital President to act as Chief Nursing Officer.

(i) **"CLINICAL FUNCTIONS"** means the authority recommended by the Medical Staff and approved by the Board to allow an allied professional to provide specific medical and/or other patient care services in the Hospital or the Network.

(j) **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(k) **"COMPLETED APPLICATION"** means that all questions on the application form have been answered to the Hospital's satisfaction, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(l) **"CORE PRIVILEGES"** or **"CORE"** means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(m) **"DAYS"** means calendar days unless otherwise specified.

(n) **"EX OFFICIO"** means by virtue of office or official position and includes full voting privileges unless stated otherwise.

(o) **"HOSPITAL"** means St. Luke's Bethlehem Hospital.

(p) **"HOUSE STAFF"** means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.

(q) **"MEC"** means the Medical Executive Committee of the Medical Staff of the Hospital.

(r) **"MEDICAL PODIATRIST"** means a Podiatrist that is not a Surgical Podiatrist.

(s) **"MEDICAL STAFF"** means all physicians, dentists, oral surgeons and surgical podiatrists who have been appointed to the Medical Staff by the Board.

(t) **"MEDICAL STAFF LEADER"** means any Medical Staff officer, department chairman, or committee chair.

(u) **"NETWORK"** means St. Luke's University Health Network

(v) **"NOTICE"** means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(w) **"PATIENT CONTACTS"** includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(x) **"PEER REVIEW COMMITTEES"** includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

(y) **"PERFORMANCE IMPROVEMENT"** or **"PI"** activities means structured processes by which members and allied health professionals can learn about and apply performance measures over a useful interval and evaluate their performance.

(z) **"PHYSICIAN**" includes both doctors of medicine ("M.D.s"), doctors of osteopathy ("D.O.s"), doctors of Oral, Maxillofacial Surgery ("D.M.D."), and Surgical Podiatrists.

(aa) **"PODIATRIST"** means a doctor of podiatric medicine ("D.P.M."), and includes both Medical Podiatrists and Surgical Podiatrists.

(bb) **"PRESIDENT"** means the individual appointed by the Board to act on its behalf in the overall management of Hospital.

(cc) **"PROFESSIONAL REVIEW ACTION"** has the meaning defined in the HCQIA, that is, an action by the Board or recommendation of the MEC taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual, which conduct affects or could affect adversely the health or welfare of a patient or patients, and which affects (or may affect) adversely the clinical privileges, or appointment, and includes a formal decision of a professional review body not to take an

action or make a recommendation described in the previous sentence, and also includes professional review activities relating to a professional review action.

(dd) **"PROFESSIONAL REVIEW ACTIVITY"** has the meaning defined in the HCQIA, that is, activity to determine whether an individual may be granted, to determine the scope or conditions of, or to change or modify, appointment or clinical privileges. All such activity is also intended to be encompassed within the scope of any applicable federal or state privilege, and includes but is not limited to credentialing, privileging, reappointment, ongoing and focused professional practice evaluations, collegial intervention, performance improvement plans, investigations and hearings.

(ee) **"PSYCHOLOGIST"** means a provider who maintains a current license to provide psychology services by the State.

(ff) **"RESTRICTION"** means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients.

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

(hh) **"SPECIAL PRIVILEGES"** means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.

(ii) **"STATE"** means the state in which the Hospital acute care campus is licensed.

(jj) **"SURGICAL PODIATRIST"** means a Podiatrist that maintains a Board Certification from the American Board of Podiatric Surgery.

(kk) **UNASSIGNED PATIENT"** means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

(ll) **"VOTING STAFF"** means Medical Staff members eligible to vote at Medical Staff meetings (but not including members who are entitled to vote only at committees).

(mm) **"VPMA"** means the Senior Vice President, Medical and Academic Affairs of the Network, or his or her designee.

APPENDIX A

RULES GOVERNING HISTORIES AND PHYSICAL EXAMINATIONS

(1) The medical history shall include the chairman complaint, details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status, relevant past, social and family histories, menstrual and obstetrical history in females, an inventory by body systems, and drug sensitivities/allergic history. The physical examination shall include vital signs and an examination of the head, chest, abdomen and extremities, or shall include a note as to the contraindications for such an examination or valid reasons why the examination was not performed.

(2) A history and physical examination shall be recorded on the patient's chart and signed within twenty-four (24) hours following admission. This report shall reflect a comprehensive current physical assessment by a Medical Staff member or appropriate allied health professional who has been granted privileges or given permission by the Hospital to perform histories or physicals.

(3) If a history and physical examination has been performed within thirty (30) days prior to admission, a durable, legible copy of this report may be used in the patient's Hospital medical record. If the history and physical has been completed prior to admission, the patient must be assessed and the inpatient medical record must be updated at the time of the admission to reflect any changes in the patient's condition since the date of the original history and physical or to state that there have been no changes in the patient's condition. All updates must be timed, dated, and signed.

(4) The medical record shall document a current, thorough physical examination prior to the performance of inpatient surgery. When the history and physical examination is not recorded before a surgical procedure or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the attending practitioner states in writing that an emergency situation exists or that any such delay would be detrimental to the patient.

(5) For outpatient surgery, the history shall include documentation of the indications and symptoms warranting the procedure, listing of the patient's current medications, any existing comorbid conditions and previous surgeries, and social history or conditions which would have an impact on the patient's care upon discharge from the facility

following the procedure. If the history and physical has been completed within thirty (30) days prior to the outpatient surgery, an assessment to update the patient's condition since the date of the original history and physical shall be completed at the time of admission for outpatient surgery, confirming the necessity of the surgery. If there have been no changes, that fact must be noted in the record. Except in emergency situations, all updates must be included in the patient's medical record prior to surgery, with the update note attached.

(6) The history and physical exam shall address whether a patient may be a victim of abuse or neglect or is suffering from an addiction or emotional/behavioral disorder. If the circumstances indicate the presence of such a condition, a full assessment of the condition shall be conducted and documented in the patient's record.

(7) The history and physical exam shall address whether the patient is likely to require restraint or seclusion, any factors that may reduce the likelihood that restraint or seclusion will be necessary, and any preexisting physical or psychological conditions that may cause the patient to experience restraint or seclusion in an adverse way.

(8) In the case of readmission of a patient, all previous records shall be available for use by the attending Medical Staff member

Appendix B

St. Luke's West End Endoscopy Center
Delegated Credentialing Policy

1. The St. Luke's West End Endoscopy Center medical staff is accountable to the Medical Staff of St. Luke's Hospital Allentown and Bethlehem and in turn the St. Luke's Hospital Bethlehem Board of Trustees for the quality of medical care provided to patients and for the ethical conduct and professional practice of its members and other practitioners who have been granted clinical privileges in the Center.

2. The St. Luke's West End Endoscopy Medical Staff will utilize the Bylaws and Rules and Regulations of the St. Luke's University Hospital Medical Staff.

3. Medical Staff requesting privileges at the Center will complete an application and delineation of privileges for the Center in order to comply with the requirements of the Pennsylvania Department of Health. The credentialing process will include a review of the requesting provider's application by the Medical Director of the Center prior to presentation to the Medical Executive Committee of St. Luke's Hospital Allentown and Bethlehem.

4. Privileges granted shall reflect the results of peer review or utilization review specific to ambulatory surgery.

5. St. Luke's West End Endoscopy Center Medical Staff will serve on Medical Staff Committees of St. Luke's Hospital Allentown and Bethlehem as determined by the Endoscopy Center Medical Director and Medical Executive Committee as necessary. At a minimum, a Center Medical Staff member will serve as a member of the GI Performance Improvement Committee.

6. No information exchanged pursuant to this delegated credentialing policy is intended to be a waiver of any privilege.