

**GETTYSBURG HOSPITAL
MEDICAL STAFF
GOVERNING DOCUMENTS**

**Includes Bylaws, Rules & Regulations
Credentialing & Privileging and Corrective
Action & Fair Hearing Plan**

Amended September 29, 2011

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ARTICLE I. GENERAL RESPONSIBILITIES OF MEDICAL STAFF APPOINTEES

1.1 OBLIGATIONS

- 1.1.1 It is the obligation and responsibility of the Medical Staff and of individual Practitioners to participate in the Hospital's Performance Improvement program by:
 - a. evaluating Practitioners and institutional performance;
 - b. ongoing monitoring of patient care practices and enforcement of Medical Staff and Hospital policies;
 - c. evaluating Practitioners' credentials for initial and continuing Medical Staff appointment and for the delineation of clinical privileges or rights to perform patient care services in the Hospital;
 - d. maintaining a continuing education program based in part on needs demonstrated through quality review and evaluation programs;
 - e. maintaining a sound system of utilization review; and actively participating in patient safety programs.
- 1.1.2 to make recommendations to the Hospital Board (Board) regarding appointments and reappointments to the Medical Staff, including Staff category, Department and Division assignments, and clinical privileges or rights to perform patient care services in the Hospital.
- 1.1.3 to assist in the Board planning activities, to assist in identifying community health needs, and to suggest to the Board appropriate institutional policies and programs to meet those needs;
- 1.1.4 to develop, administer, and recommend amendments to these Bylaws, and to exercise the authority granted by them;
- 1.1.5 to assure compliance with these Bylaws, and all other standards, policies and rules of the Staff and the Hospital;
- 1.1.6 to develop, participate in, and monitor Medical Staff educational and training programs;
- 1.1.7 to establish, maintain, and enforce sound professional practices, and to initiate and pursue corrective action when warranted;
- 1.1.8 to maintain a professional attitude, seek continuing education, maintain training, and continue to demonstrate experience, ability, competence and judgment while providing safe, efficient and patient-centered care services;
- 1.1.9 demonstrate a willingness and capability to:

- a. work with and relate to Medical Staff appointees, allied health professionals, Hospital administration, employees, visitors, and the community, in a cooperative and professional manner, and treat all individuals in the Hospital, including but not limited to all patients, employees, volunteers, Medical Staff appointees and allied health professionals, with courtesy, respect, and dignity in order to promote the provision of high quality care;
- b. abide by the Medical Staff Bylaws, and all other standards, policies, and rules of the Staff and the Hospital;
- c. discharge such Hospital, Medical Staff, Department, and committee functions for which he is responsible by appointment, election, or otherwise, and obligations appropriate to his Staff category;
- d. adhere to applicable standards of professional ethics;
- e. provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life;
- f. demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others;
- g. demonstrate interpersonal and communication skills that enable him/her to maintain patient safety, continuity of care and a professional relationship with patients, families, and other members of the healthcare team;
- h. demonstrate an ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices;
- i. demonstrate a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsibly attitude toward patients, his/her profession, and society; and
- j. demonstrate an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize healthcare;
- k. provide updated information related to qualifications and ability to practice;
- l. participate in the development, review, and revision of clinical protocols and pathways pertinent to the individual's specialty, such as those related to national patient safety initiatives and core measures.

ARTICLE II. MEDICAL STAFF STRUCTURE

2.1 MEDICAL STAFF CATEGORIES

The Medical Staff shall be divided into Active Staff, Affiliate Staff, and Honorary Staff, with the following qualifications, prerogatives, and responsibilities:

2.1.1 Active Staff

a. Qualifications

- (1) be located sufficiently close to the Hospital as determined by the Medical Executive Committee and specific to specialty,
- (2) admit or refer to the Hospital (including its clinics and ambulatory centers), or otherwise be involved in the care at the Hospital of at least 20 patients per year. It is the appointee's responsibility to maintain records sufficient to demonstrate his required usage of the Hospital.

b. Prerogatives

- (1) may exercise such clinical privileges as are granted to him;
- (2) may hold office at any level the Medical Staff organization and set on or be the chairman of any Medical Staff committee;
- (3) may vote on all matters presented at general and special meetings of the Medical Staff and of Departments and committees to which he is appointed; and
- (4) may attend Hospital or Medical Staff educational programs.

c. Responsibilities

- (1) must contribute to the organizational and administrative affairs of the Medical Staff, if requested;
- (2) must actively participate in recognized functions of the Medical Staff, including performance improvement and other monitoring activities, supervising initial appointees during their provisional period, and discharging such other Staff functions as may be required from time to time;
- (3) should attend regular and special meetings of the Medical Staff and of Departments and committees to which he is appointed;
- (4) must pay all dues and assessments promptly;
- (5) must participate, unless excused for good cause by the relevant Department chairman and the Vice President, Medical Affairs, and formally approved by the MEC and Board, in on-call schedules developed by the Hospital in order to ensure that patients who require emergency services, and are located on-site at the Hospitals main campus, receive evaluations and treatment necessary to stabilize their emergency medical conditions, without regard to the patient's ability to pay, in compliance with applicable regulatory requirements, including EMTALA. When called, the appointee shall respond within the time established by applicable Hospital or regulatory requirements and, if requested, shall respond in person on-site at the Hospitals main campus;
- (6) after having reached the age of 60, or having been an appointee of the Medical Staff for at least 30 years, the Staff meeting attendance and

payment of dues requirements for appointees of the active category shall be waived.

2.1.2 Affiliate Staff

a. Qualifications

- (1) be located sufficiently close to the Hospital as determined by the Medical Executive Committee and specific to specialty,

b. Prerogatives

- (1) may exercise such clinical privileges as are granted to him;
- (2) may not hold office at any level the Medical Staff organization or be the chairman of any Medical Staff committee;
- (3) may not vote on matters presented at general and special meetings of the Medical Staff or of Departments and committees to which he is appointed, but is encouraged to attend those meetings;
- (4) may attend Hospital or Medical Staff educational programs.

c. Responsibilities

- (1) must pay all dues and assessments promptly;
- (2) must cooperate with Hospital in its maintenance of a record of appointees' Hospital utilization, including inpatient admissions to the Hospital;
- (3) must actively participate in recognized functions of the Medical Staff, including performance improvement and other monitoring activities and discharging such other Staff functions as may be required from time to time.
- (4) after having reached the age of 60, or having been an appointee of the Medical Staff for at least 30 years, the Staff meeting attendance and payment of dues requirements for appointees of the active category shall be waived.

2.1.3 Honorary Staff

a. Qualifications

- (1) An appointee to this category must be a physician or dentist who, immediately prior to seeking appointments to the honorary category, was a member of the Medical Staff in the active or affiliate category, and has voluntarily retired from the active practice of medicine at the Hospital and has permanently relinquished all clinical and admitting privileges.

b. Prerogatives

- (1) may attend meetings of the Medical Staff and Departments to which he is appointed; however, may not vote at such meetings;
- (2) may attend Hospital or Medical Staff educational programs;
- (3) shall pay no dues or assessments.

2.1.4 Executive Staff

a. Qualifications for Executive Staff

An Appointee to this category must be a physician or dentist who is in an executive leadership position within Gettysburg Hospital, e.g., Department Chairman/Vice Chairman, Vice President of Medical Affairs, Chief Executive Officer, or Service Line Medical Director, and whose primary responsibility is not to provide direct patient care to inpatients or outpatients.

b. Prerogatives of Executive Category

An Appointee of this category may:

- (1) hold office at any level of the Medical Staff organization and sit on or be the chairman of any Medical Staff committee;
- (2) vote on all matters presented at general and special meetings of the Medical Staff and of Departments and committees to which he is appointed; and
- (3) attend Hospital or Medical Staff educational programs.

c. Responsibilities of Executive Category

An Appointee to this category must:

- (1) contribute to the organizational and administrative affairs of the Medical Staff, if requested;
- (2) actively participate in recognized functions of the Medical Staff, including Performance Improvement, Patient Safety and Infection Control activities, and discharging such other Staff functions as may be required from time to time; and
- (3) pay all dues and assessments promptly

2.1.4 Physicians in Training

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

b. Any Department wishing to utilize a resident or fellow on a moonlighting basis must establish a policy covering their use, the scope of work and recommended training and experience required for granting privileges. Those recommendations must be approved by the Credentials Committee, the MEC, and the Board.

- c. A resident or fellow working on a moonlighting basis must meet the same criteria as other physicians who apply for appointment to the Medical Staff, with the exception of Board Certification or eligibility. A formal application and appointment process must be followed. The granting of privileges must also adhere to the same process as outlined elsewhere in this Article.
- d. Unless prohibited by Department policy, physicians in training may admit patients to the service of a Medical Staff member who has admitting privileges.
- e. Although listed under “Medical Staff Categories”, physicians in training are not members of the Medical Staff and are not entitled to the Fair Hearing Process.

2.1.5 Allied Health Professionals

- a. General

Allied Health Professionals shall consist of licensed or certified health professionals in the Commonwealth of Pennsylvania other than physicians or dentists, who are not Appointees of the Medical Staff but who, by virtue of their training, experience, and demonstrated competence, are eligible to provide certain patient care services in the Hospital. The types of Allied Health Professionals currently approved by the Board are podiatrists, psychologists, nurse practitioners, physician assistants, certified nurse midwives, and certified registered nurse anesthetists.

- b. Qualifications

- (1) be located sufficiently close to the Hospital as determined by the Medical Executive Committee and specific to specialty,

- c. Prerogatives

- (1) may perform such patient care services as he is legally authorized to perform and as are granted to him (currently Allied Health Professionals are not eligible to admit patients to the Hospital, except for podiatrists, and certified nurse midwives, both of whom are eligible to co-admit patients.);
- (2) may sit on Medical Staff committees, attend meetings of the Medical Staff and section to which he is appointed (but may not vote at the Medical Staff meetings); and
- (3) may attend Hospital or Medical Staff educational programs.

- d. Responsibilities

- (1) must actively participate in recognized functions of the Medical Staff, including Performance Improvement and other monitoring activities and discharge such other Staff functions as may be required from time to time;
- (2) pay all dues and assessments promptly; and
- (3) participate as needed in caring for indigent patients.

e. Sections

(1) Allied Health Professionals shall be organized into sections. The current sections are Podiatry, Psychology, Certified Registered Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. The Medical Staff Departments listed below will have administrative responsibility for the sections, though members of the Section may be delegated the responsibility to aid in the evaluation of credentials of currently approved Allied Health Professionals, the delineation of the scope of permitted activities and the performance of quality assessment and utilization review.

- Podiatry – Department of Surgery
- Psychology – Department of Medicine
- Nurse Practitioner – Department of Attending Physician who provides oversight
- Physician Assistants – Department of Attending Physician who provides oversight
- Certified Nurse Midwives – Department of Surgery, Division of Perinatology
- Certified Nurse Anesthetists – Department of Surgery, Division of Anesthesiology

f. Additional Sections

(1) The Board may from time to time, after consultation with the Medical Executive Committee, approve additional types of Allied Health Professionals and create appropriate Allied Health Professionals Sections.

2.1.6 Professional Assistants

a. General

Professional Assistants shall consist of licensed, certified or otherwise recognized professionals who, by virtue of their training, experience, and demonstrated competence, are eligible to provide certain patient care services in the Hospital. These assistants fall outside the categories of Allied Health Professionals as listed above and could include dental assistants, specialized radiology assistants, specialized surgical assistants, etc., who are not otherwise recognized in the above staff categories

b. Prerogatives

- (1) may perform such patient care services as they are legally authorized to perform and as are granted to them (currently Professional Assistants are not eligible to admit patients to the Hospital).
- (2) may not sit on Medical Staff committees, attend meetings of the Medical Staff or section to which they are appointed; but
- (3) may attend Hospital or Medical Staff educational programs.

- c. Responsibilities
 - (1) must actively participate in performance improvement and other monitoring activities and discharge such other functions as may be required from time to time;
 - (2) will participate as needed in caring for indigent patients; but
 - (3) will not be required to pay dues.

2.2 OFFICERS

2.2.1 Officers of the Medical Staff

- a. The Officers of the Medical Staff shall be the President and Vice President
- b. Other officials of the Medical Staff include Department Chairmen, Division Chiefs, and such other officials as may be selected pursuant to these Bylaws. To the extent that any such official performs any clinical function, he must become and remain an appointee of the Medical Staff. In all events, he is subject to these is Bylaws and all other applicable standards, policies and rules of the Staff and Hospital.

2.2.2 Qualifications

- a. Officers of the Medical Staff must be appointees of the active category at the time of nomination and election and must remain appointees of the active category in good standing during their term of office.
- b. In addition, officers must have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges, may not currently be serving in a similar position at another Hospital, must be willing to faithfully discharge the duties and responsibilities of the position, must be willing to attend continuing education related to Medical Staff leadership and/or credentialing functions prior to or during the term of office, must have demonstrated an ability to work well with others and may not have any financial relationship with any other state-licensed institution that competes with the Hospital or any affiliate.
- c. Failure to maintain such status shall immediately create a vacancy in the office involved.

2.2.3 Nominations

- a. Nominations by Nominating Committee
 - (1) Nominations for Medical Staff officers can be done through a Medical Staff nominating committee which shall consist of two (2) immediate past presidents willing and able to serve, and three Medical Staff appointees of the active category elected by the Staff. These nominating committee appointees shall be elected at the quarterly meeting preceding the annual meeting of the Staff. Nominations can also be submitted from

the floor. The chairman should be chosen by the members of the nominating committee.

- (2) The nominating committee shall convene at least 30 days before the annual meeting of the Medical Staff and shall submit to the President of the Staff one (1) or more qualified nominees for the position of vice president. As soon thereafter, as is reasonably practical, but in any event before the annual meeting of the Staff, the names of such nominees shall be reported to the Staff.

b. Nominations by petition

- (1) Nominations also may be made by petition signed by at least 20% of the appointees of the active category and submitted to the President of the Medical Staff at least 15 days before the annual meeting of the Staff. As soon thereafter, as is reasonably practical, but in any event before the annual meeting of the Staff, the names of these additional nominees shall be reported to the Staff.

c. Nominations by Other Means

- (1) If, before the election, any of the individuals nominated for an office pursuant to the above shall refuse, be disqualified from, or otherwise be unable to accept the nomination, then the Nominating Committee shall submit one (1) more substitute nominee at the annual meeting of the Medical Staff.
- (2) Nominations also shall be accepted from the floor during the annual meeting of the Staff.

d. Selection

- (1) Officers shall be elected every three (3) years at the annual meeting of the Medical Staff.
- (2) Only Appointees of the Active category shall be eligible to vote.
- (3) Voting shall be by written or electronic ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving over fifty percent (50%) of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held at the same meeting between the two (2) candidates receiving the highest number of votes. If there is a single nominee for each office, the ballot may be waived and the nominee may be elected by voice affirmation.

e. Automatic Succession

- (1) The Vice President shall, upon the completion of his term of office in that position, immediately succeed to the office of President.
- (2) Each elected office shall serve a three (3) year term, commencing on the first day following his election. Each officer shall serve until the end of his term and thereafter until a successor is elected, unless he shall sooner resign or be removed from office.

f. Removal of Elected Officers

- (1) Except as otherwise provided, removal of an elected officer of the Medical Staff may be initiated by two-thirds vote of the Appointees of the Active category.
- (2) Removal may be based upon failure to have the qualifications for or to perform the duties of the position held as described in these Bylaws or for other good cause, such as failure to uphold the high standards of Medical Staff officers, failure to follow the Bylaws, policies or ethical behavior deemed necessary to serve as a role model and member in good standing of the Medical Staff.

g. Vacancies in Elected Office

- (1) If there is a vacancy in the office of President, the Vice President shall serve out the remaining term. He then may assume his own three (3) year term as President; provided, however, that his cumulative term as President shall not exceed five (5) consecutive years. If there is a vacancy in the position of Vice President, the vacancy will be filled by a special election at the next quarterly meeting of the Medical Staff that is reasonably practical, from among nominees submitted by the existing Nominating Committee.

h. Stipends for Medical Staff Leaders

- (1) The President and Vice President of the Medical Staff, as well as other key leaders (e.g. Department Chairs, Vice Chairs, Division Chiefs, key Committee chairs, etc.) may be paid an annual stipend as compensation for the administrative services they perform as Medical Staff leaders.
- (2) The amount and funding sources for such compensation shall be determined from time to time by the Medical Executive Committee in conjunction with the Vice President of Medical Affairs and as approved by the Hospital Board of Directors.

i. Duties of Officers

- (1) President

As the principal elected officer of the Medical Staff, the President shall:

- (a) aid in coordinating the activities and concerns of the Hospital Administration and of the nursing and other patient care services with those of the Medical Staff;
- (b) communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the President and the Vice President, Medical Affairs, the Hospital Administration, and other officials of the Staff;
- (c) be responsible, in conjunction with the Vice President, Medical Affairs, for the enforcement of the Medical Staff Bylaws, Policies and Procedures; for implementation of sanctions where indicated; and for the Medical Staff's compliance with

procedural safeguards where corrective action has been requested against a Practitioner;

- (d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;
- (e) serve as Chairman of the Medical Executive Committee, and as an ex officio member on all other Medical Staff committees; and
- (f) perform such additional duties as may be assigned to him by the Medical Executive Committee or the Board.

(2) Vice President

The Vice President shall:

- (a) be responsible for coordinating an annual review of the Medical Staff Bylaws and accompanying manuals, and reporting the results of that review to the Medical Executive Committee;
- (b) supervise the preparation of the annual budget of the Medical Staff;
- (c) serve as a member of the Medical Executive Committee;
- (d) in the absence of the President, or if it is otherwise necessary, assume all the duties and have the authority of the President; and
- (e) gain experience on both the Performance Improvement and Credentials committees during his term as Vice President by participating as a member on each of those committees (e.g. one (1) year on the PI committee and two (2) years on the Credentials committee); and
- (f) perform such additional duties as may be assigned to him by the President, the Medical Executive Committee, or the Board.

(3) Vice President, Medical Affairs

- (a) The Vice President, Medical Affairs (who is an officer of the Hospital) shall be a Physician, appointed by the Board, in consultation with the Medical Executive Committee and representatives of the Medical Staff selected by the Board. The Vice President, Medical Affairs shall serve as a liaison between the Medical Staff and the Hospital and has overall responsibility for medical education and the quality of medical care at the Hospital, all Medical Staff administrative functions, and Medical Staff development.

2.3 MEDICAL STAFF APPOINTEES TO THE BOARD

Medical Staff appointees to the Hospital Board of directors shall be the President of the Medical Staff and 3 other members of the active Medical Staff appointed to staggered terms in accordance with the Hospital bylaws.

2.4 CLINICAL DEPARTMENTS AND DIVISIONS

2.4.1 Organization of Departments

a. General

- (1) The Medical Staff shall be organized into Departments and Divisions, each of which shall have a Chairman or Chief who has the authority, duties, and responsibilities set forth in this Article.
- (2) Each appointee of the Medical Staff shall be assigned to at least one primary Department, but may (upon request) be assigned to and granted clinical privileges in one or more secondary Departments. The Medical Executive Committee shall, after consideration of the recommendations of the Chairpersons of the appropriate Department(s) and the Credentials Committee, recommend the primary Department (and, if requested by the appointee, the secondary Departments) membership assignment for all appointees in accordance with their qualifications.
- (3) Appointees who are assigned to secondary Departments may actively participate in the affairs of the secondary Departments, and shall be permitted to vote, but not hold elected office (in more than one Department) or serve as a Department representative in the secondary Departments.

b. Current Departments and Divisions

- (1) The current Departments, encompassing the following subspecialty Divisions, are as follows:
 - (a) Department of Medicine
 - Division of Emergency Medicine
 - Division of Radiology
 - Division of Pathology
 - Division of Hospitalist Medicine
 - (b) Department of Surgery
 - Division of Perinatology
 - Division of Anesthesia

2.4.2 Assignment to Departments

- a. Each Appointee of the Medical Staff shall be appointed to only one Department.
- b. Appointees may be granted clinical privileges in one or more of the other Departments.
- c. The exercise of clinical privileges within any Department shall be subject to the authority of the Department Chairman.

2.4.3 Functions of Departments

- a. The primary responsibility delegated to each Department is to implement and conduct review and evaluation activities that contribute to the preservation and improvement of the quality, safety, and efficiency of patient care provided in the Department. To carry out this responsibility, each Department shall:

- (1) conduct Performance Improvement and quality of care activities for the purpose of evaluating clinical work performed under its jurisdiction;
- (2) establish guidelines for the granting of clinical privileges and rights to perform patient care services and privileges within the Department and privileges and rights delineation forms for use in the credentialing process, and establish procedures for the submission of the recommendation required, under these Bylaws, regarding the clinical privileges each Appointee or applicant may exercise; provided, however, than any Appointee or applicant may, by the filing of a written request with the Department Chairman and/or the Vice President, Medical Affairs, request that the appropriate Department, Medical Executive Committee and/or Hospital Board conduct a review of any guidelines which are adopted for the granting of clinical privileges and rights to perform patient care services and privileges within the Department;
- (3) conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings of review, evaluations, and monitoring activities;
- (4) monitor, on a continuing and concurrent basis, adherence to Medical Staff and Hospital policies and procedures; requirements for alternate coverage and for consultations; and sound principles of clinical practice;
- (5) coordinate the patient care provided by Department Appointees with nursing and ancillary patient care services and with administrative support services;
- (6) submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning findings of the Department's review, evaluation, and monitoring activities, actions taken thereon, and the results of such actions; recommendations, if warranted, for maintaining and improving the quality of care provided in the Department and Hospital; and such other matters as may be required from time to time by the Medical Executive Committee;
- (7) meet at least quarterly each year for the purpose of receiving, reviewing, and considering patient care review findings and the results of the Department's other review, evaluation, and monitoring activities and of performing or receiving reports on other Department or Staff functions; and
- (8) establish such committees or other mechanisms as are necessary and desirable to perform properly in the functions assigned to it.

- b. While individual Departmental policies are encouraged as long as they do not conflict with the Bylaws of the Medical Staff or Hospital, separate departmental rules and regulations are discouraged, as these are often neither updated to reflect changes in the Bylaws of the Medical Staff or Hospital nor kept current with regulatory requirements.

2.4.4 Department Chairmen, Vice Chairmen, and Division Chiefs

- a. Each Department Chairman, Vice Chairman, and Division Chief shall be an Appointee of the Active category, shall be Board certified in the specialty of that Department or Division (except in areas for which no Board exists or where an exception has been granted by the Gettysburg Hospital Board of Directors), and shall be willing and able to discharge faithfully the functions of his office.

- b. In addition, these leaders must have no past or pending adverse recommendations concerning Medical Staff appointment or clinical privileges, may not currently be serving in a similar position at another Hospital, must be willing to faithfully discharge the duties and responsibilities of the position, must have demonstrated an ability to work well with others and may not have any financial relationship with any other state-licensed institution that competes with the Hospital or any affiliate.
- c. Selection and Appointment
 - (1) Department Chairman
 - (a) the President of the Hospital, in consultation with the Medical Executive Committee, will nominate a candidate for the position of Department Chairman. The candidate's name will be presented to the Board for its final action.
 - (b) The Vice President, Medical Affairs will review the performance of the Department Chairmen, including surveying members of the Department about the operations of the Department. The survey shall be in written form and shall be confidential. The aggregate results of the survey will be shared with the Department Chairman as part of his annual evaluation.
 - (2) Vice Chairman
 - (a) The Department Chairman, after consultation with the members of the Department, will annually nominate a candidate for the position of Vice Chairman. The candidate's name will be presented to the President of the Hospital who will present the recommendation to the Board for its final action.
 - (3) Division Chiefs
 - (a) The Department Chairman, after consultation with the members of the Division, will annually nominate a candidate for the position of Division Chief. The candidate's name will be presented to the President of the Hospital who will present the recommendation to the Board for its final action.
- d. Term of Office
 - (1) Department Chairmen, Vice Chairmen, and Division Chiefs shall be appointed on an annual basis.
- e. Removal from Office
 - (1) The Board may remove a Department Chairman, Vice Chairman or Division chief from office during his term, either by its own initiative after consultation with the Medical Executive Committee, or upon the recommendation of a Department based upon two-thirds of the

Department members eligible to vote upon Departmental matters in the Department involved voting in favor of removal. The vote may be conducted by mail ballot. Removal may be based upon failure to have the qualifications for or to perform the duties of the position held as described in these Bylaws or for other good cause, such as failure to uphold the high standards of Medical Staff officers, failure to follow the Bylaws, policies or ethical behavior deemed necessary to serve as a role model and member in good standing of the Medical Staff

f. Duties

(1) Each Department Chairman shall:

- (a) be accountable to the Medical Executive Committee, the Director of Performance Improvement, the President, the Vice President, Medical Affairs, and the Board for professional and administrative activities within his Department, for the quality and safety of patient care rendered by Appointees of the Department, and for the clinically related activities of the Department including effective conduct of the patient care audit and other quality review, quality control, evaluation and monitoring functions delegated to his Department; and further be accountable for the administratively related activities of the Department unless otherwise provided by the Hospital;
- (b) develop and implement Departmental programs in cooperation with the Vice President, Medical Affairs for ongoing monitoring of practice, credentials review and privileges delineation, medical education, and utilization review and the ongoing assessment and improvement of quality care, treatment and services;
- (c) maintain continuing review and surveillance of the professional performance of all Practitioners in the Department who have delineated clinical privileges, and report regularly thereon to the Vice President, Medical Affairs and to the Medical Executive Committee;
- (d) transmit to the appropriate authorities, as required by these Bylaws his recommendations concerning appointment and classification, reappointment, delineation of clinical privileges, and corrective action with respect to Practitioners in his Department;
- (e) appoint such committees as are necessary to conduct the functions of the Department as specified in this Article and designate a chairman of each such committee;
- (f) enforce the Medical Staff Bylaws and Policies and Procedures, and all other standards, policies, and rules of the Staff and the Hospital, within his Department, including initiating investigations and initiating and pursuing corrective action and ordering consultations to be provided or to be sought, when warranted;
- (g) implement, within his Department, actions taken by the Medical Executive Committee and by the Board;

- (h) participate in every phase of administration of his Department through cooperation with the nursing service and the Hospital Administration in matters affecting patient care including coordination and appropriate integration of interdepartmental and intradepartmental services;
- (i) assist in the preparation of such annual reports, including budgetary planning, pertaining to his Department as may be required by the Medical Executive Committee, the Vice President, Medical Affairs, or the Board;
- (j) recommend to the Staff the criteria for clinical privileges that are relevant to the care provided in the Department;
- (k) assess and recommend to the appropriate Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or Hospital;
- (l) develop and implement policies and procedures that guide and support the provision of care, treatment, and services;
- (m) recommend sufficient numbers of qualified and competent persons to provide care, treatment, and service;
- (n) provide orientation and monitor continuing education of all persons in the Department;
- (o) recommend for space or other resources needed to provide quality patient care services in the Department; and
- (p) perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Vice President, Medical Affairs, the Medical Executive Committee, or the Board.

(2) Each Department Vice Chair shall:

- (a) fulfill all the same duties of Department Chair in the absence of the Chair; and
- (b) perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Vice President, Medical Affairs, the Medical Executive Committee, or the Board.

(3) Each Division Chief shall:

- (a) be responsible to the Chairman of the Department and shall assist the Chairman, when requested, in education, Performance Improvement, credentialing, and other matters as they pertain to the Division of which he is Chief; and
- (b) perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the Vice President, Medical Affairs, the Medical Executive Committee, or the Board.

2.5 COMMITTEES OF THE MEDICAL STAFF

2.5.1 General

a. Categories

- (1) Standing and Special Committees: Standing and Special Committees shall be composed of at least three (3) Appointees of the active category and may include Appointees of other categories; Allied Health Professionals; and representatives from Hospital Administration, nursing services, medical records, pharmaceutical services, social services, and such other Departments as are appropriate. Unless otherwise specifically provided in these Bylaws, the President of the Medical Staff will appoint a committee chairman and oversee the appointment of the individual committee members by the committee chairman. The President, or his designee, shall appoint an administrative representative to serve ex officio on each Standing and Special Committee of the Medical Staff. The President of the Medical Staff and the President, or their designees, shall serve as ex officio members on all Medical Staff committees. Voting on committees is extended to all committee members unless otherwise provided in these Bylaws.
- (2) Ad Hoc Committees: Ad Hoc Committees may be appointed by the President of the Medical Staff as the occasion arises.
- (3) System/Administrative Committees: The active and affiliate Members of the Gettysburg Hospital Medical Staff and Allied Health Professionals may be requested to serve as members or participate in System and Administrative committees (regardless of the names of such committees) that perform one or more of the following functions: Pharmacy and Therapeutics; Infection Control; Tissue and Transfusion Review; Utilization Review; Ethics; Cancer. Although these System and Administrative committees are not Medical Staff Committees, they shall report their activities to the Gettysburg Hospital Performance Improvement Council, Medical Executive Committee, Medical Staff Departments, and other appropriate entities. If appropriate, one or more relevant Departments of the Medical Staff may be requested and delegated with the responsibility to perform any of these functions.

b. Committee Chairmen

- (1) Only Appointees of the Active category shall be eligible to serve as committee chairmen.
- (2) All committee chairmen who act on behalf of the Hospital in professional activities pursuant to the Bylaws are indemnified to the fullest extent permitted by law, as long as they have been approved or appointed by the Board.

c. Term and Prior Removal

- (1) Unless otherwise provided, a Medical Staff committee member (other than one serving ex officio) shall continue as such for one (1) year or thereafter until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving ex officio, may be removed

by a majority vote of the Medical Executive Committee. Removal may be based upon failure to have the qualifications for or to perform the duties of the position held as described in these Bylaws or for other good cause, such as failure to uphold the high standards of Medical Staff officers, failure to follow the Bylaws, policies or ethical behavior deemed necessary to serve as a role model and member in good standing of the Medical Staff.

d. Vacancies

- (1) Unless otherwise specifically provided, vacancies on any Medical Staff committee shall be filled at the discretion of the committee chairman.

e. Meetings

- (1) A Medical Staff committee established to perform one or more of the Staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties.

2.5.2 Medical Executive Committee

a. The Medical Executive Committee shall consist of:

- (1) the President and Vice President of the Medical Staff;
- (2) at the option of each Department, which shall be exercised in July of each year in which there is a vacancy, one (1) Appointee of the active category representing each Division set forth from time to time in these Bylaws.
- (3) the Chairman of each Department set forth from time to time in these Bylaws;
- (4) From time to time, there might be the need for representation on the MEC from a group not identified in these subsets. At the discretion of the MEC, additional members of the Active Staff and/or Allied Health Professional Staff could be added to the MEC to address such required representation; and
- (5) The Vice President, Medical Affairs, the President, the Vice President of Patient Care Services and the Vice President of Operations, all of whom shall serve on an ex officio basis without the right to vote.

b. Duties

- (1) receive and act upon reports and recommendations from the Departments, committees of the Medical Staff, System, and Administrative committees;
- (2) coordinate the activities of and policies adopted by the Medical Staff, Departments, and committees;
- (3) implement the policies of the Medical Staff;
- (4) make recommendations to the Board in matters relating to Medical Staff appointments and reappointments, Staff category, Department and

- Division assignments, clinical privileges, rights to perform patient care services, and corrective action;
- (5) account to the Board for the overall quality and efficiency of patient care in the Hospital;
 - (6) take reasonable steps to maintain professionally ethical conduct and competent clinical performance on the part of Medical Staff Appointees and Allied Health Professionals, including initiating investigations and initiating and pursuing corrective action, when warranted;
 - (7) make recommendations to the President on medico-administrative and Hospital management matters;
 - (8) inform the Medical Staff of the accreditation program and the accreditation status of the Hospital;
 - (9) participate in identifying community health needs and Hospital goals and implementing programs to meet those needs;
 - (10) represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws
 - (11) formulate Medical Staff Policies and Procedures;
 - (12) make such adjustments as may be necessary to the committee structure of the Medical Staff, including altering the membership of committees, creating new committees, eliminating unnecessary committees, and altering the functions of committees (All such changes to the committee structure may go into effect immediately, pending conforming amendment of these Bylaws pursuant to subsection *Amendments*);
 - (13) review the Performance Improvement functions, including:
 - (a) studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, etc;
 - (b) review and approve the Performance Improvement Plans;
 - (c) review summaries of Performance Improvement activities of Department, Service Lines, and committees to determine whether opportunities for improvement exist.
 - (14) coordinate and recommend to the Board guidelines for delineation of clinical privileges and rights to perform patient care services and privileges and rights delineation forms initially developed by the Departments or Allied Health Professional Advisory Committees; and
 - (15) make recommendations, if warranted, to the Medical Staff and the Board, on at least an annual basis, concerning appropriate changes in these Bylaws, and accompanying manuals.

c. Meetings

- (1) The Medical Executive Committee shall meet at least ten (10) times per year and shall maintain a permanent record of its proceedings and actions, these proceedings to be reported to the Medical Staff in a timely fashion. The Medical Executive Committee shall have the right to meet in executive session without the presence of any or all ex-officio members. Any ex-officio members not in attendance shall receive a prompt report on any actions taken by the Medical Executive Committee meeting in executive session.

2.5.3 Credentials Committee

a. Composition

- (1) at least six members of the Active Medical Staff. These members should be experienced leaders who are representative of the Medical Staff in general, and
- (2) one (1) member of the Gettysburg Hospital Board of Directors; and
- (3) the Hospital President and Vice President, Medical Affairs, ex-officio with vote

b. Duties

- (1) review the credentials of all applicants; and
- (2) make recommendations to the Medical Executive Committee relating to Medical Staff appointments and reappointments, category, Department and Division assignments, clinical privileges, and rights to perform patient care services in the Hospital, after considering the recommendations from the Chairman of each Department in which the Practitioner requests or exercises privileges or the right to perform patient care services.

c. Meetings

- (1) The Credentials Committee shall meet as often as necessary to conduct its business, but not less than monthly, unless the Chairman determines that there is no business to be conducted by the committee. The Credentials Committee shall maintain a permanent record of its proceedings and actions, these proceedings to be reported to the Medical Executive Committee in a timely fashion.

2.5.4 BylawsNominating Committee

a. Composition

- (1) at least two (2) Appointees of the active category;
- (2) Vice President of the Medical Staff;
- (3) Vice President, Medical Affairs (ex officio with vote); and
- (4) President of the Hospital (ex officio with vote)

b. Duties

- (1) Conduct an annual review of the Medical Staff Bylaws;
- (2) Submit recommendations to the MEC for changes to the above Bylaws as necessary to reflect appropriate Medical Staff practices;
- (3) Receive and evaluate Staff recommendations regarding changes to Bylaws for submission to the MEC; and
- (4) Periodically review the regulatory agency and government regulations to assure that the Bylaws are in compliance.

- c. Meetings
 - (1) The Bylaws Committee shall meet as often as necessary at the call of its chair, but at least annually.

2.5.5 Medical Records Committee

- a. Composition
 - (1) one (1) Appointee of the active category representing each of the following Departments: Surgery, Medicine, Perinatology, and Emergency Medicine;
 - (2) the Director of Medical Records;
 - (3) a representative from Pharmacy and Nursing;
 - (4) representatives, as appropriate, from other Hospital Departments
- b. Duties
 - (1) exercise review over the pertinence, legibility, and completeness of the medical records documenting the care of patients treated at the Hospital and other System entities; and
 - (2) supervise and appraise the quality of the medical records throughout the System to ensure maintenance of their quality, storage, and accessibility of both inpatient and ambulatory medical records.
- c. Meetings
 - (1) The Medical Records Review Committee shall meet at least on a quarterly basis and maintain a permanent record of its proceedings and actions, these proceedings to be reported to the Medical Executive Committee and other appropriate WellSpan Health entities in a timely fashion.

2.5.6 Infection Control Committee

- a. Composition
 - (1) At least one (1) physician member of the Active Medical Staff from each of the major clinical Departments;
 - (2) the infection control coordinator;
 - (3) a representative each from Hospital administration, nursing services, dietary, the Microbiology section of the laboratory and the operating room, each appointed by the President of the Hospital.
- b. Duties
 - (1) Review infection potentials and make an analysis of actual infection;
 - (2) Recommend corrective and preventative action based on records and reports of infections and infection potential among patients and Hospital personnel;
 - (3) Review and evaluate all aseptic, isolation, and sanitation techniques employed in the Hospital;

- (4) Review infection control in all phases of the Hospital's activities including:
 - (a) the operating room, delivery rooms, recovery rooms, and special care units;
 - (b) sterilization procedures by heat, chemicals, or otherwise;
 - (c) disposal of infectious material;
 - (d) ongoing review of all isolation procedures;
 - (e) prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
 - (f) testing of Hospital personnel for carrier status; and
 - (g) blood procurement, storage, and transfusion procedures.
- (5) review and approved or deny all special infection control studies to be conducted throughout the Hospital;
- (6) Verify required reporting to the state and local health Departments;
- (7) Institute, through its chairman, or his designee, any appropriate control measures or studies when there is reason to believe there may be a danger to any patient or personnel;
- (8) Cooperate with the disaster committee and instituting appropriate safeguards to be in place in the event of a bio terrorism attack affecting the community;
- (9) Act in such related matters as may be assigned to it by the Executive Committee or the Vice President, Medical Affairs; and
- (10) Meet at least bimonthly and keep minutes of all such meetings.

2.5.7 Performance Improvement/Patient Safety Committee

a. Composition

- (1) one (1) physician from each Department of the Medical Staff appointed by the President of the Medical Staff, and may include physician members of the subspecialties;
- (2) an equal number of non-physician members shall be appointed by the President of the Hospital and shall include representatives of nursing services, operations, performance improvement, and others.
- (3) Any person who holds financial interest in the Gettysburg Hospital is not eligible for appointment to the committee.
- (4) No person may participate in the review of any case in which they have been professionally involved.
- (5) The Vice President, Medical Affairs shall also be a member.
- (6) The chairman will be a long-standing member of the committee.
- (7) The Vice-Chairman will be a Hospital employee appointed by the President of the Hospital.

b. Duties

- (1) recommend for approval by the executive committee, a Hospital-wide performance improvement/patient safety plan for maintaining quality patient care within the Hospital. These may include mechanisms to:

- (a) establish systems to identify potential problems in patient care;
 - (b) set priorities for action on problem correction and take the required action;
 - (c) refer priority problems for assessment and corrective action to appropriate Departments or committees;
 - (d) monitor the results of performance improvement activities throughout the Hospital; and
 - (e) coordinate performance improvement activities.
- (2) submit regular confidential reports to the Executive Committee on the quality of medical care provided and on quality improvement activities conducted;
 - (3) ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members;
 - (4) when findings of the assessment process are relevant to an individual Practitioner's performance, determine their use in peer review as outlined in the peer review portion of the Policies and Procedures;
 - (5) provide ongoing monitoring of the performance improvement program by reviewing the quality and appropriateness of patient care provided by each Department, the education of patient and family, the procedures with respect to surgical case review, drug usage evaluation, medical record review, blood usage review, laboratory medicine and pathology, the pharmacy and therapeutics function and any other JCAHO required functions;
 - (6) establish and implement a risk management plan, which shall include, without limitation, procedures to identify major areas of potential clinical risk, criteria for identifying cases with unacceptable risk, and programs to reduce and correct clinical risks identified by risk management activities;
 - (7) perform other related functions delegated to it by the Executive Committee;
 - (8) act in such related matters as may be assigned to it by the Executive Committee or the Vice President, Medical Affairs;
 - (9) function in accordance with the approved utilization review plan of the Gettysburg Hospital as well as any revisions of said plan as may subsequently be approved; and
 - (10) meet at least quarterly and keep minutes of all such meetings.

2.5.8 Pharmacy and Therapeutics Committee

a. Composition

- (1) three physicians to be appointed by the President of the Medical Staff;
- (2) the chief pharmacist;
- (3) a dietitian;
- (4) the infection control coordinator;
- (5) representatives from nursing services and Hospital administration to be appointed by the President of the Hospital.

b. Duties

- (1) assist in the formation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital;
- (2) serve as an advisor group to the Medical Staff and the chief pharmacist on matters pertaining to the choice of available drugs;
- (3) make recommendations concerning drugs to be stocked on the nursing unit and by other services;
- (4) develop and review periodically a formulary or drug list for use in the Hospital;
- (5) prevent unnecessary duplication and stocking of drugs and drugs in combination;
- (6) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
- (7) establish and maintain a mechanism for defining, reviewing, and reporting adverse reactions to drugs, including antibiotics;
- (8) perform clinical antibiotic usage assessment, as well as any statistical prevalence study of antibiotic usage, including review of the prophylactic and therapeutic use of antibiotics for inpatient, ambulatory care patients, and emergency care patients;
- (9) coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics;
- (10) assist the Hospital and Medical Staff committees in the evaluation of drug utilization, drug therapy, adverse drug reactions, and intravenous therapy through a review of medical records; and
- (11) meet as often as necessary but at least quarterly and keep minutes of all such meetings.

2.5.9 Radiation Safety Committee

a. Composition

- (1) at least three Members of the Medical Staff and shall include the radiation safety officer, a pathologist, a Member of the Medical Staff at-large;
- (2) a representative of Hospital administration; and
- (3) other representatives to be appointed in compliance with NRC regulations

b. Duties

- (1) recommend the establishment of rules for nuclear medicine procedures;
- (2) monitor and implementation of establish rules and compliance therewith;
- (3) review proposed therapeutic and diagnostic uses of sealed and unsealed radionuclides;
- (4) perform such information gathering and reporting functions as may be appropriate to discharge its duties;
- (5) develop rules for the use, transport, storage, and disposal of radioactive materials as well as rules governing contact with and discharge of patients receiving therapeutic dosages of unsealed radionuclides and the protection of patients, personnel, and the public during surgery or autopsy performed upon such patients;

- (6) review all proposed diagnostic and therapeutic uses of unsealed radionuclides;
- (7) evaluate the training and experience of Practitioners desiring the award of privileges for the performance of nuclear medicine procedures and make recommendations to the Credentials Committee with respect thereto;
- (8) recommend corrective action in the event of failure of Practitioners or Hospital personnel to observe safety related rules; and
- (9) meet at least every 6 months or more often as is required to conduct its business and keep minutes of all such meetings.

2.5.10 Tissue and Transfusion Committee

a. Composition

- (1) at least one (1) representative of the Pathology Department;
- (2) two (2) representatives from the Department of Surgery representing different surgical specialties;
- (3) two (2) members of the Active Staff at-large;
- (4) a representative of the Hospital Administration;
- (5) additional members may be appointed to the committee by the President of the Medical Staff if such appointment seems warranted.

b. Duties

- (1) review on a monthly basis all surgical cases in which a specimen was removed as well as those in which no specimen was removed;
- (2) study the indications for surgery in all cases in which there is a major discrepancy between the preoperative and postoperative diagnoses;
- (3) prepare written minutes reflecting all evaluations performed and all actions taken as well as the follow-up on all findings;
- (4) perform quarterly review of blood utilization with particular emphasis on the review of blood transfusions which should include the use of whole blood versus component blood elements, the evaluation of each actual or suspected transfusion reaction, the amount of blood requested, the amount used and the amount of wastage;
- (5) prepare blood utilization reports documenting the findings of the committee and all follow-up;
- (6) review the timeliness and completeness of autopsy reports, based on established autopsy criteria; and
- (7) monitor of the Departments review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative (including pathologic) diagnosis. Following the recommendation of the surgical Departments, the Executive Committee may describe a system by which the function of the Performance Improvement Committee, with respect to tissue review, shall be coordinated with Departmental surgical case review.

2.5.11 Peer Review Committee

a. Composition

- (1) Six (6) members of the medical staff leadership comprising Department Chairs/Vice Chairs or Division Chiefs
- (2) Chairman of the Credentials Committee or designee
- (3) Peer Review Coordinator for the Medical Staff
- (4) VPMA or designee
- (5) Optional: Credentialing Coordinator

b. Duties

- (1) Monitor, measure, assess and improve patient care, treatment and services provided by practitioners with privileges,
- (2) Evaluate any case that a Division Chief or Department Chair/Vice Chair identifies, through the initial screen, to present a question in regard to quality or appropriateness of care,
- (3) Review the care of any provider who has had more than one case that, after review, indicates a concern in regard to quality or appropriateness of care to determine if a Focused Professional Practice Evaluation should be initiated,
- (4) Make recommendations to the Credentials Committee regarding any action plan for improvement for any provider who has been placed on a Focused Professional Practice Evaluation, if deemed appropriate, at any time during or upon completion of the FPPE,
- (5) Provide a final report to the Credentials Committee after completion of any FPPE as to the need for additional action or to recommend no action as the case might dictate,
- (6) Provide any other report deemed appropriate to the Credentials Committee or Medical Executive Committee in regard to peer review,
- (7) Maintain current knowledge of Regulatory Requirements as they pertain to peer review,
- (8) Make recommendations for the updating of all policies and procedures to assure best practice and regulatory compliance in regards to peer review

- c. Meetings will be held at least quarterly, or otherwise as needed to conduct the business of the committee.

2.6 MEETINGS OF THE MEDICAL STAFF

2.6.1 Regular Meetings

There will be semi-annual meetings of the Medical Staff, with the annual meeting of the staff held during the month of October. The Medical Executive Committee may authorize the holding of additional regular Medical Staff meetings by resolution. The resolution authorizing such additional meetings shall require notice specifying the date, time, and place for the meeting, and that the meeting can transact any business as may come before it.

2.6.2 Special Meetings

A special meeting of the Medical Staff may be called by the President of the Medical Staff, and will concern itself solely with its stated purpose.

2.6.3 Voting

Only Appointees to the active category shall be eligible to vote at meetings of the Medical Staff unless otherwise stated.

2.6.4 Department and Committee Meetings

- a. Departments and committees shall, by resolution provide the time for holding regular meetings and no notice other than such resolution is required.
- b. Departments shall meet as often as necessary to conduct their business, but not less than quarterly; provided, however, that designated committees or representatives of each Department shall meet at least monthly to conduct the quality review, evaluation, and monitoring activities.

2.6.5 Special Meetings

A special meeting of any Department or committee may be called by the Chairman thereof, and will concern itself solely with its stated purpose.

2.6.6 Executive Session

All Departments and committees of the Hospital may sit in executive session. During this time, all non-members may be excused.

2.6.7 Attendance Requirements

- a. While there are no mandatory attendance requirements for general Medical Staff meetings or Department/Division meetings, it is recommended that members of the Medical Staff attend as many of these meetings as possible.
- b. Because the Medical Executive Committee and Credentials Committee makes final recommendations to the Board on key issues affecting the Hospital and Medical Staff, each member of the Medical Executive Committee and Credentials Committee must attend at least seventy-five percent (75%) of the meetings of that committee each year. Failure to meet these attendance requirements without good cause will result in replacement on those committees.

2.6.8 Special Appearances or Conferences

- a. Whenever a Medical Staff or Department educational program is prompted by a Practitioner's performance, that Practitioner will be notified of the date, time, and place of the program; of the subject matter to be covered; and of its special applicability to the Practitioner's practice. The Practitioner shall be required to attend the educational program, unless excused in advance by the Vice President, Medical Affairs by reason of illness, or medical or personal emergency.

- b. Whenever a pattern of suspected deviation from standard clinical practice is identified, the President of the Medical Staff or the applicable Department Chairman may require the Practitioner to confer with him or with a Standing, Special, or Ad Hoc Committee that is considering the matter. The Practitioner shall be given special notice of this conference at least five (5) days before the conference, including the date, time, and place of the conference and a statement of the issue involved. The Practitioner shall be required to attend the conference, unless excused in advance by the Vice President, Medical Affairs by reason of illness, or medical or personal emergency.
- c. An inability to satisfy the attendance requirements set forth above may be excused by reason of illness, absence from the city, or medical or personal emergency. A Practitioner seeking to be excused from attendance shall notify the Vice President, Medical Affairs of the reason for the absence before the meeting or within twenty-four (24) hours thereafter.

2.6.9 Meeting Procedures

- a. Order of Business and Agenda at General Staff Meetings
 - (1) The order of business at a regular meeting shall be determined by the President of the Medical Staff. The notice will state the date, time, and place of any meeting of the Medical Staff, or of any regular Department or committee meeting not scheduled pursuant to resolution, shall be mailed to each person entitled to be present not less than ten (10) days before the date of such meeting.
 - (2) Alternatively, notice of Department or committee meetings may be given orally not less than five (5) days before the date of the meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.
- b. Minutes
 - (1) Minutes of all meetings shall be prepared by the secretary of the meeting and shall include the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer and approved by the attendees.
 - (2) Minutes of each Department and Medical Staff committee meeting shall be made available to the Appointees of the appropriate Department and committee and shall be provided to the Medical Executive Committee. Minutes of Medical Staff and Medical Executive Committee meetings shall be made available to all Appointees of the Medical Staff and Allied Health Professionals. A permanent file of the minutes of each meeting shall be maintained by the Office of the Vice President, Medical Affairs.
- c. Quorum
 - (1) At a meeting of any Department, or any Medical Staff committee, the members present with voting rights, but no fewer than two (2) Appointees, shall constitute a quorum.

- (2) At a meeting of the Medical Staff, the members present with voting rights, but no fewer than two (2) appointees, shall constitute a quorum. In the event that a quorum is not present at any meeting of the Medical Staff, the matter requiring a vote may be distributed to the Active Staff for electronic, mail, facsimile, telephone or hand-delivery vote.

d. Manner of Action

- (1) Except as otherwise provided in these Bylaws, the action of a majority of those present and voting at meeting at which a quorum is present shall be the action of the group. Action may also be taken without a meeting of a Department or committee by a document setting forth the desired action to be taken and voted upon by each Appointee entitled to vote.

e. Rules of Order

Rules of Order shall not be binding at a Medical Staff meeting or election, but may be used for reference at the discretion of the presiding officer for the meeting.

2.7 ADOPTION AND AMENDMENT

2.7.1 Medical Staff Responsibility

The Medical Staff shall have the responsibility to formulate, adopt, and recommend to the Board, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the adoption and amendment of Medical Staff and accompanying manuals developed to implement various sections of these Bylaws.

2.7.1 Method of Adoption and Amendment

- a. Except where otherwise stated, the following process for amendments to these Bylaws will be as follows:
 - (1) Proposals for changes to the Medical Staff Bylaws can be initiated through any of the following mechanisms:
 - (a) A motion made by the Medical Executive Committee;
 - (b) A motion made by the Bylaws Committee, or
 - (c) Any medical staff member can propose a change to the Bylaws Committee as defined in the Bylaws
 - (d) Any medical staff member may present recommendations directly to the Board relating to proposed amendments to the governing documents, thus bypassing the MEC or overriding a recommendation of the MEC. The method of achieving this is as follows:

1. The presenting party must allow at least 21 days for the active medical staff to review such a proposal
2. There must be at least a two-thirds vote of those members present and voting (or voting through electronic or other means as established elsewhere in these governing documents) in the affirmative on the proposal
3. The proposal, after passing at least a two-thirds vote, must be submitted to the Board through:
 - a. Written or electronic transmission directly to a member of the Board;
 - b. Presentation by the Hospital President;
 - or
 - c. Presented by the Medical Staff President
4. The action by the Board on the proposal will follow the same process it would follow if the proposal was submitted by the MEC

- (2) All proposed changes must be submitted to the Bylaws Committee, except in situation (d) above. The Bylaws Committee will review suggested changes and propose revised language to the Medical Executive Committee for review and comment. Following this review, the Bylaws of the Medical Staff may be adopted, amended, or repealed by the following action:
- (a) At least 21 days before a regular or special meeting for the medical Staff, the Bylaws Committee will make available a copy of the proposed bylaws or amendments thereto, to each member of the Medical Staff.
 - (b) Following the affirmative vote of two-thirds of the Appointees of the Active category present and voting at a duly convened regular or special meeting of the Medical Staff, the bylaws or amendments will be submitted to the Board for consideration and will become final upon their adoption by the Board. (As stated above, Articles IV and V are excluded from this process)

ARTICLE III. APPOINTMENT, REAPPOINTMENT AND DELINEATION OF CLINICAL PRIVILEGES

3.1 APPOINTMENT PROCEDURES

3.1.1 Eligibility Defined

- a. The following threshold criteria must be met before consideration for appointment:
 - (1) A current, unrestricted license to practice in Pennsylvania,
 - (2) Professional liability coverage in the acceptable amount
 - (3) Absence of felony convictions or misdemeanor convictions for

- offenses related to the practice of medicine,
- (4) Completion of a residency program in the specialty listed,
- (5) Board eligibility, certification or recertification in the specialty listed,
- (6) No conviction of Medicare, Medicaid or other federal or state governmental fraud or program abuse,
- (7) No exclusion or preclusion from participation in Medicare, Medicaid or other federal or state governmental health care programs, and
- (8) No adverse professional review action regarding appointment to the Medical Staff or clinical privileges by any health care facility for reasons related to clinical competence or professional conduct.

- b. Gender, race, creed and national origin are not used in making decisions regarding the granting or denying of medical staff membership or of granting privileges.

3.1.2 Application Packet

The application packet shall include the following items for Hospital Applicants - an application form, a privileges request form, a list of requirements for completing the application packet and information on how to view the Medical Staff Bylaws and accompanying manuals.

3.1.3 Application Content

Every applicant must furnish complete information concerning the following:

- a. Postgraduate training, including the name of each institution attended, degrees granted, programs completed, dates attended, and names of practitioners responsible for the applicant's performance;
- b. Copies of all currently valid medical, dental, and other professional licenses or certifications, and Drug Enforcement Administration registration, with the date and number of each;
- c. Specialty or sub-specialty board eligibility, qualification, certification, or recertification status;
- d. Health impairments, if any, affecting the applicant's ability to perform professional and Medical Staff duties fully;
- e. Professional liability insurance coverage as required of all providers in the amount of \$1 million per occurrence and \$3 million aggregate, and information on malpractice claims history and experience (suits, settlements, and judgments pending, made, or concluded) during the past ten (10) years, including the names of present and past insurance carriers;
- f. The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal, or

voluntary relinquishment (by resignation or expiration) of license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state, or national professional organizations; specialty or sub-specialty board eligibility, qualification, or certification; faculty membership at any medical or other professional school; or staff membership status, prerogatives, or clinical privileges or rights to perform patient care services at any other hospital, clinic, or health care institution or organization;

- g. Location of offices, names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; and names and locations of any other hospital, clinic, or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation;
- h. The Department and/or Division to which the applicant is seeking appointment; the Staff category which the applicant is seeking; and the specific clinical privileges or rights to perform patient care services in the Hospital which the applicant is requesting;
- i. Any current felony charges pending against the applicant and any past charges, including their resolution;
- j. Any sanctions of any kind imposed or proposed to be imposed by any federal, state, or third party payer; and
- k. Applicant's acceptance of the scope and extent of the authorization, immunity, and release provisions as set forth in the application form.

3.1.4 Effect of Application

The applicant must sign the application and in so doing:

- a. attests to the correctness and completeness of all information furnished;
- b. authorizes Hospital representatives to consult with and request information or documents from others who have been associated with him or who may have information bearing on his competence, professional ability, ethical character, other qualifications, physical and mental health status, insurance coverage, and/or all other matters included or sought in the application;
- c. consents to Hospital representatives' inspection of all records and documents that may be material to an evaluation of his competence, professional ability, ethical character, other qualifications, physical and mental health status, insurance coverage, and/or all other matters included or sought in the application;
- d. agrees to maintain an ethical practice and to provide continuous care to his patients;

- e. signifies that he has read the current Medical Staff Bylaws, and agrees to abide by their provisions and with all other standards, policies, and rules of the Staff and the Hospital; and
- f. **Grant of Immunity and Authorization to Obtain/Release Information**
By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section, whether or not appointment or clinical privileges are granted, throughout the term of any appointment or reappointment period and thereafter, and as applicable to any third-party inquiries received after the individual leaves the Medical Staff about his tenure at the Hospital.

(1) Immunity:

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

(2) Authorization to Obtain Information from Third Parties:

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

(3) Authorization to Release Information to Third Parties:

The individual 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 agents when information is requested in

order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

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

(5) Legal Actions:

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

3.1.5 Processing the Application

a. Application Packet

Upon request and receipt of the non-refundable application fee, the amount of which will be set from time to time by the Vice President, Medical Affairs, eligible applicants will be given an application packet, as defined previously. Providing all necessary documentation is received by the Medical Staff Office from the applicant upon the initial request for application, processing and approval/denial of the application should be accomplished within four months.

b. Additional Documentation

Documentation necessary to complete an application shall consist of the following (it is the applicant's responsibility to provide all of the following documentation, or to see that it is provided. Until all of the following documentation is received, the application will not be processed further):

- (1) A completed, signed application form and privileges request form;
- (2) A copy of the applicant's current license in the Commonwealth of Pennsylvania and, where applicable, his DEA number and certificate;
- (3) A copy of the applicant's current professional liability insurance policy in the minimum amount required;
- (4) Copies of certifications and letters confirming completion of an approved residency/training program or other educational curriculum;
- (5) Verification (copies of certificates or copy of letter from appropriate specialty board) of board status (i.e., board qualification, eligibility, or certification); and
- (6) Three (3) letters of recommendation sent directly to the Vice President, Medical Affairs from persons who have recently worked with the applicant and directly observed his professional performance for at least one (1) year and who can and will

provide reliable information regarding current clinical ability, judgment, ethical character, and ability to work with others. (References must be from individuals practicing in a field similar to the applicant.)

- (7) A signed “Disclosure and authorization to obtain Criminal Background Reports.”
- (8) For Allied Health Professionals, copies of current collaborative or supervisory agreements as required by Pennsylvania law.

3.1.6 Letter of Acknowledgement

Upon receipt of a completed and signed application form, the applicant will be sent a letter of acknowledgment by the office of the Vice President, Medical Affairs or designee. The letter of acknowledgment will detail any remaining documentation that must be submitted to complete the application as set forth above.

3.1.7 Verification and Additional Information

- a. Upon receipt of a completed and signed application form and supporting documentation as set forth above, the office of the Vice President, Medical Affairs, or designee will seek to verify the application’s contents and collect additional information as follows:
 - (1) Information from past insurance carriers concerning malpractice claims history and experience (suits, settlements, and judgments pending, made, or concluded) during the past ten (10) years;
 - (2) Completed references from all past practice settings;
 - (3) Sufficient information documenting the applicant’s clinical work, in acceptable form, to enable the applicant to be privileged;
 - (4) Verification of licensure status in all current and past states of licensure; and
 - (5) A criminal background check will be performed for all new applicants to the medical staff. If any of the following are discovered, the practitioner may be ineligible for appointment to the Medical Staff:
 - (a) any conviction of, or plea of guilty or no contest to, or received probation without verdict, disposition in lieu of trial or an Accelerated Rehabilitative Disposition in the disposition of, any felony charge, or any misdemeanor charge related to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence, or moral turpitude;
 - (b) An ACT 73 background check will be performed for all new applicants to the medical staff with significant likelihood of regular contact with children in the form of care, guidance, supervision, or training;
 - (6) Any other information required by applicable state or federal law or regulations -- e.g., obtaining reports from the National

Practitioner Data Bank, and confirmation of the Cumulative Sanctions List maintained by the Office of the Inspector General of the Department of Health and Human Services.

b. Burden of Providing Information

- (1) Individuals seeking appointment and reappointment 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.
- (2) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (3) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (4) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

3.1.8 Telephone Follow-Up

The Vice President, Medical Affairs, or his designee, may solicit additional information from each hospital, clinic, or health care institution or organization at which the applicant was a member of the staff or exercised clinical privileges or rights to perform patient care services during the past ten (10) years.

3.1.9 Summary

With the completion of the applicant's file, (i.e., all documentation listed above has been received); the file will then be presented to the appropriate Department Chairman (men).

3.1.10 Interview

The Department Chairman, or his designee, may, at their discretion, interview the applicant and document the results of the interview. A copy of the interview documentation will be placed in the applicant's file. The Credentials Committee, at its discretion, may also choose to interview new candidates to the medical staff.

3.1.11 Assignment of the Review Process

Upon completion of the applicant's file, the Vice President, Medical Affairs, the relevant Department Chairman and the Chairman of the Credentials Committee (following review of the applicant by the full Credentials Committee) or, in the event of the unavailability

of any of them, their designees, shall assign the applicant to either an expedited review or full review process, depending upon the extent to which the applicant has clearly demonstrated his qualifications for Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services:

3.2 EXPEDITED REVIEW PROCESS

Determinations of an applicant's eligibility for expedited review shall be based on the applicant meeting criteria for expedited review, which have been approved by the Medical Executive Committee. Privileges may be granted only when available information reasonably shows that the requesting Practitioner has the qualifications to exercise the privileges requested including a valid and unrestricted license to practice in the Commonwealth of Pennsylvania, has not had any current or previously successful challenge to licensure or registration, any involuntary termination of Medical Staff membership at another organization, or any involuntary limitation, reduction, denial or loss of clinical privileges at another organization, and only after the Practitioner has satisfied the professional liability insurance requirements set forth in these Bylaws. The determination that an applicant is not eligible for expedited review should not be viewed as an indication that the applicant is unqualified, and shall not be deemed an "adverse event" as defined in Section 6.2.4. In general, expedited review is only for those applicants who, upon a thorough review of their application file and a personal interview, have clearly demonstrated their qualifications for Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services, as requested, without any unresolved questions or issues.

- a. **Approval:** An applicant will be recommended for approval for Medical Staff Appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services, as requested, upon review and signed recommendation for approval by the relevant Department Chairman, the Chairman of the Credentials Committee (or designee) and the Medical Executive Committee. After obtaining these recommendations for approval, the Hospital Board or a subcommittee of the Board consisting of at least two members will review the recommendation for Appointment and privileges requested. The Board or the Board subcommittee may adopt or reject in whole or in part these recommendations. Action by the Board or the Board subcommittee will be handled in the manner described above.
- b. **Non-Approval:** If the relevant Department Chairman, the Chairman of the Credentials Committee (or designee) or the Medical Executive Committee do not give their signed approval of the applicant under the expedited review process, for any reason, the application shall be referred to the Vice President, Medical Affairs for review under the full review process, as described below.

3.3 FULL REVIEW PROCESS

3.3.1 Department/Division Action

- a. **Department Chairman:** The Chairman of each Department in which the applicant seeks clinical privileges or rights to perform patient care services shall review the application and its supporting documentation and forward to the Credentials

Committee a written report evaluating the applicant's training, experience, demonstrated ability, competence, and judgment, and stating how the applicant's skills are expected to contribute to the clinical and educational activities of the Department. In connection with his report, the Department Chairman may make telephone calls to solicit additional information from the applicant's past practice settings. The Chairman will consult with the appropriate Division Chief on these matters prior to issuing his appraisal of qualifications for the privileges requested, including any recommendations on limitations and scope.

- b. Vice President – Patient Care Services (or designee): The application for all Advanced Practice Nurses (CRNA, CRNP, CNM) is forwarded by the Chairman of the appropriate department to the Vice President – Patient Care Services. The Vice President – Patient Care Services reviews the application, support documentation, references and recommendation from the department chair, and will consult with the department chair if there are any areas of concern identified from the professional nursing practice perspective. The Vice President – Patient Care Services then submits signature of approval and forwards to Credentials Committee for action.
- c. Alternative Process: If the Vice President, Medical Affairs, after approval of the Credentials Committee, considers it appropriate to use an outside consultant (i.e., one with no affiliations to the Hospital or its Medical Staff) as a replacement for the Department Chairman and/or Division Chief in the appointment process, the Vice President, Medical Affairs may do so.

3.3.2 Credentials Committee Action

The Credentials Committee shall review the application, the supporting documentation, the reports from the Department Chairman and Division Chief or outside consultant (if any), and any other relevant information available to it. The Credentials Committee then shall transmit to the Medical Executive Committee the written report of the Credentials Committee and recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services. If the Credentials Committee requires further information about an applicant, it may defer transmitting its report, and it shall seek, from relevant sources, the required additional information.

3.3.3 Medical Executive Committee Action

As soon after receipt of the Credentials Committee recommendation as is reasonably practical, the Medical Executive Committee shall review the application, the supporting documentation, the reports and recommendations from the Department Chairman, Division Chief, outside consultant (if any), and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee shall either defer action on the application or prepare a written report with recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services.

3.3.4 Effect of Medical Executive Committee Action

- a. Deferral: Action by the Medical Executive Committee to defer an application for further consideration must be followed, as soon as is reasonably practical, by subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services.
- b. Favorable Recommendation: When the Medical Executive Committee's recommendation is favorable to the applicant as to approval of Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services, the Vice President, Medical Affairs shall promptly forward it, together with all supporting documentation, to the Board. "All supporting documentation" means the completed application packet and the reports and recommendations of the Department Chairman, Division Chief, outside consultant (if any), Credentials Committee, and Medical Executive Committee, including the existence of any dissenting views.
- c. Adverse Recommendation: When the Medical Executive Committee's recommendation is adverse to the applicant as defined in Section 6.2.4, the Vice President, Medical Affairs shall so inform the applicant by special notice, and the applicant shall then be entitled to the procedural rights as provided in the Corrective Action Procedures and Fair Hearing Plan.

3.3.5 Board Action

- a. On a Favorable Recommendation: The Board may adopt or reject in whole or in part a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Board is effective as its final decision. If, after a favorable recommendation of the Medical Executive Committee, the Board's action is adverse to the applicant, the Vice President, Medical Affairs shall promptly so inform the applicant by special notice, and he shall then be entitled to the procedural rights as provided in Article VI, Corrective Action Procedures and Fair Hearing Plan.

3.3.6 Basis for Recommendations and Actions

The report of each individual or group, including the Board, required to act on an application must state the reasons for each recommendation or action taken. The existence of any dissenting views at any point in the process must also be noted in the majority report.

3.3.7 Conflict Resolution

Whenever the Board determines that it will decide a matter contrary to the latest recommendation of the Medical Executive Committee, if any, the matter shall be resolved pursuant to the procedure outlined in Section 5.9 regarding Appellate rights.

3.3.8 Notice of Final Decision

- a. The Vice President, Medical Affairs shall give the applicant written notice of the Board's final decision, with copies to the President of the Medical Staff, and to the Department Chairman of each Department concerned.
- b. A decision and notice to appoint shall include:
 - (1) the Staff category to which the applicant is appointed;
 - (2) the Department and Division to which he is assigned;
 - (3) the clinical privileges or rights to perform patient care services he may exercise; an
 - (4) any special conditions attached to the appointment.

3.4 DELEGATED CREDENTIALING PROCESS

The credentialing and privileging processes for contracted telemedicine providers will differ in the following ways:

- a. Pre-application form requests, letters of acknowledgement, and notices of final decision will not be required or included.
- b. All medical staff dues and fees are waived.
- c. Individuals applying for telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in this Article, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.
- d. Applications for telemedicine privileges will be processed in accordance with the provisions of this Article in the same manner as for any other applicant, except that the Hospital may utilize 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. Once the telemedicine services begin, the Hospital shall provide, when available, information relevant to assessing the quality of care, treatment, and services provided to the telemedicine organization. Minimally, the information provided shall include sentinel events, and complaints received from patients, licensed independent practitioners, and staff at the Hospital.
- f. CMS has granted permission to use the distant site telemedicine entity's credentialing and privileging decisions when making recommendations to hospital's governing body on whether or not to issue privileges to each telemedicine physician. Credentialing Committee will utilize the distant telemedicine privileging, however we will continue review all documentation prior to making recommendation for appointment.

3.5 TEMPORARY PRIVILEGES

3.5.1 Granting of Temporary Privileges

- a. Temporary privileges of no more than one hundred twenty (120) days in length will be granted only in rare and extraordinary circumstances and may be granted only in the circumstances described below. Temporary privileges may be granted only when available information reasonably shows that the requesting Practitioner has the qualifications to exercise the privileges requested including a valid and unrestricted license to practice in the Commonwealth of Pennsylvania, has not had any current or previously successful challenge to licensure or registration, any involuntary termination of Medical Staff membership at another organization, or any involuntary limitation, reduction, denial or loss of clinical privileges at another organization; and only after the Practitioner has satisfied the professional liability insurance requirements set forth in these Bylaws. Individual requirements of consultation and reporting may be imposed by the Department Chairman responsible for supervision. Temporary privileges will not be granted unless the Practitioner has agreed in writing to abide by these Bylaws and accompanying manuals, and all other standards policies and rules of the Staff and the Hospital, in all matters relating to his temporary privileges.
- b. Circumstances
 - (1) Upon written concurrence of the Chairman of the Department were the privileges will be exercised, and upon recommendation of the President of the Medical Staff, the President of the Hospital or designee may grant temporary privileges or rights to perform patient care services in the following circumstances:
 - (a) Pendency of Application: after receipt of an application for appointment to the Medical Staff for clinical privileges, or for rights to perform patient care services in the Hospital, which application includes a request for specific temporary privileges and does not raise any concern regarding competency or qualifications, for an initial period of up to ninety (90) days, with subsequent renewals not to exceed a total of one hundred twenty (120) days. (The Hospital will not routinely grant temporary privileges to Practitioners during the pendency of their applications; it is the responsibility of each Practitioner to fill his application sufficiently in advance of his contemplated practice at the Hospital so that the application can be fully processed by that time.);
 - (b) Care of Specific Patients: upon receipt of a request, either written or via telephone, for specific temporary privileges to fulfill an important patient care, treatment, or service need for one or more specific patients from a physician, dentist, or Allied Health Professional who is not an applicant for appointment to the Medical Staff;
 - (c) Locum Tenens: upon receipt of a written request for specific temporary privileges from a physician or dentist who is servicing as a locum tenens for an Appointee of the Medical Staff but is not applying for appointment to

the Staff, for a period not to exceed one hundred twenty (120) consecutive days. (Locum tenens privileges are limited to treatment of the patients of the Staff Appointee for whom the applying physician or dentist is serving as locum tenens and do not entitle him to admit his own patients to the Hospital); and

- (d) Physicians in training
- (e) Proctoring: if a physician from outside the WellSpan system is requested to come into the Gettysburg Hospital for the purpose of proctoring a physician's first procedures, that physician must be granted temporary privileges prior to the day of the procedure. The following credentialing process should be followed:
 - a. Temporary privileges for a proctor must include documentation to reasonably show that the practitioner has the qualifications to provide the supervision required for the new procedure.
 - b. The Gettysburg Hospital credentialing office should obtain, at a minimum, copies of the following documents prior to approval of temporary privileges for a proctoring physician: a current Pennsylvania license, DEA, proof of malpractice coverage that satisfies the professional liability insurance requirements set forth by the State of Pennsylvania, and a letter from the physician's primary hospital stating they are in good standing at that facility and have been approved to do the procedure they will be coming to this hospital to supervise.
 - c. The Gettysburg Hospital credentialing office should obtain primary source Internet verification of the independent practitioner's Pennsylvania license, Medichex List Search (OMAP), Excluded Parties List System (EPLS), and the Office of the Inspector General (OIG).

c. Revocation

The Vice President, Medical Affairs, after consultations with the President of the Medical Staff and the appropriate Department Chairman must, on the discovery of any information which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and may at any other time, revoke any or all of a Practitioner's temporary privileges. Where determined to be in imminent danger to the health of any individuals, the revocation may be affected by any person entitled to impose Precautionary Suspension as defined in Article VI, Corrective Action Procedures and Fair Hearing Plan. In the event of any revocation of temporary privileges, the Practitioner's patients then in the Hospital will be assigned to another Practitioner by the appropriate Department Chairman or his designee. If the Practitioner is a member of a group practice, his patients will be assigned to

another member of his group if possible. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

d. Rights of Practitioners with Temporary Privileges

A Practitioner is not entitled to the procedural right afforded by these Bylaws and accompanying manuals including, but not limited to a fair hearing, in the event his request for temporary privileges is refused or all or any part of this temporary privileges are revoked or suspended.

3.6 EMERGENCY PRIVILEGES

In case of an emergency which could result in serious harm to a patient, or in which the life of a patient is in immediate danger, any Medical Staff Appointee or Practitioner who has the right to perform patient care services in the Hospital is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, but regardless of Department or Division affiliation, category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance considered necessary and to arrange appropriate follow-up care.

3.7 DISASTER PRIVILEGES

3.7.1 For purposes of this Section, a disaster is defined as a natural or manmade event that significantly disrupts the environment of care, significantly disrupts care, treatment, and services, or that results in sudden, significantly changed, or increased demands for the Hospital's services, or a situation in which there is immediate danger of loss of life or a permanent or serious disability and in which any delay in treatment might increase that danger. Disaster is further defined as a natural disaster, national emergency, bioterrorism, act of war, or other similar mass emergency. Following activation of the Hospital emergency management plan or following a disaster in which the treatment of patients on an emergent basis requires the assistance of medical practitioners who are not members of the Medical Staff, the President of the Medical Staff, the Chief Executive Officer, or their designees, may grant disaster privileges to a medical practitioner whose skills and services are necessary to treat Hospital patients. Prior to granting disaster privileges to any medical practitioner that is not on the Medical Staff, the Chief Executive Officer, the President of the Medical Staff, or their designee, may grant disaster privileges upon presentation of a valid government-issued photo identification issued by a federal or state agency AND one of the following:

- (a) A current picture hospital ID card that clearly identifies professional designation
- (b) A current license to practice
- (c) Primary source verification of the license
- (d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corp (MRC), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group
- (e) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by federal, state, or municipal entity)

- (f) Identification by a current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster
- 3.7.2 Verification shall take place as soon as the immediate situation is under control, and is typically completed within 72 hours from the time the volunteer practitioner presents to the organization. When the situation does not permit verification to occur within 72 hours, there must be documentation explaining why primary verification was not completed, with evidence of the practitioner's demonstrated abilities.
- 3.7.3 The medical staff is responsible for oversight of the volunteer practitioner through direct observation, mentoring, and record review, when necessary. Based on preliminary information of the volunteer practitioner's professional practice through observation, the VPMA or his designee makes a decision within 72 hours whether the disaster privileges initially granted are continued.
- 3.7.4 The Vice President, Medical Affairs may rely on telephone or electronic verification by the appropriate entity. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or in the event the Practitioner does not desire to request such privileges, the patient shall be referred by the Practitioner or, in the default thereof, by the Vice President, Medical Affairs, to another Practitioner who has been awarded appropriate privileges to provide the care required.

3.8 CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD

- 3.8.1 Successful Conclusion
 - a. Department Chairman

Sixty (60) days before the end of a Practitioner's provisional period, the office of the Vice President, Medical Affairs, through the credentialing office, shall notify the Chairman in each Department in which the Practitioner was granted clinical privileges or rights to perform patient care services, by written notice, of the date the Practitioner's provisional period ends. The applicable Department Chairman shall, at least thirty (30) days before the end of the Practitioner's provisional period, submit an appraisal of the continued qualifications for the privileges requested to the Credentials Committee for review. This appraisal will be based upon input from all appropriate sources including the results of the Focused Professional Practice Evaluation.

- b. Action Required

The Credentials Committee shall consider the appraisal of the Department Chairman and shall make a recommendation to the Medical Executive Committee, which shall in turn consider the recommendations of the Department Chairman and the Credentials Committee and make a recommendation to the Board. Final processing shall follow the procedures set forth in Section 3.2.

- 3.8.2 Extension of Provisional Period

If the Department Chairman's appraisal does not support advancement from provisional status because the Practitioner's caseload at the Hospital was inadequate to demonstrate ability to exercise the privileges or rights granted to him or because the Practitioner failed to abide by the Medical Staff Bylaws and and/or the specific of any Department to which he is appointed or granted clinical privileges or rights to perform patient care services, and the Practitioner submits to the Credentials Committee a statement to this effect describing his case load and signed by the applicable Department Chairman, the Practitioner's provisional period may be extended for one (1) additional year by approval of the Credentials Committee, the Medical Executive Committee and the Board. Only one (1) such extension is permissible. Failure to complete successfully the provisional appointment will result in a forfeiture of the Practitioner's Staff appointment, clinical privileges, or rights to perform patient care services in the Hospital.

3.9 REAPPOINTMENT PROCEDURES

3.9.1 Information Collection and Verification

a. From Practitioners

- (1) At least three (3) months before the expiration of a Medical Staff appointment, the Vice President, Medical Affairs or designee shall notify each Practitioner of the date of expiration and provide him with a form seeking information for reappointment. At least sixty (60) days before the expiration of his appointment (unless the Medical Executive Committee grants an extension of no more than thirty (30) days), each Practitioner shall complete the reappointment form and furnish at least the following:
 - (a) complete information to update the Practitioner's credentials file on items listed in his original application;
 - (b) proof of continuing training and education external to the Hospital during the preceding period and in accordance with all requirements mandated by the applicable licensing board (although, a first-year, provisional physician who was a resident in a training program the year before appointment to the Gettysburg Hospital Medical Staff will not be required to provide CME credit information at their first reappointment);
 - (c) specific requests for clinical privileges or rights to perform patient care services sought on reappointment, with any basis for requested changes;
 - (d) any requests for changes in staff category or Department or Division assignment; and
 - (e) the names and locations of any other hospital, clinic, or health care institution or organization where the Practitioner provides or provided clinical services, with the inclusive dates of each application.

- (2) Failure, without good cause, to provide this information shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic relinquishment of appointment at the expiration of the term, without any procedural rights. Appointees of the Honorary category are exempted from the requirement of completing reappointment forms. The Vice President, Medical Affairs shall verify the additional information provided, and shall notify the practitioner of any information inadequacies or verification problems. The Practitioner then has the burden of producing adequate information and resolving any doubts about the data.
- (3) As a condition of consideration for reappointment, and as a condition of continued appointment, every applicant and appointee specifically agrees to the following:
 - (a) to inform the President of the Hospital and the President of the Medical Staff of any change in the practitioner's status or any change in the information provided on the application or reapplication form. This information will be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction;
 - (b) if there is any misstatement or misrepresentation in, or omission from, the application or reapplication, the Hospital may stop processing the application or, if appointment has been granted prior to the discovery of a misstatement, misrepresentation, or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal;
 - (c) comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance; and
 - (d) comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff

leadership, or clearly document the clinical reasons for variance.

b. From Internal and External Sources

The Vice President, Medical Affairs also shall collect from the Practitioner's credentials file and other relevant sources information regarding the Practitioner's professional and collegial activities and performance and conduct in the Hospital and at any other hospital, clinic, or health care institution or organization where the practitioner provides or provided clinical services. Such information shall include but not be limited to patterns of care as demonstrated in findings of quality assurance activities; continuing education activities; attendance at required Medical Staff and Department meetings; service on Medical Staff, Department, and Hospital committees; timely and accurate completion of medical records; and compliance with the Medical Staff Bylaws and accompanying manuals, and all other standards, policies, and rules of the Medical Staff and the Hospital. All of these areas of continued competency are assessed in the Ongoing Professional Practice Evaluation (OPPE) conducted throughout the year and shared on a semi-annual basis with all practitioners.

c. Other Information

- (1) The Vice President, Medical Affairs also shall collect any other information required by applicable state or federal law or regulations -- e.g., National Practitioner Data Bank reports or confirmation of the Office of Inspector General Cumulative Sanctions List.
- (2) At the time of reappointment or at any other time during any period of appointment, the Vice President, Medical Affairs may require that a criminal background report be performed if deemed to be reasonably necessary based upon the circumstances. If any of the following are discovered, the practitioner may be ineligible for reappointment to the Medical Staff, and may be subject to removal from the Medical Staff.
 - (a) any conviction of, or plea of guilty or no contest to, or received probation without verdict, disposition in lieu of trial or an Accelerated Rehabilitative Disposition in the disposition of, any felon charge, or any misdemeanor charge related to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence, or moral turpitude.

3.9.2 Assignment of Review Process

Upon collection and verification of all relevant information regarding an applicant for reappointment, the Vice President, Medical Affairs, the relevant Department Chairman and the Chairman of the Credentials Committee (following review of the applicant by the full Credentials Committee), or, in the event of the unavailability of any of them, their designees, shall assign the demonstrated his qualifications for reappointment to the Medical Staff, category of Staff affiliation, and clinical privileges or rights to perform patient care services.

3.10 REQUEST FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

3.10.1 Modification of Membership Status

A Practitioner, either in connection with reappointment or at any other time, may request modification of his Staff category or Department or Division assignment by submitting a written request to the appropriate Department Chairman. A request for such a modification shall be processed according to the procedures set forth in Sections 3.2 and 3.3 above.

3.10.2 Modification of Privileges

- a. The Hospital utilizes “core” privileges to identify those privileges deemed to be either a routine part of the competency of physicians who have completed a residency program in a specialty area, or are general enough to be considered basic knowledge of all providers. “Special” privileges, on the other hand, are those privileges deemed to require additional training or competency through additional study or practice by way of additional course work, special conferences, proctored performance, etc. Core privileges are those often deemed necessary to provide adequate, basic patient care to the community. As such, specialists who request to relinquish core privileges in their specialty must obtain permission to do so in order not to deprive the community of those basic specialty services.
- b. Any request for a privilege to perform a special procedure must follow the “Request to Perform Additional Special Privilege” policy.
- c. Any request for a privilege to perform a new procedure not previously performed at the Hospital must follow the “Credentialing for a New Gettysburg Hospital Technology/Procedure/Privilege” policy.

3.11 TERM OF APPOINTMENT/REAPPOINTMENT

3.11.1 Initial Appointment/Provisional Period

- a. All initial appointments to the Medical Staff, all initial delineations of privileges or rights to perform patient care services in the Hospital, and all grants of increased privileges or increased rights to perform patient care services, will be for a provisional period of not less than six (6) months, nor more than one (1) year, unless extended for cause.
- b. The provisional period will include a designated time period where focused professional practice evaluation (FPPE) will occur. This evaluation could consist of case reviews by department chairs, chart reviews by peer review indicators, direct observation, discussion with consultants, supervisor reviews or any other method deemed appropriate to determine competency to perform patient care services during this provisional period.
- c. During the provisional period, if an appointee fails to fulfill the requirements and obligations of appointment, including cooperation with the FPPE process, on-call obligations, or other requirements as outlined in these Bylaws, his privileges will

automatically be relinquished at the end of the provisional period without rights to a hearing and appeal.

3.11.2 Reappointment

Reappointments to any category of the Medical Staff will be for a period of up to two (2) years. Appointees who fail to submit complete reappointment applications prior to the expiration of their term will be considered to have relinquished their medical staff membership and privileges or rights to perform patient care services in the Hospital. It is the appointee's responsibility to assure that all of this documentation is complete. There will be no extensions granted. Failure to meet this expectation will result in the need to reapply to the medical staff.

3.12 LEAVE OF ABSENCE

3.12.1 Voluntary Leave

a. Instigation

Practitioner may obtain a voluntary leave of absence by giving written notice to the Vice President, Medical Affairs for transmittal to the President of the Medical Staff, the appropriate Department Chairman, and the Board. The notice must state the approximate period of time of the leave, which may not exceed one (1) year, except for military service, pursuant to a draft, national emergency or other forced induction into the military service. The voluntary leave of absence shall terminate three months after the end of the military service or national emergency, as appropriate. During the period of time of the leave, all of the Practitioner's prerogatives, responsibilities, and clinical privileges or rights to perform patient care services are suspended.

b. Termination

A Practitioner must, at least thirty (30) days before the termination of his leave, or may at any earlier time, request reinstatement by sending a written request for reinstatement to the Vice President, Medical Affairs. The Practitioner must submit a written summary of relevant activities during the leave, if the Medical Executive Committee or Board so request, and the practitioner must demonstrate that he is then qualified for Medical Staff appointment and for the category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services that he is requesting. If the Practitioner has been on a medical leave, the request for termination of leave must include a report from his physician that answers any questions that the Credentials Committee or Medical Executive Committee may have as part of considering the request for reinstatement. The Medical Executive Committee shall make a recommendation to the Board concerning reinstatement, and further action on the request for reinstatement shall follow the procedures set forth in Sections 3.2 or 3.3.

3.13 IMPAIRED PRACTITIONERS

3.13.1 Instigation

In the event the Medical Executive Committee or the Board, in the course of the reappointment process or corrective action, considers any Practitioner to be impaired because of drug or alcohol dependence or mental, physical, or aging problems, the impaired Practitioner shall have the right to take a leave of absence to seek appropriate diagnosis and treatment, including any diagnosis or treatment recommended by the Medical Executive Committee or the Board. If the Practitioner opts for this leave of absence, all of his prerogatives, responsibilities, and clinical privileges or rights to perform patient care services are suspended, and any application he has submitted for reappointment is deemed withdrawn.

3.13.2 Termination

When the Practitioner who has opted for the leave of absence set forth above believes that he has been sufficiently rehabilitated to return to the Hospital, he may request reinstatement by sending a written request, accompanied by a report from his physician indicating that the course of treatment/therapy has been completed and that there is no reason for continued concern, for reinstatement to the Vice President, Medical Affairs. The Practitioner has the burden of demonstrating removal of his impairment and that he is then qualified for Medical Staff appointment and for the category of Staff appointment, Department and Division affiliation and clinical privileges or rights to perform patient care services that he is requesting. The Medical Executive Committee shall make a recommendation to the Board concerning reinstatement, and further action on the request for reinstatement shall follow the procedures set forth in Sections 3.2 and 3.3 for the appointment process. Any leave, which extends beyond the subsequent reappointment period, without an interim request for termination of the leave and reinstatement, will result in the expiration of appointment and clinical privileges.

3.14 RESIGNATIONS

3.14.1 Notification

A Practitioner who chooses to resign from the Medical Staff or Allied Health Staff must submit a signed letter of resignation to the Vice President, Medical Affairs. The letter must contain the effective date of the resignation.

3.15 PROFESSIONAL SERVICES PROVIDED PURSUANT TO CONTRACT

3.15.1 Qualifications

A Practitioner who is or will be exercising clinical privileges or who has or will have rights to perform patient care services pursuant to a contract with the Hospital must meet the same qualifications, must be processed for appointment, reappointment, and clinical privileges or rights to perform patient care services in the same manner, and must fulfill all the obligations of his appointment category, as any other practitioner.

3.15.2 Effect of Contract

A contract may restrict right of access to Hospital equipment, facilities, and personnel exclusively to contracting Practitioners; provided, however, that for contracts initially entered into after the effective date of the Medical Staff Bylaws:

- a. the contract was not initially entered into without consultation with the Medical Executive Committee as to the reasons for and alternatives to the arrangement; and
- b. any Practitioner whose existing privileges or rights would be affected by the Hospital's initial entry into the contract was given and a reasonable opportunity to become a party in the initial contract.

3.15.3 Board Action

In the event the provisions of this article are followed and a Practitioner's existing privileges or rights are adversely affected by the Hospital's initial entry into a contract, such event shall be deemed adverse pursuant to Section 6.2.4, and the Practitioner shall be entitled to a hearing and an appellate review as provided in Article VI, Fair Hearing and Corrective Action Plan.

3.16 ADOPTION AND AMENDMENT

Article III contents may be amended or repealed, in whole or in part, by a two-thirds affirmative vote of the Active Staff Members present and voting at a general medical staff meeting, a special meeting called for the sole purpose of amendment, or by electronic, telephonic, fax or mail vote.

ARTICLE IV. MEDICAL RECORDS

4.1 ATTENDING MEDICAL STAFF APPOINTEE (PRACTITIONER OF RECORD)

The attending Medical Staff appointee for each patient shall be responsible for the preparation and completion of the medical record of such patient. When more than one practitioner cares for the patient during a prolonged stay, the admitting provider will be considered the "practitioner of record" who will oversee and coordinate the care of the patient. Should the admitting practitioner not be the individual who will oversee the overall care of the patient, this provider will transfer that responsibility, in writing, to another practitioner who will assume that care and who then assumes that responsibility. It will be the practitioner of record who will be held accountable for appropriateness of care including core measure compliance, discharge summary compliance, etc.

4.2 INPATIENT RECORD

A complete inpatient medical record shall include: complete identification, complete history and physical examination, signed informed consent forms, reports of diagnostic studies, consultations, progress notes, discharge summary, diagnosis(es), follow-up notes, and autopsy report when indicated.

4.3 HISTORY AND PHYSICAL EXAM

- 4.3.1 A complete history shall include: chief complaint, history of present illness, past medical and surgical history, social history, family history, and a complete review of systems.
- 4.3.2 A complete physical examination shall include such examinations and tests as the attending physician deems appropriate, taking into account the patient's medical condition, age and medical history. At a minimum, the physical exam will include evaluation of the head, eyes, ears, nose, throat, pulmonary system, cardiovascular system,

gastrointestinal system, neurologic status, musculoskeletal system and integumentary system. For select patients, the genitourinary and endocrine system evaluations would also be required. Neither the examination nor the chart will be considered complete unless these are recorded, except if the attending Medical Staff appointee has made a note as to the contraindications or reasons why the procedures were not done and/or a statement indicating when the procedures were last performed. The attending Medical Staff appointee's impressions on admission and course of treatment planned also shall be included.

- 4.3.3 The history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. A history and physical examination performed by a consultant, but related to the reason for the procedure, may be used as long as it has been performed no more than 30 days prior to the procedure. Any interim changes in the patient's condition, or an indication that no interim changes have occurred, must be documented in an appropriate place on the medical record.
- 4.3.4 A history and physical examination must be on the chart in paper or electronic form before surgery. This includes both inpatient and outpatient surgery records.
- 4.3.5 An updated obstetrical progress note shall be completed on all obstetrical patients to supplement the Pre-Natal Forms.
- 4.3.6 Any alteration(s) made within the medical record must be signed and dated when the alteration(s) is made. A single line should be drawn through the incorrect entry, the word "error" entered and the signature of the individual making the change, along with the date, should be documented at the revised entry.

4.4 SIGNATURES

- 4.4.1 Every clinical entry must be personally signed, dated and timed. (This includes all inpatient and outpatient records.) Electronic signature is permitted when available. All signatures must be legible. If the signature is deemed to be illegible to anyone who views it, the practitioner must legibly print his name beside the signature. Each provider may also assign proxy signature capabilities to members of his/her practice or call group. Proxies must be aware that their signature indicates full responsibility for the content and intent of all entries covered by their signature.
- 4.4.2 All transcribed reports in the Gettysburg Hospital Medical Record must be authenticated and electronically signed in order to be considered the final official record. Any changes to a transcribed, paper report that are made on a written version will not be transcribed and, therefore, will not be an official version of the report.
- 4.4.3 A card file of Medical Staff appointees' signatures and initials shall be maintained in the Medical Records Department.

4.5 OPERATIVE REPORT

- 4.5.1 Documentation of a procedure done in the operating room requires two components, a dictated operative report and a legibly completed perioperative progress note. The perioperative progress note should be completed immediately after surgery. A complete operative report must be dictated within 24 hours. These two documents are required for both inpatient and outpatient surgical procedures. The dictated operative report should contain a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the name of the primary surgeon and any assistants. The perioperative progress note must also have all of these elements completed in an abbreviated form and should contain a brief plan.

4.6 PROGRESS NOTES

The frequency with which progress notes are made is determined by the condition of the patient. This may vary from several times a day in rapidly changing clinical conditions to less frequently in static conditions. It is Gettysburg Hospital's policy that a progress note be completed daily for all admitted patients and Outpatient Service Unit patients.

4.7 DISCHARGE SUMMARY

- 4.7.1 All admissions to the Hospital, regular or observation, require a discharge summary regardless of the length of stay. A brief dictated summary may be used for patients hospitalized less than 48 hours. The form of this summary can be a final progress note that contains more templated information, or an abbreviation of the current discharge summary template.
- 4.7.2 All relevant diagnoses established by the time of discharge as well as all operative procedures performed should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate. Abbreviations can be used if approved by the Medical Staff.
- 4.7.3 The discharge summary should recapitulate concisely the reason for hospitalization; the significant findings; any "present on admission" findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instructions given to the patient and/or family, particularly in relation to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology such as "improved." When preprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the Medical Records Department. A copy of the clinical resume may be sent to any known medical practitioner and/or medical facility responsible for the subsequent medical care of the patient.
- 4.7.4 A final progress note may be substituted for the resume in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or family.

- 4.7.5 In the event of death, a summation statement should be added to the record either as a final progress note or a separate resume. This final note should indicate the reason for admission, the findings and course in the Hospital, and events leading to death.
- 4.7.6 When a necropsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three (3) days, and the complete protocol should be made part of the record within sixty (60) days.

4.8 CONSULTS

- 4.8.1 All consults must indicate the name or specialty of the practitioner consulted, the reason for the consult, and the time frame within which the consult is to be completed.
- 4.8.2 All emergency or urgent consults must be communicated by direct contact between the consulting and the consulted practitioners.
- 4.8.3 Unless otherwise stated, all consults must be communicated within 24 hours of the order being written.

4.9 CONSENTS

4.9.1 General

It is the responsibility of the proceduralist to obtain consents from patients, legal guardians of patients, or other recognized legal surrogate, for all invasive procedures to be performed on all patients. The consent must identify the anticipated procedure, the known potential risks of the procedure, the alternatives to the procedure and any additional information that would allow a competent person to understand the risks and to be able to give full informed consent. A similar process must be followed for blood products.

4.9.2 Radiology consents for pregnant patients

The Department of Radiology has a policy that all consents for radiological procedures that involve any form of radiation to a pregnant or potentially pregnant female be obtained prior to the procedure and after the patient has had all risks and alternatives explained in language the patient understands.

4.10 CHART COMPLETION

- 4.1.1 All records shall be completed within thirty (30) days after the discharge or treatment of the patient. Failure to comply, except for extraordinary circumstances as approved by the Vice President, Medical Affairs, will result in actions outlined in the Medical Records Suspension Policy.

4.11 SECURITY AND CONFIDENTIALITY

All records are the property of the Hospital and shall not be removed from the Medical Records Department at any time without notification and specific permission of the Medical Records Administrator. Infractions of this regulation shall be treated as are incomplete charts. Information concerning records or their contents will only be released upon written request and

permission of the patient, except to Medical Staff appointees or Allied Health Professionals in good standing who are currently involved in the care of the patient; Medical Staff appointees using charts for academic purposes (i.e., conferences, studies, etc.); or those individuals involved in required quality assurance activities.

4.12 DICTATED DOCUMENTS

- (a) All dictated documents must include the date and time of dictation and date and time of transcription.
- (b) Practitioners must review and sign all documents that they have dictated.
- (c) A note indicating that the report was dictated must be written in the chart, preferably on the Progress Note sheet.
- (d) All dictated documents that are placed on the patient's hospital chart must comply with these requirements, even if dictated outside the hospital.

4.13 ORDERS

4.13.1 Where available, all orders will be entered through the use of Computerized Provider Order Entry by the practitioner initiating the order except in emergency situations whereby delay in patient care is adversely affected by entering such an order. In those emergency situations, the electronic order can be entered after the fact.

4.13.2 Oral orders

- a. Oral medication and treatment orders may be transmitted only by a licensed practitioner, dentist, podiatrist, physician assistant, pharmacist, certified nurse midwife (CNM) or certified registered nurse practitioner (CRNP). Both CNMs and CRNPs require prescriptive authority before they can write medication orders.
- b. Oral orders are defined as any medication and/or treatment order that is (a) given physically in the presence of, or (b) received via telephone by personnel authorized to receive such order as outlined below.
- c. Oral orders are permitted in emergency situations as defined above, or when it is not possible for the practitioner to enter the orders himself (e.g. no access to a computer).
- d. Personnel approved to receive oral medication and treatment orders are; registered nurses, licensed practical nurses, pharmacists, physical therapists, occupational therapists and respiratory therapists. All authorized personnel are expected to receive and transcribe only those oral orders pursuant to their role/scope of practice within the institution. All other personnel not specifically mentioned in this section are to be considered unauthorized to receive oral orders.
- e. All personnel authorized to receive oral orders shall enter the oral order directly into the medical record using the electronic order entry process. The practitioner

must remain on the phone to answer prompts from the electronic order entry system as those entries are completed. Authorized receiving personnel must then read the order back, in its entirety, to the ordering individual and wait for a confirmation of accuracy from the authorized ordering practitioner prior to executing the order.

- f. All oral orders must be electronically authenticated (signed) by the ordering individual or an associate of the ordering individual within twenty-four (24) hours of issue.
- g. Any orders entered by a medical student must be validated by the supervising physician/dentist/podiatrist prior to the execution of the order.
- h. All orders entered by a physician assistant must be co-signed by the supervising physician within seventy-two (72) hours. Oral orders must be signed within twenty-four (24) hours and transcribed documents must be signed within ten (10) days.
- i. All orders for outpatient tests/studies necessary at the time of discharge must address the party responsible for follow up on those orders in one of the following ways:
 - (1) The discharging provider can issue the order and assume the responsibility for follow up on the results of those tests/studies and will indicate that in the final progress note or discharge summary.
 - (2) The provider who issues the order can transfer the responsibility for follow up on the results of the test/study to another provider by making direct contact with that provider and documenting in the final progress note or discharge summary the name of the provider who will assume the responsibility for the results of the test/study, the date and time that transfer of responsibility occurred and the telephone number of that provider.
 - (3) The provider who feels that an outpatient test/study is indicated can contact the outpatient provider to discuss this need and the outpatient provider can assume the responsibility for ordering the test/study and also assume the responsibility for following up on the results.

4.14 TRANSFER OF SERVICES

A patient may be transferred from one practitioner's service to another, during the course of hospitalization, assuming that the receiving practitioner has a similar scope and privileges that will allow him to manage the care of the patient equal to or at a higher level than the transferring practitioner. Documentation of the transfer must be made in the progress note section of the medical record. The receiving practitioner must also note in the medical record that the transfer was accepted.

4.15 DELINQUENCY

Repeated instances of not completing the required chart documentation for all patients will be dealt with according to the Disruptive Practitioner Policy and gradually escalating sanctions. The

Department Chairman will be responsible for addressing the issue individually with physicians who have late entries, followed by VPMA discussion and then MEC recommendations.

4.16 ADOPTION AND AMENDMENT

Article IV content does not require a vote by the general medical staff. Due to the multiple legal and regulatory requirements that dictate much of the content contained in this Article, amendments will be made by a majority vote of the MEC and forwarded to the Medical Staff for information only.

ARTICLE V. CORRECTIVE ACTION AND FAIR HEARING PROCESS

5.1 COLLEGIAL INTERVENTION

This plan encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement and peer review. Relevant Medical Staff leaders will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in such a file, the individual will have an opportunity to review it and respond in writing.

5.2 CORRECTIVE ACTION

5.2.1 Initiation

- a. Corrective action may be initiated whenever a Practitioner makes or exhibits acts, statements, demeanor, or professional conduct (within or outside the Hospital) which is, or is likely to be, detrimental to the quality or efficiency of patient care, disruptive to the Hospital's operations, or an impairment to the community's confidence in the Hospital. Corrective action also may be initiated whenever a Practitioner fails to satisfy any of the requirements set forth in these Bylaws, accompanying manuals, or Hospital policies and procedures, and including but not limited to the Medical Staff policies regarding Code of Conduct and Impaired Practitioners.
- b. All requests for corrective action must be in writing, submitted to the Vice President, Medical Affairs, and supported by reference to specific activities or conduct, which constitute grounds for the request. The Vice President, Medical Affairs shall promptly submit a request for corrective action to the Medical Executive Committee, with a copy to the Board and the Practitioner involved.

5.2.2 Procedure

Corrective action may be requested and initiated by any officer of the Medical Staff; by the Department Chairman of any Department in which the Practitioner holds appointment, exercises clinical privileges, or performs patient care services; by the Chief

Executive Officer; by the Medical Executive Committee; by the Vice President, Medical Affairs; or by the Board.

5.2.3 Investigation

a. Medical Executive Committee

The Medical Executive Committee shall make all reasonable efforts in order to obtain the facts of the matter. If, based upon the initial review of a concern submitted to the Medical Executive Committee (MEC), the MEC determines that a formal investigation is warranted, such investigation may be assigned to an Ad Hoc Committee or Hearing Officer at the discretion of the Medical Executive Committee. The MEC should also identify any policy that pertains to the issue (e.g. Code of Conduct, Impaired Practitioner policies), and assure that those pertinent policy(ies) are followed in the investigation. The investigative body shall collect and analyze all information necessary in order to obtain the facts underlying the request for corrective action. Such investigation may include witness interviews, document review, or other information gathering as may be appropriate. The Practitioner shall be offered an opportunity to meet with the Medical Executive Committee, and discuss, explain or refute any of the issues which gave rise to the investigation. The Medical Executive Committee or Ad Hoc Committee, at its discretion, may consult with an outside consultant. If the investigation is conducted by an Ad Hoc Committee, it must forward a written report of the investigation to the Medical Executive Committee as soon as is reasonably practical after the assignment to investigate. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below.

5.2.4 Medical Executive Committee Action

a. As soon as is reasonably practical after a request for corrective action is referred to it and in accordance with the process set forth in Section 5.1.3 above, the Medical Executive Committee shall deliberate, and make a recommendation to the Board. Its recommendation may include without limitation:

- (1) recommending rejection of the request for corrective action;
- (2) recommending a warning or a formal letter of reprimand;
- (3) recommending a probationary period with retrospective review of cases, but without individual requirements of consultation or supervision;
- (4) recommending individual requirements of consultation or supervision;
- (5) recommending reduction, suspension, or revocation of clinical privileges or rights to perform patient care services;
- (6) recommending reduction of Staff category;
- (7) recommending suspension or revocation of Staff appointment; or
- (8) other remedies as deemed appropriate to correct or modify the Practitioner's behavior or actions which necessitated the request for corrective action.

b. The following actions are considered adverse and entitle the individual to a hearing:

- (1) denial of initial appointment to the Medical Staff;
- (2) denial of reappointment to the Medical Staff;
- (3) revocation of appointment to the Medical Staff;
- (4) denial of requested clinical privileges;
- (5) revocation of clinical privileges;
- (6) suspension of clinical privileges for more than 30 days (other than automatic relinquishment);
- (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
- (8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

5.2.5 Effect of Medical Executive Committee Recommendation and Board Decision

- a. Favorable Recommendation: When the Medical Executive Committee decision is favorable to the Practitioner, the Vice President, Medical Affairs shall promptly forward it to the Practitioner and to the Board for review. The Board may accept, reject or modify the recommendation of the Medical Executive Committee.
 - (1) If the Board decision is favorable to the Practitioner, the matter shall be deemed resolved and the decision final.
 - (2) If the Board decision is adverse to the Practitioner as defined above, the Vice President, Medical Affairs shall so inform the Practitioner by special notice as well as the Medical Executive Committee. The Practitioner shall then be entitled to the procedural rights as provided in this Corrective Action Procedures and Fair Hearing Plan.
- b. Adverse Recommendation: When the Medical Executive Committee recommendation is adverse to the Practitioner as defined in 5.2.4 (b) above, the Vice President, Medical Affairs shall so inform the Practitioner by special notice as well as the Medical Executive Committee. The Practitioner shall then be entitled to the procedural rights as provided in this Correction Action Procedures and Fair Hearing Plan.

5.3 PRECAUTIONARY SUSPENSION

5.3.1 Initiation

- a. Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the President of the Medical Staff, the Chairman of a clinical department, the Vice President, Medical Affairs, the president of the Hospital, or the Medical Executive Committee will each have authority 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 including, but not limited to, immediately after the occurrence of an event that causes

concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

- c. Precautionary suspension or restriction is an interim administrative step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- d. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President of the Hospital and the President of the Medical Staff, and shall remain in effect unless it is modified by the President of the Hospital or Medical Executive Committee.
- e. The individual in question shall be provided a brief written description of the reason(s) for the suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.
- f. A suspended Practitioner's patients then in the Hospital will be assigned to another Practitioner by the appropriate Department Chairman or his designee. If the suspended Practitioner is a member of a group practice, his patients will be assigned to another member of his group if possible. The wishes of the patient shall be considered in choosing a substitute Practitioner.

5.3.2 Investigation

Within fourteen days after imposition of a precautionary suspension, the Medical Executive Committee shall convene to conduct an initial review and consider the facts under which action was taken. The Medical Executive Committee initial review shall be limited to a determination of whether the precautionary suspension should be continued pending further investigation or whether the precautionary suspension shall be immediately lifted, or whether the precautionary suspension shall be modified. Thereafter, the applicable procedure in Section 5.3.1 above shall be followed.

5.4 AUTOMATIC RELINQUISHMENT

5.4.1 When Initiated

Any action taken by any licensing board, professional liability insurer, court, or government agency regarding any of the matters set forth below must be promptly reported to the Vice President, Medical Affairs. Automatic relinquishment or restriction of privileges shall take effect immediately and continue until the matter is resolved and a request for reinstatement of privileges has been acted upon by the Medical Executive Committee and approved by the Board of Directors. If the automatic relinquishment extends for more than 90 days, the Practitioner shall be deemed to have resigned from the Medical Staff.

- a. State License: Action by the state licensing board or agency revoking, limiting or suspending a Practitioner's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of all Hospital

clinical privileges. In the event the Practitioner's license is only partially restricted or placed on probation the clinical privileges that would be affected by the license restriction shall automatically be similarly restricted.

- b. Controlled Substance Authorization: Revocation, limitation, or suspension of a Practitioner's federal or state controlled substance certificate shall result in automatic relinquishment of all Hospital clinical privileges.
- c. Sanctioned Provider: Government action that results in a Practitioner becoming excluded, terminated, or otherwise ineligible from participation in any federal or state health care program (such as Medicare and Medicaid) shall result in automatic relinquishment of all clinical privileges. Government action that results in a Practitioner becoming suspended from participation in any federal or state health care program shall result in automatic suspension of all clinical privileges, pending final resolution of the matter.
- d. Criminal Activity: Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, violence, or a plea of guilty or nolo contendere to charges pertaining to the same shall result in automatic relinquishment of Medical Staff appointment and all clinical privileges.
- e. Medical and Other Records: The failure to prepare and/or complete medical records, and such other records as are required by these Bylaws in a timely fashion will result in automatic and immediate relinquishment of a Practitioner's clinical privileges or rights to perform patient care services in the Hospital, until the delinquency is corrected.
- f. Membership Status: Repeated suspensions which impact patient care will be dealt with by utilization of the disruptive physician policy.
- g. Professional Liability Insurance: The failure to maintain the amount of professional liability insurance required will result in immediate and automatic relinquishment of a Practitioner's Medical Staff appointment, clinical privileges, and rights to perform patient care service in the Hospital, until the delinquency is corrected.
- h. Dues: The failure to pay Medical Staff dues or assessments as provided in these Medical Staff Bylaws will result in immediate and automatic relinquishment of a Practitioner's Medical Staff appointment, clinical privileges, and rights to perform patient care services in the Hospital, until the delinquency is corrected. If a practitioner's Medical Staff dues remain unpaid by December 31, then the practitioner's Medical Staff appointment, clinical privileges, and rights to perform patient care services in the Hospital shall be revoked.
- i. Failure to satisfy threshold eligibility criteria, for example Board Certification, if required, continued medical education as required, etc.
- j. Failure to provide information requested by the Medical Executive Committee regarding medical care, privileging information or any other matter deemed by the MEC to be pertinent to medical staff appointment or privileges.

5.4.2 Procedure

Automatic relinquishments shall be imposed by the Vice President, Medical Affairs or his designee, with notice provided to the Medical Executive Committee and the Department Chairman of each Department to which the Practitioner is appointed, or in which he exercises clinical privileges or performs patient care services. Notice shall also be provided to the Practitioner. Further corrective action may be taken following imposition of automatic relinquishments.

5.4.3 Reinstatement

When automatic relinquishment of privileges is caused by a remediable action, once the remedial action is resolved to the satisfaction of the Department Chair or Division Chief of the department/division to which the member is assigned, the Department Chair or Division Chief can make a recommendation for immediate reinstatement pending the formal review by the Medical Executive committee and final approval by the Board. Those actions leading to automatic relinquishment that involve issues requiring formal notice from licensing agencies, federal agencies, malpractice insurers, etc., must be reviewed by the MEC and Board prior to automatic reinstatement of privileges.

5.5 INITIATION OF HEARING

5.5.1 Triggering Recommendations or Actions

The recommendations or actions defined as adverse in Section 5.2.4 (b) of the Medical Staff Bylaws shall entitle the Practitioner affected thereby to a hearing and appellate review rights, unless otherwise stated in the Medical Staff Bylaws. Notwithstanding any other provision of these Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review with respect to any adverse decision or action.

5.5.2 Notice of Adverse Decision or Action

A Practitioner against whom an adverse recommendation has been made or adverse action has been taken shall promptly be given special notice of such action by the Vice President, Medical Affairs. Such notice shall:

- a. advise the Practitioner of his right to a hearing;
- b. advise the Practitioner of the reasons for the adverse action;
- c. require that the Practitioner shall have thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;
- d. summarize the Practitioner's hearing rights under this Fair Hearing Plan including those set forth in Section 5.5.3 below;
- e. state that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter; and

- f. state that following receipt of his hearing request, the Practitioner will be notified of the date, time, and place of the hearing.

5.5.3 Request for Hearing

A Practitioner shall have thirty (30) days following his receipt of a notice to file a written request for a hearing. Such request shall be hand delivered to the Vice President, Medical Affairs or sent to him by certified mail, return receipt requested.

5.5.4 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 5.5.3 above waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. The Vice President, Medical Affairs shall promptly send the Practitioner special notice of action taken, and shall notify the President of the Medical Staff, the Board and the Chairman of each Department to which the Practitioner is appointed of each such action.

5.5.5 Effect of Waiver

A waiver constitutes an acceptance of a Medical Executive Committee recommendation and applicable Board decision in accordance with the Medical Executive recommendation, an adverse decision or adverse action of the Board, or Automatic Suspension.

5.5.6 Hearing Prerequisites

a. Notice of Time and Place for Hearing

Upon receipt of a timely request for hearing, the Vice President, Medical Affairs shall deliver such request to the President of the Medical Staff and to the Board. The Vice President, Medical Affairs, in consultation with the President of the Medical Staff, shall promptly schedule and arrange for a hearing. At least thirty (30) days before the hearing, the Vice President, Medical Affairs, in consultation with the President of the Medical Staff, shall send the Practitioner special notice of the date, time, and place of the hearing, and a list of the witnesses and exhibits, if any, expected to testify or be presented at the hearing on behalf of the body whose recommendation or action prompted the hearing. This list may be supplemented or amended at any time, including during the hearing, so long as the additional material is relevant to the Corrective Action or clinical privileges, and the Practitioner and his legal counsel shall have sufficient time to study the additional information in order to respond to it. Information regarding the abilities or ethics of the Practitioner requesting the hearing concerning events occurring at any time before or after initial imposition of Corrective Action or denial of appointment to the Medical Staff shall be deemed relevant for purpose of this section. A hearing for a Practitioner who is under suspension shall be held as soon as the arrangements for it can reasonably be made.

b. Appointment of Hearing Committee

(1) By Hospital

A hearing occasioned by an adverse decision shall be conducted by an Ad Hoc Hearing Committee appointed by the Vice President, Medical Affairs, in consultation with the President of the Medical Staff, and shall be composed of at least three (3) individuals who may or may not be active members of the Medical Staff. The Vice President, Medical Affairs, in consultation with the President of the Medical Staff, shall designate one of the Ad Hoc Hearing Committee Appointees as Chairman. No Practitioners in direct economic competition with the affected Practitioner may serve on the Ad Hoc Hearing Committee.

(2) Service on Hearing Committee

A Hearing Committee member shall not be disqualified from serving on an Ad Hoc Hearing Committee merely because he participated in investigating the underlying matter at issue or because he has heard of the case, or has knowledge of the facts involved.

(3) Outside Hearing Committee

If the Vice President, Medical Affairs considers it appropriate to constitute an Ad Hoc Hearing Committee from among persons with no affiliations to the Hospital or its Medical Staff, he may do so in consultation with the President of the Medical Staff. Such persons shall not be in direct economic competition with the affected Practitioner.

(4) Hearing Officer Option

As an alternative to a hearing panel, when the situation being addressed is more behavioral than clinical in nature, the Vice President, Medical Affairs has the option of appointing a Hearing Officer to conduct the hearing and to generate a recommendation to the MEC and/or Board. The Hearing Officer must not be in competition with the affected Practitioner.

5.6 HEARING PROCEDURE

5.6.1 Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at the hearing shall be deemed to have waived his rights in the same manner and with the same consequences as provided in Section 5.5.4.

5.6.2 Presiding Officer or Hearing Officer

The Hearing Officer, if one is appointed, or if a Hearing Officer is not appointed, the Chairman of the Ad Hoc Hearing Committee shall be the Presiding Officer. The Presiding Officer or Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and

documentary evidence. He shall be entitled to determine the order of procedure during the hearing, and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

5.6.3 Rights of Parties

a. Pre-Hearing Process

No less than fifteen days prior to the hearing, the Practitioner shall provide the Hospital with a list of witnesses and exhibits, if any, expected to testify or be presented at the hearing on behalf of the Practitioner. This list may be supplemented or amended at any time by the Practitioner, including during the hearing, so long as (i) the additional material is relevant in order to rebut evidence and the case presented by the Medical Staff, and (ii) legal counsel to the Medical Staff shall have sufficient time to study the additional information in order to respond to it. Except as otherwise provided in this Corrective Action Procedures and Fair Hearing Plan, neither party shall be entitled to any discovery of information or documents. All such requests shall be subject to the discretion of the Presiding Officer or Hearing Officer. It is strongly recommended that a pre-hearing conference be conducted to exchange information, documents and witness lists. During this pre-hearing conference, all procedural issues and objections will be heard and dealt with in advance of the hearing. The affected practitioner and/or the attorney for that practitioner may not contact employees on the Hospital's witness list except as agreed to by Hospital counsel or directed by the presiding officer.

b. Hearing Process

During a hearing, each of the parties shall have the right to:

- (1) call, examine, and cross examine witnesses;
- (2) introduce exhibits;
- (3) impeach any witness;
- (4) rebut any evidence; and
- (5) representation by an attorney or other person of the party's choice.

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

5.6.4 Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, before and/or after the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. Oral evidence shall be taken only on oath or affirmation administered by any person appropriately designated by him and entitled to notarize documents in the Commonwealth of Pennsylvania.

5.6.5 Official Notice

In reaching a decision, the Ad Hoc Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the Commonwealth of Pennsylvania.

5.6.6 Burden of Proof and Order of Presentation

The Medical Staff shall proceed with its case first and has the burden of establishing that the adverse recommendation or action is supported by substantial evidence. Following completion of the Medical Staff case, the Practitioner requesting the hearing shall then present his case, and shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn there from, are either arbitrary, unreasonable, or capricious.

5.6.7 Record of Hearing

A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Ad Hoc Hearing Committee may select the method to be used for making the record, such as court reporter, electronic recording unit, or any other method that would produce a detailed verbatim transcription. The Practitioner shall be entitled to obtain copies of the record upon payment of any reasonable charges associated with the preparation of the record.

5.6.8 Postponement

Requests for postponement of a hearing shall be granted by the Ad Hoc Hearing Committee only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

5.6.9 Presence of Hearing Committee Members and Vote

A majority of the Ad Hoc Hearing Committee must be present throughout the hearing and deliberations. If a Committee member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

5.6.10 Recess and Adjournment

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

5.7 HEARING COMMITTEE REPORT AND FURTHER ACTION

5.7.1 Hearing Committee Report

As soon as is reasonably practical after final adjournment of the hearing, the Ad Hoc Hearing Committee, or Hearing Officer, shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing, and to the MEC. All findings and recommendations by the Ad Hoc Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it. The Vice President, Medical Affairs shall promptly forward the Ad Hoc Committee report to the Practitioner.

5.7.2 Action on Hearing Committee Report

The MEC shall consider the Ad Hoc Hearing Committee's (or Hearing Officer's) report and affirm, modify, or reverse the initial recommendation or action in the matter. The MEC shall transmit its result, to the Vice President, Medical Affairs. The Vice President, Medical Affairs shall notify the Practitioner of the MEC's decision.

5.7.3 Notice and Effect of Result

a. Effect of Favorable Result

If the MEC's recommendation is favorable to the Practitioner who requested the hearing, such result shall become the final recommendation of the MEC and the recommendation shall be forwarded to the Board for final review. If the Board chooses to accept the recommendations, the result will be final. If the Board disagrees with the favorable recommendation of the MEC, it can revise the recommendation. If the revised recommendation is still adverse to the Practitioner, the Practitioner will have the right to appeal.

b. Effect of Adverse Result

If the result of the MEC continues to be adverse to the Practitioner who requested the hearing, the Practitioner shall be informed of his right to request an appellate review by the Board by special notice.

5.8 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.8.1 Request for Appellate Review

A Practitioner shall have twenty (20) days following his receipt of a notice to file a written request for an appellate review. Such request shall be hand delivered to the Vice President, Medical Affairs or sent to him by certified mail, return receipt requested, and may include a request for a copy of the report of the Ad Hoc Hearing Committee or Hearing Officer, the hearing record, and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse recommendation or in taking the adverse action. The request for appellate review shall specifically set forth the basis for the Practitioner's request including the specific facts which the Practitioner believes justifies the appeal requesting that the Board reconsider its decision. An appeal may only be pursued by the Practitioner on the basis that there was a substantial failure to

comply with the Medical Staff Bylaws or other governing documents, or that the decision was arbitrary, capricious, or not supported by substantial evidence.

5.8.2 Waiver by Failure to Request Appellate Review

A Practitioner who fails to request an appellate review within the time and in the manner specified above waives any right to such review.

5.8.3 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for an appellate review, the Vice President, Medical Affairs shall promptly arrange for an appellate review by the Board. An appellate review for a Practitioner who is under a suspension shall be held as soon as the arrangements for it can reasonably be made. At least thirty (30) days before the appellate review, the Vice President, Medical Affairs shall send the Practitioner special notice of the date of the review. The time for the appellate review may be extended by the appellate review body for good cause, if a request therefore is made as soon as is reasonably practical.

5.8.4 Appellate Review Body

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an Appellate Review Committee of five (5) members of the Board appointed by the Chairman of the Board. If an Appellate Review Committee is appointed, the Chairman of the Board shall designate one of the Committee's members as Chairman.

5.9 APPELLATE REVIEW PROCEDURE

5.9.1 Nature of Proceedings

The proceedings by the appellate review body shall be in the nature of an appellate review based upon the record of the hearing before the Ad Hoc Hearing Committee/Hearing Officer, that Committee's/Officer's report, and all subsequent actions thereon. The appellate review body also shall consider any written statements submitted, and such other material as may be presented and accepted under Section 5.9.2 below.

5.9.2 Written Statements

The Practitioner seeking the appellate review must submit a written statement detailing the findings of facts, conclusions, and/or procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the Vice President, Medical Affairs at least fifteen (15) days before the scheduled date of the appellate review. A written statement in reply may be submitted by the Board at least five (5) days before the scheduled date of the appellate review, and legal counsel may assist in its preparation. The Vice President, Medical Affairs shall provide a copy thereof, if any, to the practitioner before the scheduled date of the appellate review. At the discretion of the appellate review body, both parties may be permitted to submit written statements at the conclusion of the appellate review, or the appellate review body may request the presence of either party before the appellate review body's deliberations. It is not the intent of the

Appellate Review to reopen the initial review process. Deliberations will be confined to the elements of the recommendations by the Hearing Committee/Hearing Officer.

5.9.3 Presence of Members and Vote

A majority of the appellate review body must be present throughout the review and deliberations. If a member of the appellate review body is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

5.9.4 Action Taken

The appellate review body may recommend that the Board affirm, modify, or reverse the adverse result or action taken by the Board, or, in its discretion, may refer the matter back to the Ad Hoc Hearing Committee/Hearing Officer for further review and recommendations to be returned to it in accordance with its instructions. As soon as is reasonably practical after receipt of the Ad Hoc Hearing Committee's/Hearing Officer's subsequent recommendations after referral, the appellate review body shall make its recommendation to the Board.

5.9.5 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

5.10 FINAL DECISION OF THE BOARD

5.10.1 Effect of Review Body Decision

The appellate review body's recommendation shall be forwarded to the Board, and the Board's action on the appellate review body's recommendation is the final decision in the matter. The Practitioner shall not be entitled to additional hearings or appellate review.

5.10.2 Notice

The Vice President, Medical Affairs shall send special notice of the final decision of the Board to the Practitioner who requested the appellate review, with a copy to the President of the Medical Staff.

5.11 GENERAL PROVISIONS

5.11.1 Hearing Officer Appointment and Duties

The use of a Hearing Officer to preside at the evidentiary hearing provided for in this Fair Hearing Plan is optional and is to be determined by the Vice President, Medical Affairs in consultation with the President of the Medical Staff. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. If a Hearing Officer is appointed, he shall act as the Presiding Officer of the hearing.

5.11.2 Representation and Attorneys at Law

The affected Practitioner, at his own expense, shall be entitled to be represented by an attorney or other person of his own choosing at any hearing or at any appellate review appearance, and he must state his intention to be so represented. The Medical Executive Committee, the Board, the Ad Hoc Hearing Committee, and the appellate review body shall be allowed representation by an attorney at law.

5.11.3 Waiver

If at any time after receipt of special notice of an adverse recommendation, action, or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with this Corrective Action Procedures and Fair Hearing Plan or to proceed with the matter, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect and under this Corrective Action Procedures and Fair Hearing Plan with respect to the matter involved.

5.11.4 Outside Consultants

If at any time throughout the process outlined in this Corrective Action Procedures and Fair Hearing Plan, the Medical Executive Committee, the Board, the Ad Hoc Hearing Committee, or the appellate review body considers it appropriate to consult an outside consultant (i.e., one with no affiliations to the Hospital or its Medical Staff), such body may do so.

5.11.5 Mediation

Upon mutual agreement of the Hospital and the Practitioner, the parties shall submit all disputed matters which are the basis for any requested hearing to mediation ("Mediation"). The matter shall be submitted to a panel of two mediators comprised of at least one physician. The panel of mediators shall be mutually acceptable to both parties. Each party shall be responsible for its own attorneys' fees, expert fees, cost of producing exhibits, or loss of income due to participation in the Mediation. The parties shall be equally responsible for all other fees, costs or expenses associated with the Mediation including mediator fees. The Mediation process shall be determined by a mediation agreement to contain mutually acceptable terms and conditions. Mediation shall occur prior to the scheduled hearing. Only upon mutual agreement of the parties and subject to mutually acceptable terms and conditions shall the hearing be postponed for purposes of completing the Mediation.

5.12 Adoption and Amendment

Article V content does not require a vote by the general medical staff. Due to the multiple legal and regulatory requirements that dictate much of the content contained in this Article, amendments will be made by a majority vote of the MEC and forwarded to the Medical Staff for information only.

ARTICLE VI. GENERAL PROVISIONS

6.1 MEDICAL STAFF DUES AND SPECIAL ASSESSMENTS

6.1.1 Dues

Subject to the approval of the Medical Staff at the annual meeting, the Medical Executive Committee will establish the amount and manner of disposition of the annual dues. (Voting members in any election concerning dues will include all Practitioners who will be required to pay dues.) Dues are payable at the beginning of each new Medical Staff year. Failure, unless excused by the Medical Executive Committee for good cause, to render payment within two (2) months of the start of the Medical Staff year shall, after special notice of the delinquency, result in automatic suspension pursuant to Corrective Action Procedures and Fair Hearing Plan. If a Practitioner's Medical Staff dues remain unpaid by December 31, then the Practitioner's Medical Staff appointment, clinical privileges, and rights to perform patient care services in the Hospital shall be revoked.

6.1.2 Special Assessments

- a. If funds of the Medical Staff are insufficient for any expenditure authorized by the Medical Executive Committee, additional funds may be obtained through a special assessment of the Medical Staff. Before any such assessment, there must be a special meeting of the Medical Staff, called by the President of the Medical Staff for that purpose. At this meeting, there must be a quorum present and a two-thirds affirmative vote of those present and voting is necessary for approval of the assessment. (Voting members in any election concerning assessments will include all Practitioners who may be affected by the proposed assessment.)
- b. The Medical Executive Committee may, for good cause, assess fines against a Staff Member for failure to adhere to any provision of these Bylaws. Payment of those fines will be due within 2 weeks of the assessment. Failure to pay the fines, except for good cause as agreed to by the Medical Executive Committee, will result in automatic relinquishment of privileges until such date as the fines are paid in full.

6.2 MEDICAL STAFF YEAR

For the purposes of business of the Medical Staff, the business year will commence on November 1.

6.3 CONFLICT MANAGEMENT

Should conflict arise between the organized medical staff and the MEC, the MEC and the Board, or the medical staff and Administration (either the organized medical staff as a whole or the MEC and Administration) regarding policies, rules and regulations, or amendments to these bylaws, an ad hoc committee will be formed to address the conflict until a recommendation for resolution is obtained. The ad hoc committee will consist of representatives of the affected groups appointed by those groups who can speak knowingly about the issue. This ad hoc committee will make a final recommendation for resolution of the conflict to the full Board, which will have final say in the matter.

6.4 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for

convenience only and are not intended to limit or define the scope or effect of any of the provisions of these Bylaws.

6.5 EFFECTIVE DATE

These Bylaws shall become effective on September 29, 2011.

6.6 ADOPTION

6.6.1 MEDICAL STAFF

The foregoing Bylaws of the Medical Staff of Gettysburg Hospital were adopted and recommended to the Board by the Medical Staff.

President of the Medical Staff

Date

6.6.2 BOARD

The foregoing Bylaws of the Medical Staff of Gettysburg Hospital were approved and adopted by resolution of the Board after considering the Medical Staff's recommendation.

Chairman of the Board

Date

Including amendments adopted:

Date of Board Approval

June 28, 1956
November 30, 1956
February 15, 1968
January 16, 1969
September 18, 1969
January 15, 1976
July 15, 1976
March 16, 1978
October 17, 1981
March 10, 1982
December 8, 1982
January 19, 1984
April 17, 1984
July 18, 1985
May 15, 1986
July 14, 1993
September 11, 1996
January 21, 1999
July 18, 2002
September 18, 2003
October 27, 2005
July 30, 2009
December 16, 2010
March 17, 2011
June 23, 2011
September 29, 2011