The Good Samaritan Hospital; Lebanon, PA
Bylaws of the Medical Staff
Definitions
Page 1 of 3

DEFINITIONS

1) **HOSPITAL** means The Good Samaritan Hospital of Lebanon, Pennsylvania.

2) **BOARD OF TRUSTEES** or **BOARD** means the governing body of the Corporation.

3) **PRESIDENT & CHIEF EXECUTIVE OFFICER** means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

4) **MEDICAL STAFF** or **STAFF** means the formal organization of all licensed physicians, dentists and podiatrists who are privileged to attend patients in the Hospital.

5) **MEDICAL EXECUTIVE COMMITTEE** or **MEC** means the Executive Committee of the Medical Staff.

6) **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services.

7) **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional and exercisable subject to the conditions imposed in these bylaws and in other Hospital and Medical Staff policies.

8) **PRACTITIONER** means, unless otherwise expressly limited, any appropriately licensed physician (M.D. or D.O.), dentist or podiatrist applying for, or exercising, clinical privileges in this Hospital.

9) **ALLIED HEALTH PROFESSIONAL** or **AHP** means an individual, other than a licensed physician, dentist or podiatrist who exercises independent judgment within the areas of his professional competence and who is qualified to render direct or indirect medical, dental, podiatric or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. Such AHP's shall include, without limitation, bacteriologists, chemists, clinical pharmacologists, clinical psychologists, dental auxiliaries, nurse clinicians/practitioners, other doctoral scientists, physician assistants, physiologists and qualified therapists (e.g., occupational, physical, respiratory).

10) **MEDICAL STAFF YEAR** means the period from July 1 through June 30.

11) **EX OFFICIO** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

12) **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested.
13) ATTENDING A PATIENT means providing diagnostic and/or therapeutic care to a patient on either inpatient or outpatient basis.

14) FAIR HEARING PLAN means the procedures set forth in Article VII.

15) FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) means a time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner’s ability to provide safe, high quality patient care.

16) ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) or PROFESSIONAL PRACTICE EVALUATION means a document summary of ongoing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise or revoke existing privilege(s) prior to or at the end of the license renewal cycle.

17) GENERAL COMPETENCE refers to the status of having attained competence in six areas of medical practice developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. These areas include:

a. Patient Care – Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and are at the end of life.

b. Medical/Clinical Knowledge – Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and education of others.

c. Practice-Based Learning and Improvement – Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

d. Interpersonal and Communication Skills – Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, family, and other members of health care teams.

e. Professionalism – Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.
f. System-Based Practice – Practitioners are expected to demonstrate both an understanding of the concerns and systems in which health care is provided and the ability to apply this knowledge to improve health care.

18) CREDENTIALS COMMITTEE means the Credentials Committee of the Medical Staff.

19) VICE PRESIDENT OF MEDICAL AFFAIRS or MEDICAL DIRECTOR means the individual appointed by the President and Chief Executive Officer to assist the officers of the medical staff in conducting staff affairs, including but not limited to governance, quality assurance, medical education and credentialing.

20) DEPARTMENT CHAIRMAN means the individual elected by the members of a Hospital department to act as chairman of the department.

21) ATTENDING PHYSICIAN means the medical staff member who is the physician of record for a given patient.

22) PROTECTED HEALTH INFORMATION means information defined as “Protected Health Information” pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.
# MEDICAL STAFF BYLAWS

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preamble</td>
</tr>
<tr>
<td></td>
<td>Definitions</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td>NAME</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>PURPOSE AND SELF GOVERNANCE</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>MEDICAL STAFF MEMBERSHIP &amp; CLASSIFICATIONS</td>
</tr>
<tr>
<td>3.1</td>
<td>Membership</td>
</tr>
<tr>
<td>3.2</td>
<td>Effect Other Affiliations</td>
</tr>
<tr>
<td>3.3</td>
<td>Classification of the Medical Staff</td>
</tr>
<tr>
<td>3.3-1</td>
<td>Active Staff</td>
</tr>
<tr>
<td>3.3-2</td>
<td>Courtesy Staff</td>
</tr>
<tr>
<td>3.3-3</td>
<td>Consulting Staff</td>
</tr>
<tr>
<td>3.3-4</td>
<td>Affiliate Staff</td>
</tr>
<tr>
<td>3.3-5</td>
<td>Coverage Staff</td>
</tr>
<tr>
<td>3.3-6</td>
<td>Honorary Staff</td>
</tr>
<tr>
<td>3.3-7</td>
<td>TeleMedicine Staff</td>
</tr>
<tr>
<td>3.4</td>
<td>Limitation of Prerogatives</td>
</tr>
<tr>
<td>3.5</td>
<td>Waiver of Qualifications</td>
</tr>
<tr>
<td>3.6</td>
<td>Provisional Status</td>
</tr>
<tr>
<td>3.6-1</td>
<td>Observation / Proctoring (FPPE) For Initial Appointment</td>
</tr>
<tr>
<td>3.6-2</td>
<td>External Peer Review</td>
</tr>
<tr>
<td>3.6-3</td>
<td>Modification of Membership Status or Privileges</td>
</tr>
<tr>
<td>3.6-4</td>
<td>Term of Observation</td>
</tr>
<tr>
<td>3.6-5</td>
<td>Qualifications of Proctors</td>
</tr>
<tr>
<td>3.7</td>
<td>Basic Qualifications for Membership</td>
</tr>
<tr>
<td>3.7-1</td>
<td>Basic Qualifications</td>
</tr>
<tr>
<td>3.7-2</td>
<td>General Requirements</td>
</tr>
<tr>
<td>3.7-3</td>
<td>Documentation of H&amp;P’s</td>
</tr>
<tr>
<td>3.8</td>
<td>Waiver of Qualification</td>
</tr>
<tr>
<td></td>
<td>Administrative and Medico-Administrative Officers</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>APPOINTMENT &amp; REAPPOINTMENT</td>
</tr>
<tr>
<td>4.1</td>
<td>Procedure for Application</td>
</tr>
<tr>
<td>4.1-1</td>
<td>- Request for Application</td>
</tr>
<tr>
<td>4.1-2</td>
<td>- General Procedure</td>
</tr>
<tr>
<td>4.2</td>
<td>Application for Initial Appointment</td>
</tr>
<tr>
<td>4.2-1</td>
<td>Application Form and Content</td>
</tr>
<tr>
<td></td>
<td>- Qualifications</td>
</tr>
<tr>
<td></td>
<td>- Requests</td>
</tr>
<tr>
<td></td>
<td>- References</td>
</tr>
<tr>
<td></td>
<td>- Professional Sanctions</td>
</tr>
<tr>
<td></td>
<td>- Professional Liability Insurance</td>
</tr>
<tr>
<td>NUMBER</td>
<td>ARTICLE NAME</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>4.2-2</td>
<td>Effect of Application</td>
</tr>
<tr>
<td>4.2-3</td>
<td>Processing the Application</td>
</tr>
<tr>
<td></td>
<td>- Applicants Burden</td>
</tr>
<tr>
<td></td>
<td>- Verification of Information</td>
</tr>
<tr>
<td></td>
<td>- Notification of Medical Staff</td>
</tr>
<tr>
<td></td>
<td>- Departmental Action</td>
</tr>
<tr>
<td></td>
<td>- Credentials Committee Action</td>
</tr>
<tr>
<td></td>
<td>- Medical Executive Committee Action</td>
</tr>
<tr>
<td></td>
<td>- Board Action</td>
</tr>
<tr>
<td></td>
<td>Conflict Resolution</td>
</tr>
<tr>
<td>4.3</td>
<td>Reapppointment After Adverse Decision</td>
</tr>
<tr>
<td>4.4</td>
<td>Reapppointment Process</td>
</tr>
<tr>
<td>4.4-1</td>
<td>Information Form for Reapppointment</td>
</tr>
<tr>
<td>4.4-2</td>
<td>Content of Reapppointment Information Form</td>
</tr>
<tr>
<td>4.4-3</td>
<td>Information Considered</td>
</tr>
<tr>
<td>4.4-4</td>
<td>Department Action</td>
</tr>
<tr>
<td>4.4-5</td>
<td>Credential and Medical Executive Committee Action</td>
</tr>
<tr>
<td>4.4-6</td>
<td>Final Processing and Board Action</td>
</tr>
<tr>
<td>4.4-7</td>
<td>Basis for Recommendation</td>
</tr>
<tr>
<td>4.4-8</td>
<td>Time Period for Processing</td>
</tr>
<tr>
<td>4.5</td>
<td>Leave of Absence</td>
</tr>
<tr>
<td>4.5-1</td>
<td>Leave Status</td>
</tr>
<tr>
<td></td>
<td>Termination of Leave</td>
</tr>
<tr>
<td></td>
<td>Extension of Leave</td>
</tr>
<tr>
<td>4.6</td>
<td>Requests for Modification of Membership Status</td>
</tr>
<tr>
<td>4.7</td>
<td>Duration of Appointment</td>
</tr>
<tr>
<td>4.7-1</td>
<td>Duration of Initial Appointments and Modifications</td>
</tr>
<tr>
<td>4.7-2</td>
<td>Reapppointments</td>
</tr>
<tr>
<td>5</td>
<td>DETERMINATION OF CLINICAL PRIVILEGES</td>
</tr>
<tr>
<td>5.1</td>
<td>Exercise of Clinical Privileges</td>
</tr>
<tr>
<td>5.2</td>
<td>Basis for Privileges Determination</td>
</tr>
<tr>
<td>5.2-1</td>
<td>Peer Recommendations</td>
</tr>
<tr>
<td>5.3</td>
<td>Procedure</td>
</tr>
<tr>
<td>5.4</td>
<td>Special Conditions for Dental and Podiatric Privileges</td>
</tr>
<tr>
<td>5.5</td>
<td>Special Conditions for Allied Health Professional Services</td>
</tr>
<tr>
<td>5.6</td>
<td>Provisional Clinical Privileges</td>
</tr>
<tr>
<td>5.7</td>
<td>Temporary Privileges</td>
</tr>
<tr>
<td>5.8</td>
<td>Emergency Privileges</td>
</tr>
<tr>
<td>5.9</td>
<td>Disaster Privileges</td>
</tr>
<tr>
<td>6</td>
<td>REVIEW OF MEDICAL STAFF CONDUCT</td>
</tr>
<tr>
<td>6.1</td>
<td>Basis for Review</td>
</tr>
<tr>
<td>6.2</td>
<td>Initiation</td>
</tr>
<tr>
<td>6.3</td>
<td>Investigation</td>
</tr>
<tr>
<td>6.4</td>
<td>Medical Executive Committee Action</td>
</tr>
<tr>
<td>6.5</td>
<td>Procedural Rights</td>
</tr>
<tr>
<td>6.6</td>
<td>Summary Suspensions</td>
</tr>
<tr>
<td>6.6-1</td>
<td>Initiation of Suspension</td>
</tr>
<tr>
<td>NUMBER</td>
<td>ARTICLE NAME</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>6.6-2</td>
<td>Review of the Suspension</td>
</tr>
<tr>
<td>6.6-3</td>
<td>Modification or Termination of Precautionary Suspension</td>
</tr>
<tr>
<td>6.6-4</td>
<td>Procedural Rights</td>
</tr>
<tr>
<td>6.7</td>
<td>Automatic Suspension</td>
</tr>
<tr>
<td>6.7-1</td>
<td>License</td>
</tr>
<tr>
<td>6.7-2</td>
<td>DEA Number</td>
</tr>
<tr>
<td>6.7-3</td>
<td>Conviction of a felony</td>
</tr>
<tr>
<td>6.7-4</td>
<td>Medical Records</td>
</tr>
<tr>
<td>6.7-5</td>
<td>Malpractice Insurance</td>
</tr>
<tr>
<td>6.7-6</td>
<td>State or Federal Program</td>
</tr>
<tr>
<td>6.7-7</td>
<td>Imposition and Notice of Automatic Suspension</td>
</tr>
<tr>
<td>6.7-8</td>
<td>Care of Practitioners Patients</td>
</tr>
<tr>
<td>6.7-9</td>
<td>Procedural Rights</td>
</tr>
</tbody>
</table>

7. **INTERVIEWS, HEARINGS AND APPELLATE REVIEW**

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Interviews</td>
</tr>
<tr>
<td>7.2</td>
<td>Preamble and Appellate Review</td>
</tr>
<tr>
<td>7.2-1</td>
<td>Intra-organizational Remedies</td>
</tr>
<tr>
<td>7.2-2</td>
<td>Exhaustion of Remedies</td>
</tr>
<tr>
<td>7.2-3</td>
<td>Definitions</td>
</tr>
<tr>
<td>7.3</td>
<td>Grounds for Hearing</td>
</tr>
<tr>
<td>7.4</td>
<td>Notice of Action or Proposed Action</td>
</tr>
<tr>
<td>7.5</td>
<td>Hearings</td>
</tr>
<tr>
<td>7.5-1</td>
<td>Adverse Medical Executive Committee Recommendation</td>
</tr>
<tr>
<td>7.5-2</td>
<td>Adverse Board Decision</td>
</tr>
<tr>
<td>7.5-3</td>
<td>Procedure and Process</td>
</tr>
<tr>
<td>7.6</td>
<td>Requests for Hearing</td>
</tr>
<tr>
<td>7.6-1</td>
<td>Notice of Right to Hearing</td>
</tr>
<tr>
<td>7.6-2</td>
<td>Hearing Request</td>
</tr>
<tr>
<td>7.6-3</td>
<td>Time, Place and Date for Hearing</td>
</tr>
<tr>
<td>7.6-4</td>
<td>Notice of Charges</td>
</tr>
<tr>
<td>7.6-5</td>
<td>Judicial Review Committee</td>
</tr>
<tr>
<td>7.6-6</td>
<td>Failure to Appear</td>
</tr>
<tr>
<td>7.6-7</td>
<td>Postponements and Extensions</td>
</tr>
<tr>
<td>7.7</td>
<td>Hearing Procedure</td>
</tr>
<tr>
<td>7.7-1</td>
<td>Pre-Hearing Procedure</td>
</tr>
<tr>
<td>7.7-2</td>
<td>The Hearing Officer</td>
</tr>
<tr>
<td>7.7-3</td>
<td>Record and Conduct of the Hearing</td>
</tr>
<tr>
<td>7.7-4</td>
<td>Rights of the Parties</td>
</tr>
<tr>
<td>7.7-5</td>
<td>Miscellaneous Rules</td>
</tr>
<tr>
<td>7.7-6</td>
<td>Burden of Going Forward and Burden of Proof</td>
</tr>
<tr>
<td>7.7-7</td>
<td>Adjournment and Conclusion</td>
</tr>
<tr>
<td>7.7-8</td>
<td>Decision of Judicial Review Committee</td>
</tr>
<tr>
<td>7.8</td>
<td>Appeals</td>
</tr>
<tr>
<td>7.8-1</td>
<td>Time for Appeal</td>
</tr>
<tr>
<td>7.8-2</td>
<td>Reasons for Appeal</td>
</tr>
</tbody>
</table>

8. **ALLIED HEALTH PROFESSIONALS**

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Definitions</td>
</tr>
<tr>
<td>8.1 A</td>
<td>Independent Allied Health Professional</td>
</tr>
<tr>
<td>8.1 B</td>
<td>Dependent Allied Health Professional</td>
</tr>
<tr>
<td>NUMBER</td>
<td>ARTICLE NAME</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>8.2</td>
<td>Qualifications</td>
</tr>
<tr>
<td>8.3</td>
<td>Procedure for Specification of Service</td>
</tr>
<tr>
<td>8.4</td>
<td>Prerogatives</td>
</tr>
<tr>
<td>8.5</td>
<td>Membership Status</td>
</tr>
<tr>
<td>8.6</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>8.7</td>
<td>Corrective Action/Termination</td>
</tr>
<tr>
<td>8.8</td>
<td>Procedural Rights</td>
</tr>
<tr>
<td>9</td>
<td>CLINICAL ORGANIZATION OF THE MEDICAL STAFF</td>
</tr>
<tr>
<td>9.1</td>
<td>Clinical Services</td>
</tr>
<tr>
<td>9.2</td>
<td>Assignment to Departments</td>
</tr>
<tr>
<td>9.3</td>
<td>Functions of Department</td>
</tr>
<tr>
<td>10</td>
<td>OFFICERS</td>
</tr>
<tr>
<td>10.1</td>
<td>General Officers of the Staff</td>
</tr>
<tr>
<td>10.1-1</td>
<td>Identification</td>
</tr>
<tr>
<td>10.1-2</td>
<td>Other Officials of the Medical Staff</td>
</tr>
<tr>
<td>10.1-3</td>
<td>Qualifications</td>
</tr>
<tr>
<td>10.1-4</td>
<td>Nominations</td>
</tr>
<tr>
<td>10.1-5</td>
<td>Election</td>
</tr>
<tr>
<td>10.1-6</td>
<td>Exceptions</td>
</tr>
<tr>
<td>10.1-7</td>
<td>Term of Office</td>
</tr>
<tr>
<td>10.1-8</td>
<td>Removal of Elected Officers</td>
</tr>
<tr>
<td>10.1-9</td>
<td>Vacancies of Elected Offices</td>
</tr>
<tr>
<td>10.2</td>
<td>Duties of General Officers</td>
</tr>
<tr>
<td>10.2-1</td>
<td>President</td>
</tr>
<tr>
<td>10.2-2</td>
<td>Vice President</td>
</tr>
<tr>
<td>10.2-3</td>
<td>Immediate Past President</td>
</tr>
<tr>
<td>10.2-4</td>
<td>Secretary</td>
</tr>
<tr>
<td>10.2-5</td>
<td>Treasurer</td>
</tr>
<tr>
<td>10.3</td>
<td>Other Officials of the Medical Staff</td>
</tr>
<tr>
<td>10.3-1</td>
<td>Department Chairman</td>
</tr>
<tr>
<td>10.3-2</td>
<td>Vice Chairman of the Department</td>
</tr>
<tr>
<td>10.3-3</td>
<td>Medical Director</td>
</tr>
<tr>
<td>10.3-4</td>
<td>Medical Director of Laboratories</td>
</tr>
<tr>
<td>11</td>
<td>MEDICAL EXECUTIVE COMMITTEE</td>
</tr>
<tr>
<td>11.1</td>
<td>Designation and Substitution</td>
</tr>
<tr>
<td>11.2</td>
<td>Composition</td>
</tr>
<tr>
<td>11.2-1</td>
<td>Membership</td>
</tr>
<tr>
<td>11.2-2</td>
<td>Elected Membership</td>
</tr>
<tr>
<td>11.2-3</td>
<td>Removal from Office</td>
</tr>
<tr>
<td>11.2-4</td>
<td>Vacancies in Office</td>
</tr>
<tr>
<td>11.3</td>
<td>Quorum</td>
</tr>
<tr>
<td>11.4</td>
<td>Manner of Acting</td>
</tr>
<tr>
<td>11.5</td>
<td>Meetings</td>
</tr>
<tr>
<td>11.6</td>
<td>Duties and Responsibilities</td>
</tr>
<tr>
<td>12</td>
<td>COMMITTEES OF THE MEDICAL STAFF</td>
</tr>
<tr>
<td>12.1</td>
<td>Participation on Interdisciplinary Hospital Committees</td>
</tr>
<tr>
<td>12.2</td>
<td>Operation of Staff Committees</td>
</tr>
<tr>
<td>12.2-1</td>
<td>Composition and Appointment</td>
</tr>
<tr>
<td>12.2-2</td>
<td>Term and Prior Removal</td>
</tr>
<tr>
<td>NUMBER</td>
<td>ARTICLE NAME</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>12.2-3</td>
<td>Vacancies</td>
</tr>
<tr>
<td>12.2-4</td>
<td>Meetings</td>
</tr>
<tr>
<td>12.3</td>
<td>Staff Functions</td>
</tr>
<tr>
<td>12.4</td>
<td>Staff Committees</td>
</tr>
<tr>
<td>12.4-1</td>
<td>Cancer Committee</td>
</tr>
<tr>
<td>12.4-2</td>
<td>Credentials Committee</td>
</tr>
<tr>
<td>12.4-3</td>
<td>Critical Care Committee</td>
</tr>
<tr>
<td>12.4-4</td>
<td>Performance Improvement Committee</td>
</tr>
<tr>
<td>12.4-5</td>
<td>Joint Conference</td>
</tr>
<tr>
<td>12.4-6</td>
<td>Maternity and Newborn Committee</td>
</tr>
<tr>
<td>12.4-7</td>
<td>Medical Education and Library Committee</td>
</tr>
<tr>
<td>12.4-8</td>
<td>Nominating Committee</td>
</tr>
<tr>
<td>12.4-9</td>
<td>Graduate Medical Education Committee</td>
</tr>
<tr>
<td>12.4-10</td>
<td>Medical Staff and Allied Health Professional Committee</td>
</tr>
<tr>
<td>12.4-11</td>
<td>Pharmacy and Therapeutics Committee</td>
</tr>
<tr>
<td>12.4-12</td>
<td>Utilization Review Committee</td>
</tr>
<tr>
<td>12.4-13</td>
<td>Robotics Committee</td>
</tr>
</tbody>
</table>

### MEETINGS

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>General Staff Meetings</td>
</tr>
<tr>
<td>13.1-1</td>
<td>Regular Meetings</td>
</tr>
<tr>
<td>13.1-2</td>
<td>Order of Business and Agenda</td>
</tr>
<tr>
<td>13.1-3</td>
<td>Special Meetings</td>
</tr>
<tr>
<td>13.2</td>
<td>Committee and Department Meetings</td>
</tr>
<tr>
<td>13.2-1</td>
<td>Regular Meeting</td>
</tr>
<tr>
<td>13.2-2</td>
<td>Special Meeting</td>
</tr>
<tr>
<td>13.3</td>
<td>Notice of Meetings</td>
</tr>
<tr>
<td>13.4</td>
<td>Quorum and Proxy</td>
</tr>
<tr>
<td>13.5</td>
<td>Manner of Action</td>
</tr>
<tr>
<td>13.6</td>
<td>Minutes</td>
</tr>
<tr>
<td>13.7</td>
<td>Attendance Requirements</td>
</tr>
<tr>
<td>13.7-1</td>
<td>Regular Attendance</td>
</tr>
<tr>
<td>13.7-2</td>
<td>Absence from Meetings</td>
</tr>
<tr>
<td>13.7-3</td>
<td>Special Appearance</td>
</tr>
</tbody>
</table>

### CONFIDENTIALITY, IMMUNITY AND RELEASES

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Special Definitions</td>
</tr>
<tr>
<td>14.2</td>
<td>Authorization and Conditions</td>
</tr>
<tr>
<td>14.3</td>
<td>Confidentiality of Information</td>
</tr>
<tr>
<td>14.4</td>
<td>Immunity from Liability</td>
</tr>
<tr>
<td>14.4-1</td>
<td>For Action Taken</td>
</tr>
<tr>
<td>14.4-2</td>
<td>For Providing Information</td>
</tr>
<tr>
<td>14.5</td>
<td>Activities and Information Covered</td>
</tr>
<tr>
<td>14.5-1</td>
<td>Activities</td>
</tr>
<tr>
<td>14.5-2</td>
<td>Information</td>
</tr>
<tr>
<td>14.6</td>
<td>Releases</td>
</tr>
<tr>
<td>14.7</td>
<td>Cumulative Effect</td>
</tr>
</tbody>
</table>

### GENERAL PROVISIONS

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ARTICLE NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Staff Rules and Regulations</td>
</tr>
<tr>
<td>15.2</td>
<td>Departmental Rules and Regulations</td>
</tr>
<tr>
<td>15.3</td>
<td>Professional Liability Insurance</td>
</tr>
<tr>
<td>NUMBER</td>
<td>ARTICLE NAME</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>15.4</td>
<td>Staff Dues</td>
</tr>
<tr>
<td>15.5</td>
<td>Forms</td>
</tr>
<tr>
<td>15.6</td>
<td>Construction of Terms and Headings</td>
</tr>
<tr>
<td>15.7</td>
<td>Transmittal of Reports</td>
</tr>
<tr>
<td>16</td>
<td><strong>ADOPTION AND AMENDMENT OF BYLAWS</strong></td>
</tr>
<tr>
<td>16.1</td>
<td>Medical Staff Responsibilities</td>
</tr>
<tr>
<td>16.2</td>
<td>Methodology</td>
</tr>
<tr>
<td>ADDENDUM A</td>
<td><strong>GSH OUTPAIENT SURGERY CENTER</strong></td>
</tr>
</tbody>
</table>
BYLAWS OF THE MEDICAL STAFF
of
THE GOOD SAMARITAN HOSPITAL

PREAMBLE

WHEREAS, The Good Samaritan Hospital of Lebanon, PA is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania; and

WHEREAS, its purpose is to serve as a community general hospital providing safe patient care, treatments and services, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff is to strive for quality patient care in the Hospital, that the Medical Staff must work with and is subject to the ultimate authority of the Board, and that the cooperative efforts of the Medical Staff, Administration and Board are necessary to fulfill the Hospital's aims and goals in providing quality care to its patients;

WHEREAS, all medical staff members commit to working cooperatively and professionally with each other and hospital employees and management to promote safe, appropriate patient care. Medical staff leaders will strive to address professional practice issues fairly, reasonably and collegially in a manner that is consistent with quality care and patient safety.

THEREFORE, the physicians, dentists, podiatrists and allied health professionals practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

Revision approved at MEC 04/16/2013; GMS 05/28/2013; BOT0 7/23/2013
ADDENDUM A

Article I

The Medical Staff practicing at the GSH Outpatient Surgery Center shall function under the Bylaws and this Addendum to The Good Samaritan Hospital of Lebanon, Pennsylvania, with the following differences.

Article II – Purpose

The purposes of this addendum is to recognize the differences in practice and structure of the GSH Outpatient Surgery Center, including ambulatory surgical procedures

1. Surgical procedures performed at the GSH Outpatient Surgery Center are limited to those that do not exceed:
   
   a. A total of four (4) hours of operating time;
   b. A total of four (4) hours directly supervised recovery.
   c. The above time limits may be exceeded only if the patient’s condition demands care or recovery beyond the four (4) hour limit and the need for additional time could not have been anticipated prior to surgery.

2. If surgical procedures require anesthesia, the anesthesia shall be one of the following:
   
   a. Local or regional anesthesia
   b. General anesthesia of four (4) hours or less duration

3. Surgical procedures may not be of a type that:
   
   a. Are associated with the risk of extensive blood loss.
   b. Require major or prolonged invasion of body cavities.
   c. Directly involve major blood vessels.
   d. Are emergency or life threatening in nature, unless no hospital is available for the procedure and the need for surgery could not have been anticipated.
4. Physical Status of the Patient
   a. All patients receiving local, regional or general anesthesia must have a physical status or ASA Score assessment
   b. Procedures cannot be performed at the GSH Outpatient Surgery Center on patients with a physical status (PS) or ASA score that is greater than three (3).

5. In obtaining informed consent, the practitioner performing the surgery is responsible for the disclosure of:
   a. The risks, benefits and alternatives associated with the anesthesia that will be administered at the GSH Outpatient Surgery Center.
   b. The risks benefits and alternatives associated with the procedure at the GSH Outpatient Surgery Center instead of in a hospital.
   c. Blood transfusion cannot be administered at the GSH Outpatient Surgery Center.

6. In addition to the above, the following criteria apply to the performance of ambulatory surgery on children under 18 years of age:
   a. Procedures will not be performed on children less than six (6) months of age at the GSH Outpatient Surgery Center.
   b. The medical record shall include documentation that the child’s primary care provider was notified by the surgeon in advance of the performance of a procedure at the GSH Outpatient Surgery Center and that the opinion was sought from the primary care provider regarding the appropriateness of the use of this facility for the proposed procedure. When the opinion of the child’s primary care provider is not obtainable, the medical record shall include documentation which explains why the opinion could not be obtained.
   c. Surgical procedures on persons older that six (6) months and younger than eighteen (18) years of age shall be performed only under the following conditions:
      i. Anesthesia services shall be provided by an anesthesiologist who is a graduate of anesthesiology residency program accredited by the accreditation council for graduate medical education or its equivalent, or by certified registered nurse anesthetist trained in pediatric anesthesia, either of whom shall have documented demonstrated historical and continuous competence in the care of these patients.
ii. The practitioner performing the procedure shall be either board certified by or have obtained pre-board certification status with the American Board of Medical Specialties, the American Osteopathic Board of Surgery, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery.

d. A medical professional who has successfully completed a course in advanced pediatric life support offered by the American Academy of Pediatrics and either the American College of Emergency Physicians or the American Heart Association shall be present in the facility

**Article III - Medical Staff Membership**

**Section I: Definition of Medical Staff Membership**

Membership on the Medical Staff of The Good Samaritan Hospital including the GSH Outpatient Surgery Center is a privilege which shall be extended only to professional, appropriately licensed, competent physicians, dentists, podiatrists and allied health professionals who continuously meet the qualifications, standards and requirements set forth in the Bylaws and this amendment.

Allied health professionals are licensed or certified health practitioners other than physicians, dentists or podiatrists who through their training, experience and demonstrated competence are eligible to provide specific services to the GSH Outpatient Surgery Center.

**Section II Qualifications and Responsibilities for Membership**

1. Every practitioner who seeks or currently has appointment to the Medical Staff, clinical privileges or right to perform patient care services must meet the qualification requirements outlined in Article III, 3.2 and 3.3 in the Bylaws of “The Medical Staff of The Good Samaritan Hospital” of Lebanon, Pennsylvania.

2. Section III Durations or Initial Appointments and Modifications, reappointments, observation requirements, leave of absence, are outlined in the Bylaws of “The Medical Staff of The Good Samaritan Hospital” of Lebanon, Pennsylvania.
Article IV - Categories of the Medical Staff

The categories of the Medical Staff, including active staff, associate staff, courtesy staff, consulting staff, affiliate staff, coverage staff, honorary staff, limitation of prerogatives, and waiver of qualifications are outlined in Article IV, 4.1 to 4.10 in the Bylaws of “The Medical Staff of The Good Samaritan Hospital” of Lebanon, Pennsylvania and this amendment.

Article V - Allied Health Professionals

Allied Health Professional, including definitions, qualifications, procedure for specification of service, prerogatives, membership status, responsibilities, corrective action/termination and procedural rights for dependent AHP’s are outlined in Article V, 5.1 to 5.8 in the Bylaws of “The Medical Staff of The Good Samaritan Hospital” of Lebanon, Pennsylvania and this amendment.

Article VI - Procedure for Appointment and Reappointment

The procedure for appointment and reappointment to the Medical Staff is outlined in Article VI, 6.1 to 6.6 in the Bylaws of “The Medical Staff of The Good Samaritan Hospital” of Lebanon, Pennsylvania.

Article VII - Determination of Clinical Privileges

Clinical privileges shall be granted in accordance with the Bylaws of “The Medical Staff of The Good Samaritan Hospital and shall be site specific to the GSH Outpatient Surgery Center.

Article VIII - Corrective Actions

Corrective Actions when needed shall occur as outlined in Article VIII of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

Article IX - Interviews, Hearing and Appellate Reviews

Interviews, Hearings and Appellate Reviews, when needed, shall occur as outlined in Article IX of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.
Article X - Staff Departments

The medical staff practicing at the GSH Outpatient Surgery shall participate in the Medical Staff Departments, as appropriate to their specialty, of The Good Samaritan Hospital.

Article XI - Officers

1. The governing body shall appoint a Medical Director of the GSH Outpatient Surgery Center, who shall be board certified by an American Board of Medical Specialties recognized board or the dental, podiatric or osteopathic equivalent.

2. The governing body may appoint an interim director during the time between the departure of a director and the selection of a new director.

   a. The interim director shall be a physician who is able to demonstrate qualifications acceptable to the medical staff of the GSH Outpatient Surgery Center and meets regulatory requirements,

   b. If the interim director is not board certified, the PA Department of Health will specify the maximum period of time for which the interim director may serve.

3. The medical director shall be a member of the Medical Executive Committee of The Good Samaritan Hospital in order to

   a. Serve as the primary means of accountability to The Good Samaritan Hospital and governing body for the appropriateness of the professional practice and ethical conduct of the medical staff, including allied health professionals, granted privileges at the GSH Outpatient Surgery Center.

   b. Ensure quality and efficiency of medical care is evaluated and that identified problems are appropriately addressed as they pertain to the GSH Outpatient Surgery Center.

   c. Maintain effective communication throughout the health care team providing care at the GSH Outpatient Surgery Center.

   d. Ensure these Bylaws and applicable Rules and Regulations and policies and procedures are upheld for orderly conduct at the GSH Outpatient Surgery Center.

   e. Ensure medical staff concerns and resource needs are communicated to the organized medical staff and governing body as appropriate.
f. Participate in the quality management plan as appropriate to the GSH Outpatient Surgery Center, including but not limited to:

i. Medical staff functions including:
   (1) Peer based review of clinical performance of individuals with clinical privileges
   (2) Anesthesia services

ii. Quality monitoring and evaluation of:
   (1) Surgical Case and Tissue review
   (2) Nursing services
   (3) Pharmaceutical services
   (4) Pathology and radiology services
   (5) Infection control procedure and infection rates
   (6) Appropriateness of procedures performed at the GSH Outpatient Surgery Center
   (7) Patient Safety and reports of events, accidents, injuries and safety hazards.

iii. Professional Practice Evaluation:
   (1) Professional Practice Evaluations shall occur as outlined in the Medical Staff Rules and Regulations for the Department of Surgery of The Good Samaritan Hospital of Lebanon, Pennsylvania.

Articles XII – Meetings

Participation in Meetings shall occur as outlined in Article XII of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

Article XIV - Confidentiality, Immunity and Releases

Confidentiality, Immunity and Releases, will occur as outlined in Article XIII of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

Article XV - General Provisions

General provisions are as outlined in Article XIII of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

Article XVI - Adoption and Amendment of the Bylaws

Adoption and Amendment of the Bylaws, will occur as outlined in Article XVI of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

Article XVII - Fair Hearing Plan

The Fair Hearing Plan is as outlined in Article XVII of the Bylaws of “The Medical Staff of The Good Samaritan Hospital”.

ARTICLE 1

NAME

The name of this organization shall be "The Medical Staff of WellSpan Good Samaritan Hospital" of Lebanon, Pennsylvania.
PURPOSE AND SELF GOVERNANCE

2.1 PURPOSE

The purpose of the Medical Staff is:

A. To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and limited health professionals and to strive toward the continual upgrading of the quality and efficiency of patient care delivered in the Hospital consistent with the state of the healing arts and resources locally available.

B. To strive to ensure that all patients admitted to, or treated in The Good Samaritan Hospital, shall receive patient focused quality care without regard to race, religion, color, ancestry, economic status, educational background, marital status, disability, sex, age, sexuality orientation, national origin, or source of payment;

C. To conduct education and research that will maintain ethical and scientific standards of medical care and will lead to continuous advancements of professional knowledge and skill, while maintaining the quality of care and dignity for all patients;

D. To develop and maintain rules of self governance and conduct of the Medical Staff that assure the quality of professional care performed within The Good Samaritan Hospital, including recommendations for appointment and reappointment to the Medical Staff.

E. To provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning processes.

F. To provide the forum whereby issues concerning the Medical Staff may be discussed by the Medical Staff with the WellSpan Good Samaritan Hospital Board of Directors and the President of WellSpan Good Samaritan Hospital, or their designees.

G. To approve and amend the Medical Staff Bylaws, to supervise and ensure compliance with these Bylaws, Policies, Rules and Regulations of the Medical Staff, WellSpan Good Samaritan Hospital policies approved by WellSpan Good Samaritan Hospital Board of Directors.
H. To provide oversight of care, treatment and services provided by practitioners with privileges; provide for a uniform quality of safe patient care, treatment and services; report to, and be accountable to, the governing body.

I. To provide the means for effective communication among the Medical Staff, Hospital Board and Administration on issues of mutual concern.

I. To cooperate with educational institutions in under-graduate, graduate, post-graduate and continuing education.

2.2 SELF GOVERNANCE

The Medical Staff’s right to self-governance shall include, but not be limited to the following:

A. Establishing in these Bylaws and Rules and Regulations the criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards.

B. Establishing in the Bylaws and Rules and Regulations clinical criteria and standard to oversee and manage quality improvement, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

C. Selecting and removing Medical Staff Officers.

D. Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff.

E. The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff.

F. Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.
3.1 **MEMBERSHIP**

Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the staff shall confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the Board in accordance with the Bylaws. No practitioner shall admit or provide services to patients in the Hospital unless he/she is a member of the staff or has been granted temporary privileges in accordance with the procedures set forth in Section 5.7. Membership on the Medical Staff or clinical privileges shall not be granted or denied on the basis of race, religion, color, age, sex, national origin, ancestry, economic status, marital status, disability or sexual orientation, provided the individual is competent to render care of the generally-recognized professional level of quality established by the Medical Executive Committee and the Board of Directors and provided the Hospital provides the services within the proposed setting.

3.2 **EFFECT OF OTHER AFFILIATIONS**

No practitioner shall be automatically entitled to membership on the Medical Staff, or to exercise any particular clinical privileges, merely because he/she is licensed to practice in this or any other state, is a member of any professional organization, is certified by any clinical board or had, or presently has, staff membership or privileges at this Hospital or at another health care facility.

3.3 **CLASSIFICATION OF THE MEDICAL STAFF**

The staff shall include an active category and there shall also be courtesy, consulting, coverage, and honorary categories.

Membership in these categories shall be limited to graduates of professional schools, recognized by the Commonwealth of Pennsylvania for licensure, with one of the following degrees:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Dental Medicine (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Podiatric Medicine (D.P.M.)
3.3-1 **ACTIVE STAFF**

A. **QUALIFICATIONS**

The active staff shall consist of the attending physicians, dentists and podiatrists, each of whom:

1. Meets the basic requirements for membership set forth in Section 3.7;

2. Is located closely enough (office and residence) to the Hospital to provide continuous care to his/her patients, and meet active staff obligations (this area is defined as a 15-mile radius; exceptions may be granted upon documentation to the satisfaction of the Medical Executive Committee and Board of Trustees, that specific reliable arrangements for emergency care/service are in place for use whenever necessary); and

3. Regularly admits patients to, or is otherwise regularly involved in the care of patients in the Hospital.

B. **PREROGATIVES**

The prerogatives of an active staff member shall be to:

1. Admit patients without limitation, unless otherwise provided in the Medical Staff Rules and Regulations;

2. Exercise such clinical privileges as are granted to him/her pursuant to Article V, and, after review pursuant to the monitoring protocol has terminated, participate in Emergency Department "on-call" schedule;

3. Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he/she is a member, unless otherwise provided by resolution of the staff, such department or committee, and approved by the Medical Executive Committee and the Board; and

4. Hold office in the staff organization and in the department and committees of which he/she is a member, unless otherwise provided by resolution of the staff, such department or committee, and approved by the Medical Executive Committee and the Board.
C. **RESPONSIBILITIES**

Each member of the active staff shall:

1. Meet the basic responsibilities set forth in Section 3.7;

2. Retain responsibilities within his/her area of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

3. Actively participate in the patient care studies, utilization review and other quality evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession, in the emergency services program, in accepting departmental service assignments, and in discharging such other staff functions as may be required from time to time;

4. Satisfy the requirements set forth in Article XII for attendance at meetings of the staff and of the department and committees of which he/she is a member; and

5. Pay Medical Staff dues and participate in Emergency Department "on-call" schedule.

3.3-2 **COURTESY STAFF**

A. **QUALIFICATIONS**

The courtesy staff shall consist of physicians, dentists and podiatrists, each of whom shall be privileged to attend private patients in the Hospital. They are eligible to vote, may serve on committees and be involved in teaching, but, are not eligible to hold office. A medical staff physician having a courtesy staff designation will not be routinely placed on the Emergency Room call schedule for his/her respective department. However, the courtesy staff physician may be required to be included on his/her departmental Emergency Room call schedule when needed to meet federal and/or state regulations. The Vice President of Medical Affairs will determine when that need is present. The courtesy medical staff shall be reserved for those physicians who have previously served on the active Medical Staff for a minimum period of 10 years.
1. A member of the courtesy staff may admit up to 24 inpatients or consultations and perform unlimited outpatient procedures in a calendar year (newborn inpatients do not count as part of the 24 patient restriction). If he/she wishes to become more active or attends more than 24 private patients in a calendar year, exclusive of newborn inpatients, he/she must apply and be willing to assume all responsibilities of active staff membership. After appointment to such staff he/she shall be assigned by the Medical Executive Committee to the department showing the greatest need.

2. Those dentists and podiatrists requesting courtesy staff privileges will not have to serve the 10 years on active staff that is required of other practitioners on the Courtesy medical staff.

3. Each member of the courtesy staff shall meet the qualifications specified for members of the Active staff as stated in Section 3.3-1.

B. PREROGATIVES

1. Members of the courtesy staff shall have such privileges as may be determined by the Executive Committee in conformity with these Bylaws.

2. At times of full Hospital occupancy or of shortage of Hospital beds or other facilities, as determined by the President and Chief Executive Officer, the elective patient admission of courtesy staff members shall be subordinate to those of active staff members.

C. RESPONSIBILITIES

Each member of the courtesy staff shall be required to:

1. meet the basic requirements specified in Section 3.7 and, further shall retain responsibilities within his/her area of professional competence for the care and supervision of each patient in the hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

2. Participate in the evaluation and education activities required as part of the Medical Staff’s continuing efforts to improve the clinical performance of its members and, thus, the quality of patient care;

3. Satisfy the requirements set forth in Article XII for attendance at meetings for the staff and of the department and committees of which he/she is a member; and

4. Pay Medical Staff dues.
3.3-3 CONSULTING STAFF

A. QUALIFICATIONS

1. The consulting staff shall consist of physicians, dentists and podiatrists of recognized professional ability who are not primarily active in the Hospital, but are willing to serve in the prescribed consulting capacity. Each member of the consulting staff must meet the basic qualifications set forth in Section 3.7.

2. The appropriate number of consulting physicians required to deliver optimum patient care shall be determined by the Executive Committee.

B. PREROGATIVES

1. The purpose of the consulting staff is to support the active staff by providing expertise and assistance through consultations. A member of the consulting staff does not have independent inpatient or outpatient privileges.

2. No member of the consulting staff may be represented in his/her service by an agent (i.e., resident) or associate not individually and formally approved by the staff. Under special circumstances, it may be necessary for members of the consulting staff to render their service without charge.

3. The attending physician may request consultation with physicians other than those listed on the consulting staff with the permission of the President of the Medical Staff or appropriate department chairman.

C. RESPONSIBILITIES

1. The consulting staff is not eligible to vote, hold office, or serve on committees. A consulting staff member will pay 25% of the full medical staff dues. Do not have any meeting attendance requirements.

2. The consulting staff will be responsible to the President of the Medical Staff and the appropriate department chairman.
3.3-4 **AFFILIATE STAFF**

The affiliate staff shall consist of those practitioners who desire to be associated with, but who do not intend to practice at, the Hospital. The primary purpose of the affiliate staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to active staff members for admission and care. The grant of appointment to the affiliate staff is a courtesy only, which can be terminated by the Board upon recommendation of the Medical Executive Committee, without any right to a hearing or appeal.

A. **QUALIFICATIONS**

The affiliate staff shall consist of physicians, dentists, and podiatrists each of whom meets the basic requirements set forth in Section 3.7.

B. **PREROGATIVES**

1. Members of the affiliate staff:

   (i) May submit history and physicals (H&P’s) for outpatient procedures performed by podiatrists and dentists;

   (ii) May be granted limited privileges to order certain outpatient therapies, but should these privileges be requested (a) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies to the satisfaction of the Credentials Committee, Medical Executive Committee and the Board of Directors and (b) must abide by applicable bylaws or policies of the Hospital for requested privileges.

   (iii) May visit their hospitalized patients and review their Hospital medical records but may not write orders, progress notes, or other notations in the medical record;

   (iv) May not admit or attend to patients, exercise any clinical privileges, or actively participate in the provision or management of care to patients at the Hospital;

   (v) May attend educational activities of the medical staff and the Hospital;
(vi) May not vote, hold office, serve as a department chairperson, or serve as a chairperson or member of a medical staff committee.

(vii) Do not have any meeting attendance requirements and will not be listed on any Hospital call schedules; and

(viii) Are expected to pay 25% of the full medical staff dues.

C. **RESPONSIBILITIES**

Each member of the affiliate staff shall be required to discharge the basic requirements specified in Section 3.7

3.3.5 **COVERAGE STAFF**

A. **QUALIFICATIONS**

1. The coverage staff shall consist of physicians, dentists and podiatrists each of whom meets the basic requirements set forth in Section 3.7.

2. The purpose of the coverage staff is solely to provide patient care in lieu of sponsoring member(s) of the medical staff. To be eligible for this category, the applicant must be an appropriately licensed practitioner and be sponsored in writing by a member of the medical staff for whom the applicant will be covering. The applicant must then follow the appointment/reappointment processes and apply for clinical privileges as outlined in Article IV and Article V, respectively.

B. **PREROGATIVES**

1. The coverage staff is not eligible to vote, hold office, or serve on committees. Members of this category have no meeting attendance requirements and shall not pay dues.

2. Membership and privileges are automatically terminated when their affiliation with the sponsoring medical staff member(s) is terminated or when the sponsoring agreement ends, with no right to hearing or appeal.

C. **RESPONSIBILITIES**

1. Coverage staff are required to provide continuous care/coverage for patients consistent with the Departmental requirements of their discipline.
2. The coverage staff will be responsible to the President of the Medical Staff and the appropriate department chairman.

3.3-6 HONORARY STAFF

A. QUALIFICATIONS

The honorary staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, and their previous long-standing service to the Hospital.

B. PREROGATIVES

Honorary staff members are not eligible to admit patients to the Hospital, or exercise clinical privileges at the Hospital. They may, however, but are not required to, attend staff and department meetings and any staff or hospital education meetings. Honorary staff members shall not be eligible to vote at departmental or general medical staff meetings or to hold office in this Medical Staff organization. Honorary staff members may vote in committees on which they are members.

- If a member of the honorary staff wishes to be granted clinical privileges, he/she should request a transfer to the active, courtesy, or consulting staffs.

C. RESPONSIBILITIES

Each member of the honorary staff shall be required to discharge the basic requirements specified in Section 3.7.

3.3-7 TELEMEDICINE STAFF

CREDENTIALING WHEN HOSPITAL IS ORIGINATING SITE:

1. Hospital can fully privilege and credential the practitioner in accordance with Hospital Medical Staff Bylaws credentialing and privileging standards and according to The Joint Commission Medical Staff Standards;

2. The practitioner may be privileged at Hospital using credentialing information from the distant site (e.g. the site where the practitioner is physically located) if the distant site is a Joint Commission-accredited organization. The distant-site practitioner must have a Pennsylvania medical license; or
3. Hospital can use a credentialing and privileging decision from the distant site to make a final determination if all the following requirements are met:
   - The distant site is a Joint Commission-accredited hospital;
   - The practitioner is privileged at the distant site for those services to be provided at Hospital;
   - Hospital receives a current list of the practitioner’s privileges from the distant site;
   - Hospital provides the distant site with internal performance review information that can be utilized to assess the practitioner’s quality of care, treatment and services for use in performance improvement and privileging including adverse outcomes related to sentinel events resulting from the telemedicine services provided and complaints from patients, staff or other practitioners; and
   - Hospital confirms that all distant-site telemedicine providers’ credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation for credentialing medical staff.

4. In all instances, Hospital must base its privileging and credentialing decisions on evidence of an internal review of the practitioner’s performance that is useful to assess the practitioner’s quality of care, treatment and services. At a minimum, this information includes all adverse outcomes that result from the telemedicine service provided and complaints about practitioner from patients, licensed independent practitioners, or staff at Hospital.

A. **QUALIFICATIONS:**

The Telemedicine staff shall consist of physicians each of who meet the basic requirements set forth in Section 3.7. In addition, each such physician must:

1. Either:
   i) be employed by or contract with a physician group practice that contracts with the Hospital, on an exclusive or non-exclusive basis (a “Contracted Provider”) or,
   ii) be employed by or contract with a hospital or ambulatory care organization that contracts with the Hospital (a “Contractor”), is fully and unconditionally accredited by The Joint Commission (TJC) and provides the Hospital with a written statement that the Contractor credentialed the applicant using the process described in TJC’s then applicable standards;

2. Exercise his or her privileges solely through the use of telecommunication systems;

3. Be appropriately trained in the use of the telecommunications systems that are being utilized; and
4. Agree to resign from the Medical Staff immediately upon termination of his or her employment or contract with the Contractor or Contracted Provider or termination of any contractual arrangement between the Contractor or the Contracted Provider and the Hospital.

B. **PREROGATIVES:**

The prerogatives of a Telemedicine staff member shall be to:

1. Provide interpretive or consultative services through the use of telecommunications systems at the request of a member of the Medical Staff other than a member of the Telemedicine Staff. A member of the Telemedicine Staff may not admit patients to the Hospital, write orders or perform invasive procedures; and

2. Not be eligible to vote, to hold office, or to serve on Medical Staff committees

C. **RESPONSIBILITIES:**

Members of the Telemedicine Staff shall:

1. Carry out the basic responsibilities specified in Section 3.7;
2. No meeting attendance requirements;
3. Not be required to take emergency call; and
4. Not be required to pay medical staff dues.

3.4 **LIMITATION OF PREROGATIVES**

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner’s staff membership, by other Sections of these Bylaws, and by other policies of the Hospital.

3.5 **WAIVER OF QUALIFICATIONS**

Any qualification may be waived at the discretion of the Board after recommendation by the Medical Executive Committee, upon determination that such waiver will serve the best interests of the patients and the Hospital.
3.6 PROVISIONAL STATUS

All initial Medical Staff appointees shall be in provisional status. Active, courtesy, consulting, coverage and telemedicine members in provisional status shall be assigned to a Department in which their performance shall be evaluated to determine their eligibility for advancement to non-provisional status in the active, courtesy, consulting, coverage and telemedicine staff categories. These requirements shall not apply to re-appointees when there has been no prior termination of appointment.

A. QUALIFICATIONS
   Active, courtesy, consulting, coverage and telemedicine staff members in provisional status shall consist of those physicians, dentists and podiatrists who meet the qualifications applicable to their specific staff category and the membership requirements set forth in Section 3.7, but who has not completed the proctoring requirements set forth in Section 3.6-1 below, if applicable, and/or have been in provisional status for less than twelve (12) months.

B. PREROGATIVES
   The prerogatives of a staff member in provisional status shall be consistent with the prerogatives of the specific staff category in which his/her privileges are sought. He/she may exercise such clinical privileges as are granted to him pursuant to the provisions of Article V. He/she shall not be eligible to hold office in the Medical Staff organization, but shall be required to pay medical staff dues as required by those practitioners holding privileges in the staff category in which he/she holds provisional status.

C. RESPONSIBILITIES
   A Medical Staff member in provisional status shall have the same responsibilities as those practitioners holding privileges in the staff category in which he/she holds provisional status. In addition he/she shall be required to participate in proctoring as required by Section 3.6-1.

3.6-1 OBSERVATION/PROCTORING (FPPE) FOR INITIAL APPOINTMENTS
   Except as otherwise determined by the Board, all initial appointments to any category of the staff and all staff members granted new clinical privileges shall be subject to proctoring (Focused Professional Practice Evaluation – FPPE). A minimum three (3) months of monitoring commences with the approval of the Credentials Committee. A total of ten (10) cases shall be reviewed unless the Provider is a low volume Practitioner it is then acceptable to review as many charts as possible and offer comments about the performance on an outpatient basis. Proctoring shall be in accordance with criteria set forth in the appropriate Medical Staff Department Rules and Regulations and/or the Medical Staff Quality Assessment and Improvement Policy and may include direct observation of performance and/or chart review. Each initial appointee or recipient of new clinical privileges shall be assigned to a Department for monitoring of performance on an appropriate number of cases established by the Medical Executive Committee, or the
Department as designee of the Medical Executive Committee and shall be observed by the chairman of the Department, or such chairman's designee (the proctor), during the period of proctoring specified in the Department's Rules and Regulations, to determine his/her eligibility for continued staff membership in the staff category in which he/she was initially appointed and for exercising the new clinical privileges initially granted in that Department. His/her exercise of clinical privileges in any other Department shall also be subject to observation by that Department's chairman or his/her designee. During the period of observation, the practitioner will not be listed on the Emergency room call schedule, unless specifically approved by the Department chairman. An initial appointee or recipient of new clinical privileges shall remain subject to observation until the Medical Executive Committee has received:

A. A statement signed by the chairman of the Department to which he/she is assigned that the practitioner meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the staff category to which he/she was appointed.

B. A statement signed by the chairman of the Department in which the practitioner will exercise clinical privileges that he/she has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted to him/her.

The Medical Executive Committee may accept evidence of satisfactory performance under monitoring in an institution or facility outside the Hospital, provided that the proctor is acceptable to the Committee.

Following receipt of this information, the Medical Executive Committee shall make a recommendation to the Board of Trustees as to the termination of the practitioner's provisional status, upon receipt of which the Board shall make a final determination.

3.6-2 **EXTERNAL PEER REVIEW**

External peer review will take place in the context of focused review (Section 3.6-1), investigation (Section 6.3), application processing (Article IV and V), or under any of the following circumstances if deemed appropriate by the medical staff Department, Medical Executive Committee, or Board of Trustee:

(a) ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from the review could directly impact an individual's membership or privileges;

(b) lack of internal expertise, when no one on the medical staff has adequate expertise in the clinical procedure or area under review;

(c) when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring;

(d) to promote impartiality in peer review; or
(e) upon the reasonable request of a practitioner under review.

In addition, a practitioner subject to focused review or investigation may require the Hospital or Medical Staff to obtain external peer review, regardless of the reason therefore, upon request.

3.6-3 MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A. Medical Staff members who are granted additional privileges shall also complete a period of proctoring. This observation shall be conducted by the appropriate Department Chairman or his/her designee, following which a final recommendation on approval or disapproval of the change shall be made to the Board for final determination.

B. da Vinci Surgical System/Robically Assisted Minimally Invasive (RAMI) Medical Staff members who are applying for additional privileges in da Vinci Surgical System/Robotically Assisted Minimally Invasive (RAMI) may be granted provisional privileges upon completion of all training components and requirements. Final recommendations on approval or disapproval of additional da Vinci Surgical System Robotically Assisted Minimally Invasive (RAMI) privileges shall be made to the Board of Trustees for final determination after successful completion of requisite proctored cases.

3.6-4 TERM OF OBSERVATION PERIOD

The observation period for initial appointment shall extend for a minimum of three (3) months commencing at the time of appointment to the staff by the Board of Trustees. This observation period is considered by the Board to be a period of provisional appointment to the staff. At the conclusion of this three (3) month period, the designated proctor shall have the duty of reviewing the work of the practitioner and reporting to the appropriate Department Chairman. If performance has been satisfactory, the Chairman will then recommend termination of observation to the Medical Executive Committee for presentation to the Board. If the proctor and/or Department Chairman feel that observation should be continued, they shall make such recommendation to the Board, which may extend the period of observation for a period of up to twelve (12) months total, including the initial observation period. At the conclusion of such period, the designated proctor shall again review the work of the practitioner and report to the Department Chairman, which time a final recommendation shall be made to the Board for final determination. Under exceptional circumstances, a recommendation may be made and action taken by the Board to extend the observation period beyond twelve (12) months. In the event a staff member in provisional status is not approved for advancement to non-provisional status within twelve (12) months or such longer period of observation as shall
be determined by the Board, the Medical Executive Committee shall initiate action to
terminate the membership and privileges of such staff member, upon written notice to
him/her. An adverse decision by the Board which results in termination of staff
membership, shall afford the practitioner the hearing and appeal rights set forth in Article
VII. A member whose membership and privileges are terminated pursuant to the terms of
this Section 3.6-4 may reapply for membership and clinical privileges twelve (12) months
following such termination.

3.6-5 QUALIFICATIONS OF PROCTORS

A. Either the Department Chairman or his/her designee may serve as the proctor for a
new member of the medical staff; provided, however, that any designee should be
a peer of the new member (i.e. having similar professional degrees) and should
have similar clinical privileges as those being requested.

B. Either the Department Chairman or his/her designee may serve as the proctor for a
practitioner requesting additional privileges; provided, however, that any designee
should have the same privileges as those being requested. In addition, at the
request and upon the approval of the Department Chairman or the Credentials
Committee, an outside proctor, not a member of the Medical Staff, may be
required. Any costs associated with the use of an outside proctor will be borne by
the practitioner.

3.7 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.7-1 BASIC QUALIFICATIONS

In order to obtain or maintain membership on the Medical Staff or be granted clinical
privileges, an applicant must have and provide evidence of:

A. **Licensure:** Current unrestricted certificate or license to practice medicine or
surgery, dentistry or podiatry in the Commonwealth of Pennsylvania.

B. **Professional Degree:** Have a Doctor of Medicine, Doctor of Osteopathy, Doctor of
Dental Medicine, Doctor of Dental Surgery, or Doctor of Podiatric Medicine degree.

Satisfactory completion of appropriate postgraduate education:

(i) For Doctors of Medicine and Doctors of Osteopathy, or for Doctors of Dental
Medicine or Doctors of Dental Surgery seeking privileges beyond general dentistry,
includes completion of a program of internship/residency/fellowship, creating
eligibility for certification by a specialty board recognized by the American Board of
Medical Specialties, the American Osteopathic Association, or the American Dental
Association or the American Podiatric Medical Association.
C. **Board Certification:** An applicant must be board certified and/or subspecialty certified by a member board of the American Board of Medical Specialties (ABMS), a member board of the American Osteopathic Association Bureau of Osteopathic Specialties (AOABS), the American Board of Oral and Maxillofacial Surgery, a member board of the Joint Committee on the Recognition of Specialty Boards (JCRSB); or an applicant must have within the last five (5) years completed a post-graduate training program which qualifies the applicant to seek certification by one of these certifying organizations. New post-graduate training program graduates are expected to become certified before five (5) years have transpired since the date of completion of their latest residency or fellowship training. This board certification requirement does not apply to dentists and is applicable only to those individuals who receive initial Staff appointment or initial grant of Privileges on or after November 1, 2013. Those individuals who applied for and received initial Staff appointment or initial grant of Privileges prior to November 1, 2013 and who have continuously maintained that appointment and/or those Privileges will be considered grandfathered under this clause.

D. **Maintenance of Board Certification:** All Medical Staff Members and all Privilege holders who are required by these Bylaws to attain board certification and/or subspecialty certification by a member board of the American Board of Medical Specialties (ABMS), a member board of the American Osteopathic Association Bureau of Osteopathic Specialties (AOABS), the American Board of Oral and Maxillofacial Surgery, a member board of the Joint Committee on the Recognition of Specialty Boards (JCRSB); must also continuously maintain at least one board certification and/or subspecialty certification throughout the period during which they maintain such appointment and/or Privileges. The “continuous” aspect of this maintenance requirement may be temporarily waived for periods up to thirty (30) months by individual application to the MEC which may act in its sole discretion. This board certification maintenance requirement does not apply to dentists and is applicable only to those individuals who receive initial Staff appointment or initial grant of Privileges on or after November 1, 2013. Those individuals who applied for and received initial Staff appointment or initial grant of Privileges prior to November 1, 2013 and who have continuously maintained that appointment and/or those Privileges will be considered grandfathered under this clause.

E. Eligibility to participate in the Medicare, Medicaid and other federally sponsored health care programs.
F. Affirm that he/she has not experienced any of the following:
   1. Revocation or suspension of license to practice in any location (state, province, etc.),
   2. Probation or limitation of practice by the Commonwealth of Pennsylvania,
   3. Termination of medical staff privileges at another facility for professional reasons (i.e., non-contractual), or relinquishment of privileges under threat of such termination,
   4. Denial of a request for medical staff privileges at another facility for professional reasons,
   5. Imposition of sanctions by any healthcare or governmental agency as a result of any civil or criminal action.

G. Evidence of professional liability insurance coverage in an amount meeting the minimum requirements for such coverage for physicians practicing in the Commonwealth of Pennsylvania.

H. Evidence of required background checks/clearances including the Pennsylvania Child Abuse History Clearance and Pennsylvania State Police Criminal Record Check as per Medical Affairs Policies MA-06 and MA-07. These clearances must be renewed every twenty-four (24) months.

I. Influenza Vaccination Qualification: An individual meets the influenza vaccination qualification if the individual has provided proof of an annual influenza vaccination or possesses an approved medical or religious exemption to the influenza vaccination process as outlined in the Influenza Vaccine Program; Medical Affairs Policy MA-08 (except individuals applying for Telemedicine privileges).

A practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article VII.
3.7-2 GENERAL REQUIREMENTS

In order to obtain or maintain membership on the Medical Staff or be granted clinical privileges, a practitioner must:

A. Provide information with regard to his/her experience, background, training, demonstrated ability, physical health status and, upon request of the Medical Executive Committee or of the Board, mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by him/her will receive care of the generally recognized professional level of quality and efficiency and that he/she is qualified to provide a needed service within the Hospital;

B. Provide references (1 from an Administrator or Department Chairman of previously affiliated facilities) demonstrating ability to adhere strictly to the ethics of his/her profession, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities;

C. Provide evidence of current competence in his/her respective field, ability to perform the clinical privileges requested, and adherence to the standards of General Competence.

D. Provide evidence of his/her ability to provide patients with continuous care that meets the professional standards established by the Medical Staff;

E. Agree to make appropriate arrangements for coverage of his/her patients as determined by the Medical Staff;

F. Agree to abide by Federal and State regulations with respect to professional billing practices;

G. Agree to abide by the decisions of all duly appointed Medical Staff committees and cooperate with safe patient care, treatment and services and Medical Staff activities, including proctoring, performance improvement, utilization review, peer review and attendance at Medical Staff meetings;

H. Agree to notify the Board in writing immediately of any change or termination of professional liability insurance coverage;

I. Agree to abide by the Medical Staff Bylaws, Rules and Regulation and other Medical Staff and administrative policies, including the Compliance Code of Conduct and policies regarding discrimination and harassment, privacy, confidentiality and security of Protected Health Information;
J. Agree to notify the Board in writing immediately upon the occurrence of any Pennsylvania Board of Medicine accusation, reprimand, change in medical license status, or other adverse action by any health care entity or law enforcement agency including any reprimands, conviction or plea of guilty or nolo contendere to any misdemeanor or felony, the settlement or adverse judgment or verdict of any professional liability suit against the practitioner, a voluntary or involuntary termination of medical staff privileges or voluntary or involuntary limitation or imposition of a monitoring requirement, reduction, loss or change of clinical privileges at another health care entity, contact by an investigator from a regulatory agency such as FDA, DEA, DPW, etc. regarding an investigation of the practitioner;

K. Agree to provide the Board in writing information as to details of any prior or pending government agency or third-party payor proceeding or litigation challenging or sanctioning the practitioner’s patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare or Medicaid fraud and abuse proceedings and convictions;

L. Agree to fulfill, if required by his/her category of privileges, necessary continuing medical education requirements by completing 100 hours of Continuing Medical Education every two (2) years of staff membership (20 hours, at least must be reported in Category I);

M. Agree to participate in quality assurance and quality improvement activities, and any other required training activities of the Medical Staff, and to hold knowledge of the content of these activities strictly confidential;

N. Agree to notify the President of the Medical Staff in writing of any geographical relocation of his/her practice or residence or any limitation or cessation of his/her professional practice of thirty (30) days or more in duration;

O. Agree to prepare, update and complete, in a timely, accurate manner, the medical record and other required records for all patients the practitioner in any way provides care to while at the Hospital. This includes documentation of patient history and physical examinations, in all settings, as follows:

**DOCUMENTATION OF HISTORY AND PHYSICAL EXAMINATION**

1. A history and physical examination shall be recorded within twenty-four (24) hours of admission.

2. If the History and Physical is greater than thirty (30) days old, a new, complete History and Physical must be documented in the medical record. A History and Physical may be valid beyond thirty (30) days and up to a
maximum of one year only in the case of a specific treatment regimen that involves a series of steps for completion (i.e., IV therapy, wound care). However, at each visit for the specific regimen, the History and Physical must be reviewed and a written indication of no change in condition, or if applicable, changes since last visit.

3. Standard “Short Form” (SSU) history and physical examination form may be used for inpatients whose hospital stay is anticipated to be up to forty-eight (48) hours or for Short Stay Unit patients who must be admitted following surgery and remain hospitalized no more than forty-eight (48) hours. A history and physical addendum or admission note outlining the reason for inpatient admission must be include for the latter. Short form history and physicals shall cease to be adequate if the patient’s hospitalization is prolonged beyond forty-eight (48) hours for any reason.

A. **INPATIENT HISTORY AND PHYSICAL CONTENT REQUIREMENTS**

1. Medical history
   -Chief complaint
   -Details of present illness
   -Relevant past, social and family histories
   -Inventory of body systems
   -Current medications and dosages
   -Any known allergies, including medication reactions

2. Summary of patient’s psycho-social needs, as appropriate (may be addressed in Nursing Admission Assessment and/or Social Services Assessment)

3. Physician examination should include heart, lung, mental status and remaining body systems to the degree of detail pertinent to the age and sex of the patient, the patient’s symptoms, other physical findings and diagnostic data.

4. Statement of the conclusions or impressions drawn from the admission history and physical

5. Plan for diagnostic and/or treatment measures

B. **OUTPATIENT HISTORY AND PHYSICAL CONTENT REQUIREMENTS**

1. History to include:
   (a) Indications/symptoms for procedure
   (b) Current medications and dosages
   (c) Any known allergies, including medication
reactions
(d) Existing co-morbid conditions, if any

2. Physical examination (NO ANESTHESIA, OR TOPICAL, LOCAL OR REGIONAL BLOCK):
   (a) Assessment of mental status: AND
   (b) An examination specific to the procedure proposed to be performed

3. Physical examination (IV SEDATION):
   (a) Indications/symptoms for procedure
   (b) Current medications and dosages
   (c) Any known allergies, including medication reactions
   (d) Exam of heart and lungs by auscultation

4. Physical examination (GENERAL, SPINAL, OR EPIDURAL):
   (a) Indications/symptoms for procedure
   (b) Current medications and dosages
   (c) Any known allergies, including medication reactions
   (d) Existing co-morbid conditions, if any
   (e) Assessment of and written statement about patient’s general condition

Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

C. Except when a history and physical is performed on the day of surgery, there shall be a pre-procedure note on the day of surgery by a physician, or individual qualified to administer anesthesia, evaluating the patient’s current status for surgery.

D. Pre-procedure notes on patients undergoing spinal or general anesthesia shall include an anesthesia history, including risk of anesthesia, by a person qualified to give anesthesia. (May be a component of pre-admission and/or pre-anesthetic evaluation)
3.7-3 **WAIVER OF QUALIFICATIONS**

Any qualification requirements in this Section 3.7 or any other Section or Article of these Bylaws not required by law or governmental regulation may be waived at the discretion of the Board of Directors upon recommendation of the Medical Executive Committee, upon determination that such waiver will serve the best interests of the patients of the Hospital.

3.8. **ADMINISTRATIVE AND MEDICO-ADMINISTRATIVE OFFICERS**

A practitioner employed full-time by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff. Conversely, a medico-administrative officer, who renders both administrative duties and clinical care, must be a member of the Medical Staff, achieving this status by the procedure provided in Article IV. His/her clinical privileges must be delineated in accordance with Article V. The Medical Staff membership and clinical privileges of any medico-administrative officer shall be contingent on his/her continued occupation of that position, unless otherwise provided in an employment agreement, contract or other arrangement.

- Addition of 3.3-7 approved at MEC 08/20/2013; GMS 09/24/2013; BOT 10/22/2013
- Revisions to 3.7-1 approved at MEC 08/20/2013; GMS 09/24/2013; BOT 10/22/2013
- Revisions to 3.6 and 3.6-A approved at MEC 11/19/2013; GMS 01/28/2014; BOT 02/24/2014
- Addition of 3.6-38 approved at MEC 07/15/2014; GMS 09/23/2014; BOT 10/21/2014
- Revisions to 3.6-1 approved at MEC 08/18/2015; GMS 09/22/2015; BOT 10/27/2015
- Revisions to 3.7-1 approved at MEC 08/18/2015; GMS 09/22/2015; BOT 10/27/2015
- Revisions to 3.3-48 approved at MEC 04/19/2016; GMS 05/17/2016; BOD 05/24/2016
APPONITMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

4.1 PROCEDURE FOR APPLICATION

The Medical Staff, with the assistance of the Administration, through its designated departments, committees and officers, shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership or status or privileges and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform these same investigation, evaluation, and recommendation functions in connection with any Allied Health Professional or other individual who seeks to exercise clinical privileges or provide specific services in any department or service of the Hospital, whether or not such individual is eligible for Medical Staff membership.

4.1-1 REQUEST FOR APPLICATION

When a staff application is requested, it shall be in writing, either by letter or on the prescribed form. It shall indicate the applicant’s intentions regarding membership and general privileges. The potential applicant will be encouraged to have an interview with the Medical Director before submitting the formal application.

4.1-2 GENERAL PROCEDURE

Every applicant for appointment or reappointment to the Medical Staff shall:

A. Submit a properly completed application, signed by the applicant, to the Vice President of Medical Affairs, on the forms prescribed for that purpose by the Credentials Committee and Medical Executive Committee. Properly completed means that all provisions have been completed or an explanation provided of any that are not and all required supporting documentation has been submitted.

B. Acknowledge that he/she will notify the Vice President of Medical Affairs of any changes in the information provided in the application during the application process or at any subsequent time.

C. Submit any information regarding any past or present exclusion from a federal or state health care program.

D. Submit relevant information pertaining to the applicant’s physical and mental health.
4.2. APPLICATION FOR INITIAL APPOINTMENT

4.2-1 APPLICATION FORM AND CONTENT

Each application shall be submitted on the prescribed form, be legible, and be signed by the applicant. The appropriate fee shall accompany the application. All information requested on the form must be supplied and shall include, in addition to the information set forth in Section 4.1-2 above:

A. Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Section 3.7 and of any additional qualifications specified in these Bylaws for the particular staff category to which the applicant requests appointment. A valid picture ID issued by a state or federal agency (e.g. driver's license or passport) and evidence of Pennsylvania licensure shall be included.

B. Requests: Requests stating the staff category, department and clinical privileges for which the applicant wishes to be considered.

C. References: The names of at least 2 persons who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character, and ability to work with others.

D. Professional Sanctions: Information as to whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily relinquished:

1. Staff membership status or clinical privileges at any other hospital or health care institution
2. Membership/fellowship in local, state or national professional organizations
3. Specialty board certification/ admissibility
4. License to practice any profession in any jurisdiction
5. Drug Enforcement Administration (DEA) number

If any of such actions ever occurred or are pending, the particulars thereof shall be included.
Professional Liability Insurance: Evidence that the applicant carries at least the minimum amount of professional liability insurance coverage required by Pennsylvania State law (see Section 15.3) and information on his/her malpractice claims history and experience during the past five years, including a consent to the release of information by his/her present and past malpractice insurance carrier.

Notification of Release & Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Article XIV.

Administrative Remedies: A statement whereby the practitioner agrees that, when an adverse ruling is made with respect to his/her staff membership, staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

4.2-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, each applicant:

A. signifies his/her willingness to appear for interviews in regard to his/her application;

B. authorizes the Credentials Committee and Hospital Administration to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications, including the National Practitioner Data Bank;

C. consents to the Credentials Committee and Hospital Administration inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, of his/her physical and mental health status and of his/her professional ethical qualifications;

D. authorizes the Hospital to carry out all required background checks;

E. Authorizes the release of all records and documents that, in the judgment of the Vice President of Medical Affairs, Department Chairman, Credentials Committee, Medical Executive Committee or Board of Trustees, may be material to an evaluation of the applicant’s qualifications.
F. acknowledges that he/she has been given a copy of or an opportunity to read these By-laws, the Staff Rules and Regulations, the Hospital Corporate By-laws, and summaries of other Hospital and Staff policies relating to clinical practice in the Hospital. Further, it shall include a statement that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges, and be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he is granted membership and/or clinical privileges;

G. releases from any liability all Hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

H. releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

For purposes of this Section, the term "Hospital Representative" includes the Board, its Directors and Committees; the President and Chief Executive Officer or his/her designee; the Medical Staff Organization and all Medical Staff Members, Departments and Committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

4.2-3 PROCESSING THE APPLICATION

A. APPLICANT'S BURDEN

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, background, training, demonstrated ability, and, upon request of the Credentials Committee or of the Board, physical and mental status, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.7.
The applicant for appointment shall have the burden of producing complete, accurate and adequate information for a proper evaluation of his/her qualifications, including all requirements specified in the Medical Staff Bylaws and the Medical Staff Rules and Regulations, for resolving any doubt about these matters, and of providing any additional information requested by the Vice President of Medical Affairs. This burden may include submission to a medical, psychiatric, or psychological examination, at the applicant’s expense.

B. MISSTATEMENTS AND OMISSIONS:

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

II. If appointment has been granted prior to the discovery of a misstatement or omission, the information will be brought to the attention of appropriate individuals according the Article 6.6-1 (Initiation of Summary Suspension) to consider imposing a summary suspension pending formal action by MEC.

III. No action taken pursuant to this section will entitle the applicant or appointee to a hearing or appeal.

IV. An application shall be deemed complete when all requested information has been provided by the applicant and verified or confirmed by the Hospital.

C. VERIFICATION OF INFORMATION

The Office of Medical Affairs shall, in a timely fashion (but no longer than 120 days) seek to collect or verify the references, licensure, malpractice insurance, and other qualification evidence submitted, and shall notify the applicant of any problems in obtaining the information required in accordance with Section 4.2-3.A. above. The National Practitioner Data Bank will be queried. Verification of Pennsylvania licensure will either be in written or electronic form. Information on the application will be verified initially, and at reappointment.
D. NOTIFICATION OF RECEIPT OF APPLICATION

The Vice President of Medical Affairs, upon receipt of the completed application, shall notify the President of the Staff, President and Chief Executive Officer, Medical Executive Committee, and Credentials Committee. The application will also be reported at the next general staff meeting. The receipt of an application shall also be reported to each Department in which the applicant seeks privileges at the next Department meeting, and any pertinent information concerning the applicant should be forwarded to the Department Chairman.

E. DEPARTMENTAL ACTION

The Department Chairman shall review the completed application, with supporting documentation and any other relevant information concerning the applicant’s qualifications. After such review, the Chairman shall transmit to the Credentials Committee his/her recommendations as to staff appointment and, if appointment is recommended, as to staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. (No recommendation adverse to the applicant shall be made until or unless the Department Chairman has personally met with the applicant.) The reason for any special recommendations shall be stated and supported by reference to the completed application and all other documentation considered by the Department, all of which shall be transmitted with the report. Any contrary views arising from other staff members shall also be reduced to writing, supported by reasons and references, and transmitted with the report.

F. CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, the supporting documentation, the Department Chairman’s report and recommendations, and such other information available to it that may be relevant to consideration of the applicant’s qualifications for the staff category, department and service affiliation, and clinical privileges requested, in compliance with the Medical Staff Bylaws.

The Credentials Committee shall interview the applicant in person. When the Chairman of the Credentials Committee deems that it is not practical for the applicant to be interviewed in person, the Chairman may allow the interview to be conducted by telephone or video. For applicants applying for coverage privileges, a medical staff member for whom the coverage applicant will be working must be interviewed by the Credentials Committee before such privileges can be granted.
Upon completion of its investigation, the Credentials Committee will forward its report to the Medical Executive Committee. It will provide one of the following recommendations:

(A) **Approval** - including staff category, department or service affiliation, and clinical privileges
(B) **Approval** - with special modifications
(C) **Rejection** - with reasons stated
(D) **Deferral** - with reasons stated, where the committee has grounds to believe it can develop further information relevant to the application

G. **MEDICAL EXECUTIVE COMMITTEE ACTION**

The recommendation of the Credentials Committee will be reported at the next meeting of the Medical Executive Committee following its receipt. If procedural questions are raised, the Credentials Committee may be interviewed. The Medical Executive Committee will conduct any further investigation regarding the applicant's character, competence, health and/or ethics it deems appropriate, and shall then take one of the following actions and forward the application to the Board of Trustees:

(A) **Concurrence**
(B) **Concurrence with modifications - reasons stated**
(C) **Non-concurrence - reasons stated**
(D) **Refer back to Credentials Committee for further investigation or discussion**

In the event that the Medical Executive Committee notes its recommendation to the Board as adverse to the applicant, the applicant shall be notified of the adverse recommendation and of his/her right to request a hearing pursuant to Article VII. No final action shall be taken by the Board of Trustees until the applicant has waived or exhausted his/her hearing rights.
H. BOARD ACTION

Upon the receipt of the application, supporting information and recommendations from the Medical Executive Committee, and provided that the applicant has not requested a hearing on an adverse recommendation of the Medical Executive Committee or if requested, such hearing has occurred, the Board of Trustees shall act upon the application. The Board may either adopt or decline to adopt the recommendation of the Medical Executive Committee, or refer the matter back to the Medical Executive Committee for further proceedings. If the decision of the Board of Trustees is to appoint the applicant to the Medical Staff, the Board shall approve the specific privileges to be granted to the Medical Staff member. The Board of Trustees shall give great weight to the actions and recommendations of the Medical Executive Committee and, in no event, shall act in an arbitrary and capricious manner. When the Board has adopted the decision, it shall be considered the final decision of the Hospital, and shall be subject to the rights set forth in Article VII.

All decisions of the Board of Trustees approving or disapproving the appointment of an applicant shall be forwarded in writing to the applicant, with a copy to the Vice President of Medical Affairs and to all other appropriate internal or external persons or entities, as follows:

(i) **Favorable Recommendation**: When favorable action has been taken by the Board of Trustees, the President and Chief Executive Officer of the Hospital shall transmit its decision to the applicant. The President shall secure the applicant’s signature to these Bylaws and the Rules and Regulations. Such signature, together with the application, will constitute his/her agreement to be governed by said Bylaws, Rules and Regulations. A decision and notice to appoint shall include: (1) the staff category to which the applicant is appointed; (2) the Department to which he/she is assigned; (3) clinical privileges he/she may exercise; and (4) any special conditions attached to the appointment. The applicant will be notified no later than 2 weeks from the time the final decision is made. When the Board approves a new staff membership, a probationary period in accordance with the provisions of Section 3.6 shall exist.

(ii) **Unfavorable Recommendation**: When unfavorable action has been taken by the Board of Trustees, the President and Chief Executive Officer of the Hospital shall transmit its decision, together with the reasons therefore, to the applicant. The Board shall take final action in the matter only after the applicant has exhausted or waived his procedural rights as provided in Article VII.
A Medical Staff member who has been the subject of an adverse decision denying an application, an adverse corrective action decision, or a resignation in lieu of medical disciplinary action shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by such action for a period of at least one (1) year from the date the adverse decision became final, the date the application was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or Board may require in demonstration that the basis for the earlier adverse action no longer exists.

(iii) Referral Back to Medical Executive Committee: When the Board of Trustees fails to accept the recommendation of the Medical Executive Committee and refers the application back for further consideration; the Secretary shall present the application again to the Medical Executive Committee. Any such referral back shall state the reason therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision.

I. CONFLICT RESOLUTION

Whenever the Board's proposed decision will be contrary to the Medical Staff's recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation before making its final decision.

4.3 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.
4.4 REAPPOINTMENT PROCESS

4.4-1 INFORMATION FORM FOR REAPPOINTMENT

The Secretary of the Medical Staff shall, at least ninety (90) days prior to the expiration date of the present staff appointment of each Medical Staff member, provide such staff member with an information form for use in considering his/her reappointment. Each staff member who desires reappointment shall, at least forty-five (45) days prior to such expiration date, send his/her reappointment application to the appropriate Department Chairman. Failure without good cause to so return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining the issue of good cause.

4.4-2 CONTENT OF REAPPOINTMENT APPLICATION

The staff member shall deliver a completed signed reappointment application to the Medical Staff Coordinator within the time period described in Section 4.4-1. The Office of Medical Affairs shall, in a timely fashion, seek to collect or verify the information required, and shall promptly notify the applicant of any problems in obtaining the verifications required. The National Practitioner Data Bank will be queried. Verification of Pennsylvania licensure will either be in written or electronic form. It shall be the applicant's obligation to obtain the required information, in accordance with the provisions of Section 4.2-3.A. with regard to applications for initial appointment. An application shall be deemed complete when all requested information has been provided by the applicant and verified or confirmed by the Hospital.

The reappointment application shall request information necessary to update the Medical Staff file on the staff member's health-care related activities other than as a member of the staff. This information shall include, without limitation, information about the following:

A. Continuing training, education and experience that qualifies the staff member for the privileges sought on reappointment.

B. Current health status. (Upon request of the Medical Executive Committee or the Board, documentation of current physical and/or mental health status may be required).

C. The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding period.
D. Membership, awards or other recognition conferred or granted by any professional health care societies, institutions, or organizations.

E. Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, or licensing authority.

F. Malpractice insurance coverage (including cancellation, non-renewals and limits), and experience.

G. Previous or currently pending challenges to licensure or registration or the voluntary relinquishment of license or registration; voluntary or involuntary changes in medical staff membership at another hospital; or loss, limitation or reduction of clinical privileges, voluntary or involuntary, at another hospital.

4.4-3 INFORMATION CONSIDERED

Information to be used for the reappointment of a Medical Staff member will include: 1) on-going individual performance data in the form of aggregate data (when available), and 2) information obtained from the reappointment application submitted by the medical staff member, including the information required by the terms of Section 4.4-2 above.

A. The type of aggregate performance data used for the reappointment process is determined by individual medical staff departments, as delineated in Department Rules and Regulations and approved by the Medical Executive Committee.

B. The Credentials Committee or Medical Executive Committee may require additional proctoring (FPPE), in accordance with Section 3.6, for any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

4.4-4 DEPARTMENT ACTION

A Department Chairman shall review the reappointment application, performance data, and the staff member's file and shall transmit to the Credentials Committee and the Medical Executive Committee, on the prescribed form, a report and recommendation that appointment be:

1) renewed without modification,
2) renewed with modified staff category, department affiliation, and/or clinical privileges, or
3) terminated
A chairman may also recommend that the Medical Executive Committee defer action. Each such report shall satisfy the requirements of Section 4.2-3 D. Any minority views shall also be reduced to writing and transmitted with the majority vote.

4.4-5 CREDENTIALS AND MEDICAL EXECUTIVE COMMITTEE ACTION

The Credentials Committee shall review a summary of each information form and any other relevant information available and make, on the prescribed form, a recommendation to the Medical Executive Committee that appointment be:

1) renewed without modification,
2) renewed with modified staff category, department affiliation, and or clinical privileges,
3) terminated, or
4) defer action

The Medical Executive Committee shall review the recommendation of the Credentials Committee and any other relevant information available to it and shall, on the prescribed form, forward to the President and Chief Executive Officer for transmittal to the Board, its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation, and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of Sections 4.2-3 E and F. Any minority views shall also be reduced to writing and transmitted with the majority report.

4.4-6 FINAL PROCESSING AND BOARD ACTION

Following the Board’s receipt of the recommendation of the Medical Executive Committee, the procedure provided in Section 4.2-3 G through I shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those Sections shall be read, respectively, as "staff member" and "reappointment."

4.4-7 BASIS FOR RECOMMENDATIONS

Each recommendation and action concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon such member’s professional ability and clinical judgment in the treatment of patients, his/her on-going individual performance data, his/her professionalism, his/her ability to provide appropriate, compassionate and effective patient care, his/her professional ethics, his/her discharge of staff obligations, his/her cooperation with other practitioners, Hospital personnel and with patients, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.
Each member agrees that inquiry of the National Practitioner Data Bank shall be a part of the reappointment appraisal.

4.4-8 TIME PERIOD FOR PROCESSING

Transmittal of the reappointment application to a staff member and his/her return of it shall be carried out in accordance with Section 4.4-1. Thereafter each person, department and committee required by these Bylaws to act thereon, shall complete such action in timely fashion so that all reports and recommendations concerning the reappointment of a staff member shall have been transmitted to the Medical Executive Committee for its consideration and action pursuant to Section 4.4-5 and to the Board for its action pursuant to Section 4.4-6, all prior to the expiration date of the staff membership of the member being considered for reappointment.

The time periods specified herein are to guide the acting parties in accomplishing their tasks. If the processing has not been completed by the expiration date of the appointment, the staff member shall maintain his/her current membership status and clinical privileges until such time as the processing is completed unless corrective action is taken with respect to all or any part thereof, or unless the delay is due to the practitioner's failure to return the internal information form as required, in which case the provisions of Section 4.4-1 relating to voluntary termination of privileges shall apply. Such extension of an appointment shall not be deemed to create a right for the staff member to be automatically reappointed for the coming year.

4.5 LEAVE OF ABSENCE

4.5-1 INITIATION:

A. A staff member may request a leave of absence for medical, academic, military or exceptional reasons, a voluntary leave of absence from the Medical Staff by submitting written notice to the President of the Medical Staff at least ninety (90) days prior to the commencement of the leave where feasible. The written notice shall state the reason for the requested leave of absence and a specific period of time for the leave of absence, which may not exceed one (1) year except for military leave or other reason approved by President of the Medical Staff.

B. The Vice President of Medical Affairs will determine whether a request for a leave of absence shall be granted and after consulting with the President of the Medical Staff and the relevant department Chairman. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.
C. Members of the Medical Staff must report to the Vice President of Medical Affairs anytime they are away from medical staff or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the VPMA, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.

D. Leaves of absence are matters of courtesy, not a right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

DUTIES of MEMBER on LEAVE

A. During the leave of absence, the individual shall not exercise any clinical privileges and shall be excused from all medical staff responsibilities (i.e. meeting attendance, committee service, and emergency service call obligations). All medical records must be completed as soon as reasonable possible. The obligation to pay dues shall continue during a leave of absence except that a member granted a leave of absence for U.S. military service shall be exempt from this obligation.

REINSTATEMENT

A. At least ninety (90) days prior to the termination of the leave, or at any earlier time, unless such advance notice is waived by the Medical Executive Committee, Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, including information relevant to current competency and health status, if the Medical Executive Committee or Board so requests, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant department Chairman, the President of the Medical Staff, the Vice President of Medical Affairs, the Chairman of the Credentials Committee and in accordance with the Medical Staff and Allied Health Professional Health Committee (Article 12.4-10).

B. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member’s privileges and prerogatives.

C. Upon return from the leave of absence, the staff member shall return to the same clinical service, in the same staff category and with the same clinical privileges that existed upon his/her departure. However, a leave of absence due to any physical, medical, psychological or other impairment that may interfere with his/her ability to practice medicine shall necessitate a review by the Medical Executive Committee before prior clinical privileges being restored.
D. If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. If any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee if appropriate, MEC and the Board. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct and if a report to the National Practitioner Data Bank is determined to be required, the individual shall be entitled to request a hearing and appeal.

E. If the reinstatement process is not completed due to the individuals’ failure, without good cause, to provide the requested information, the individual will be notified in writing, by certified mail or other delivery method, including electronic delivery, which provide for confirmation or receipt that failure to provide the information within ten (10) days will be deemed an automatic relinquishment of medical staff membership and clinical privileges. The Medical Executive Committee shall, in its sole discretion and after giving such member the opportunity to address the Committee, determine whether or not good cause existed. A member who is deemed to have automatically relinquished his/her medical staff membership and clinical privileges as set forth in this section shall not be entitled to the procedural rights provided in Article XII. A request for staff membership subsequently received from the staff member shall be treated and processed as an application for initial appointment.

F. If an individual’s current appointment is due to expire during the leave, the individual’s appointment and clinical privileges shall expire at the end of the appointment period and the individual shall be required to submit an application for initial appointment. Therefore, the procedures provided in Sections 4.2-3F through 4.2-3I shall be followed.

4.5-2 TERMINATION OF LEAVE

A. If it becomes apparent that a Practitioner has been absent for an extended period and has not requested an LOA, the Vice President of Medical Affairs and the Medical Staff President would have the authority to initiate an LOA, thus also triggering the necessary reassessment and evaluation of the Practitioner before he/she resumes practice.

B. Depending on the length of and activities performed during the leave, the Medical Executive Committee or Department focus review (FPPE) may request an observation requirement for a period of time (or other appropriate measure) during which the practitioner’s clinical performance shall be observed by the Department Chairman or his representative to determine the practitioner’s continued professional ability. Each department shall develop their own recommendations based specifically on the focus review which will be presented to MEC for approval.
C. Failure to request reinstatement prior to the end of the scheduled leave or to provide a requested summary of activities as above provided shall be deemed a voluntary resignation from the staff and shall result in automatic termination of staff membership, privileges and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining the issue of good cause. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

D. Where, by law, reinstatement is automatic, as may be the case with staff members who have armed forces obligations, this Section 4.3-2 may be waived.

4.5-3 MEDICAL LEAVE OF ABSENCE

Upon return from a Medical LOA and in conjunction with 4.5-2C, the Practitioner will provide to the Medical Staff President a report from the treating physician or program stating that the individual is physically and/or mentally capable of resuming to hospital practice and can safely exercise the clinical privileges requested.

4.5-4 EDUCATIONAL LEAVE OF ABSENCE

Upon return from an Educational LOA and in conjunction with 4.5-2C, the Practitioner will provide to the Medical Staff President documentation of successful completion of the education and a report from the program faculty.

4.5-5 EXTENSION OF LEAVE

An extension of leave may be granted by the Medical Executive Committee for good cause and on timely written notice prior to the expiration of the original leave.

4.6 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS/PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his staff category or department assignment or privileges by submitting a written application on a prescribed form to the Secretary of the Medical Staff. Such application shall be processed in substantially the same manner as provided in Section 4.4 for reappointment, and all changes granted shall be valid until the member’s next reappointment review.
4.7  DURATION OF APPOINTMENT(S)

4.7-1  APPOINTMENTS and REAPPOINTMENTS

Appointments and subsequent reappointments to any category of the Medical Staff cannot exceed a period of two (2) years. This provision shall not apply to members who have no patient care responsibilities or prerogatives (e.g. honorary staff members).

- Revisions to 4.7-1 approved at MEC 08/20/2013; GMS 09/24/2013; BOT: 10/22/2013
- Revisions to 4.2.3 approved at MEC 08/18/2015; GMS 09/22/2015; BOT 10/27/2015
- Revisions to 4.5 approved at MEC 08/18/2015; GMS 09/22/2015; BOT 10/27/2015
DETERMINATION OF CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Every practitioner, or other professional, providing direct clinical services at this Hospital by virtue of Medical Staff membership or otherwise, shall in connection with such practice, and except as otherwise provided in this Article, be entitled to exercise only those clinical privileges or specified services specifically granted to him by the Board in accordance with these Bylaws.

Each medical Department shall develop and provide the privileges delineation and criteria the Department shall use for recommending privileges in the initial appointment, reappointment and evaluation of staff members. If privilege delineation is based primarily on experience, the practitioner's credentials record shall reflect the specific experience and successful results that form the basis for granting of privileges.

5.2 BASES FOR PRIVILEGES DETERMINATION

The Medical Staff shall make an objective and evidence-based decision regarding each request for clinical privileges, based on the applicant's:

- The applicant's current licensure and/or certification, as appropriate, verified with the primary source
- The applicant's specific relevant education, training and experience, verified with the primary source
- Evidence of physical and mental ability to perform the requested privilege
- Data from professional practice review by any organization(s) that currently privileges the applicant, if available
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner's performance within the Hospital
- Results of the Hospital's query of the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege is requested
5.2-1 PEER RECOMMENDATIONS

A. Peer recommendations shall include written information regarding the practitioner’s current:

- Medical clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

B. Peer recommendations may be in the form of written documentation reflecting informed opinions on each applicant’s scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purposes of validating current competence.

C. Before recommending privileges, the applicable body shall also evaluate:

- Challenges to any licensure or registration
- Voluntary or involuntary relinquishment of any license or registration
- Voluntary or involuntary termination of medical staff membership
- Voluntary or involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of any unusual pattern of an excessive number of professional liability actions resulting in a final judgment against the applicant
- Relevant practitioner-specific data and comparison to aggregate data regarding performance, judgment, and clinical and technical skills, when available
- Morbidity and mortality data when available

D. Information regarding each practitioner’s scope of privileges is updated as changes in clinical privileges for each practitioner are made.
5.3. **PROCEDURE**

A. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a staff member for a modification of privileges must be supported by documentation of training, experience, competence and ability to perform the requested privilege.

All requests for initial privileges or reappointment shall be processed pursuant to the procedures approved by the organized medical staff and the Board of Trustees and outlined in Article IV and this Article.

B. Requests for privileges in a service area new to the Hospital:

1. Privileges will not be considered until the Vice President of Medical Affairs has received confirmation that the Hospital has, or plans to have, the resources to support the privileges or new services.

2. When confirmation is obtained the Vice President of Medical Affairs will present to the Credentials Committee criteria that must be met by the requesting physician in order for the privileges to be granted.

3. Hospital, based on recommendations by the organized medical staff and approved by the Board of Trustees, shall develop criteria that will be considered in the decision to grant, limit or deny a requested privilege.

4. Criteria will include any additional education, training, and number of supervised procedures (Focused Professional Practice Evaluation – FPPE) that must be completed before the privilege can be granted.

5. The criteria must be presented to the Credentials Committee for approval. Once the Credentials Committee approves the criteria, the criteria must then be approved by the Medical Executive Committee, and the Board.

6. Upon approval of the privilege criteria by the Board of Trustees, the request for privileges, with all necessary documentation showing that the appropriate privilege criteria have been met (i.e. additional education, training, and supervised procedures) will be submitted to the various bodies in accordance with the requirements of Articles III and IV.
7. The Chairman will review the information and made a recommendation regarding approval to the Credential Committee. The Chairman may discuss the criteria to be utilized in making his/her decision with the Department as a whole.

8. The Credentials Committee will review the request and will refer it to the Medical Executive Committee with a recommendation regarding approval.

9. The Medical Executive Committee may accept evidence of satisfactory performance under monitoring in an institution or facility outside the Hospital, provided the proctor is acceptable to the Committee.

10. If the Medical Executive Committee concurs with the Credentials Committee report, it will refer the request to the Board of Trustees for final approval. The Board Executive Committee may grant approval in lieu of the full Board.

11. The Medical Staff member will be notified no longer than two (2) weeks from the time the final decision is made.

C. When a new/additional privilege is requested by a current staff member for an already approved privilege/service, the following procedure will be followed:

1. The request, with all necessary documentation showing that the appropriate privileging criteria have been met (i.e. additional education, training, and supervised procedures) will be submitted to the Department Chairman.

2. The Chairman will review the information and make a recommendation regarding approval to the Credentials Committee. The Chairman may discuss the criteria to be utilized in making his/her decision with the Department as a whole.

3. The Credentials Committee will review the request and will refer it to the Medical Executive Committee with a recommendation regarding approval.

4. If the Medical Executive Committee concurs with the Credentials Committee report, it will refer the request to the Board of Trustees for final approval. The Board Executive Committee may grant approval in lieu of the full Board.
5. The Medical Staff member will be notified no more than two (2) weeks from the time the final decision is made.

D. In the case of a denial, the applicant shall be informed of the reason for the denial. The decision to grant, deny, revise, or revoke privileges is disseminated and made available to all appropriate internal and external persons or entities, as defined by the Hospital and applicable law.

E. When an adverse decision is made, the affected practitioner shall be advised of available due process, or when applicable, the option to implement the provisions of Article VII.

5.4 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists and podiatrists should be processed in the manner specified in this Article V. Surgical procedures performed by these practitioners shall be under the overall supervision of the Chairman of the Department of Surgery or his/her designee. All dental and podiatric patients shall receive the same prompt basic medical appraisal as patients admitted to other surgical services.

An oral surgeon who admits a patient without medical problems may complete an admission history and a physical examination and assess the medical risks of the procedure to the patient if qualified to do so. Criteria to be used in identifying such a qualified oral surgeon shall include, but shall not necessarily be limited to, the following: successful completion of a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education; and, as determined by the Medical Staff, evidence that the oral surgeon who admitted the patient is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the oral surgical procedure an oral surgeon proposes to perform.
Patients with medical problems admitted to the Hospital by qualified oral surgeons and patients admitted for dental or podiatric care by individuals who are not qualified oral surgeons, or by podiatrists, shall receive the same basic medical appraisal as patients admitted for other services. This includes having a physician who either is a member of the Medical Staff or is approved by the Medical Staff to perform an admission history, a physical examination, and an evaluation of the overall medical risk and record the findings in the medical record. The responsible dentist or podiatrist shall take into account the recommendations of this consultation in the overall assessment of the specific procedure proposed and the effect of the procedure on the patient. When significant medical abnormality is present, the final decision must be a joint responsibility of the medical consultant and the dentist or podiatrist. The dentist or podiatrist shall be responsible for that part of the history and physical examination related to his/her area of practice. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of dental or podiatric patients.

5.5 **SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL SERVICES**

Requests to perform specified patient care services from allied health professionals shall be processed in the manner specified in Section 8.3. A dependent allied health professional may, subject to any licensure requirement or other legal limitations, exercise independent judgment within the areas of his/her professional competence and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient’s care.

5.6 **PROVISIONAL CLINICAL PRIVILEGES**

All clinical privileges initially granted to a member by the Board of Trustees are provisional and subject to the terms of Article III, Section 3.6.
5.7 TEMPORARY PRIVILEGES

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time, in accordance with the following:

5.7-1 CIRCUMSTANCES

Upon written concurrence of the Chairman of the Department where the privileges will be exercised, the President of the Medical Staff and the President and Chief Executive Officer or their designees may grant temporary privileges in the following circumstances:

A. Pendency of Application: While an application for staff appointment is pending, an appropriately licensed practitioner may be granted temporary privileges for a period of up to ninety (90) days, but not to exceed the pendency of the application. These privileges may only be granted if the National Practitioner Data Bank has been queried, and if the application has received a favorable recommendation from the Credentials Committee. In exercising such privileges, the applicant shall act under the supervision of the Chairman of the Department to which he is assigned and in accordance with the conditions specified in Section 5.7-2.

B. Care of Specific Patients: Upon receipt of a written request for specific temporary privileges, an individual otherwise eligible for Medical Staff privileges but who is not an applicant for membership may be granted temporary privileges for the care of one or more specified patients. Such privileges shall be restricted to the treatment of not more than three (3) patients in any one year by such practitioner, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

Temporary privileges within this category will be granted only after the practitioner submits all information reasonably requested by the Medical Affairs Office, including but not limited to a current Pennsylvania state license, current DEA license; evidence of relevant training or experience, current competence and ability to perform privileges as requested; proof of current malpractice insurance coverage; proof that the practitioner is currently in good standing on another hospital medical staff; proof that those privileges relating to the services to be performed at the Hospital are current at the hospital where he/she is in good-standing; and verification that the practitioner has not been sanctioned by any state or federal healthcare program. In addition, the practitioner shall have no adverse findings with the National Practitioner Data Bank.
The Good Samaritan Hospital
Byllaws of the Medical Staff
Article V
Determination of Clinical Privileges
Page 8 of 11

C. **Medical/Surgical Service Need:** If patients of the Hospital will be placed at risk for not adequately meeting their needs because of the lack of an essential medical or surgical service (i.e. no credentialed physician(s) on staff or available to provide that service), a practitioner(s) may be granted temporary privileges to perform medical services for which a shortage exists for no more than one hundred twenty (120) days. Should the need continue beyond that time, the practitioner(s) would be required to apply (and be approved) for membership on the Medical Staff to be allowed to continue to care for patients.

Temporary privileges within this category will be granted only after the practitioner submits all information reasonably requested by the Medical Affairs Office, including but not limited to a current Pennsylvania state license; current DEA license; evidence of relevant training or experience, current competence, ability to perform privileges as requested; proof of current malpractice insurance coverage; proof that the practitioner is currently in good-standing on another hospital medical staff; proof that those privileges relating to services to be performed at the Hospital are current at the hospital where he/she is in good-standing; and verification that practitioner has not been sanctioned by any state or federal healthcare program. In addition, the practitioner shall have no adverse findings with the National Practitioner Data Bank.

D. **Temporary Resident Privileges:** Upon receipt of a written request for temporary resident privileges, a practitioner who is either in his/her first year of post-graduate training, or is licensed to practice in Pennsylvania, and is qualified and accepted to an accredited residency program may be granted temporary resident privileges. He/she must be under the supervision of an active staff member and must follow the Rules and Regulations and general guidelines set forth for residents at the Hospital.

E. **Locum Tenens:** Upon receipt of a written request for specific temporary privileges, a practitioner of documented competence who is serving as a locum tenens for a Medical Staff member, and who is a member of the medical staff at another health care facility may, without applying for membership on the Staff, be granted temporary privileges for an initial period of up to ninety (90) days, not to exceed two (2) such occurrences per year. Such privileges may be renewed for one (1) successive period of up to ninety (90) days, but not to exceed his/her period of service as a locum tenens. Services under this category shall be limited to treatment of patients of the practitioner or practitioner group for whom he/she is serving as locum tenens. A practitioner requesting such privileges shall be responsible for the payment of processing fees. He/she shall not be entitled to admit his/her own patients to the Hospital.
5.7-2 CONDITIONS

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner’s licensure, qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirements of Section 15.3 regarding professional liability insurance. The Chairman of the Department to which the practitioner is assigned shall be responsible for monitoring the performance of the practitioner granted temporary privileges, or for designating a Department member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed by the Chairman of the Department responsible for supervision of a practitioner granted temporary privileges or his/her designee. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has been given access to, and the opportunity to read, the Medical Staff Bylaws and Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

5.7-3 TERMINATION

On the discovery of any information, or the occurrence of any event of a nature which raises question about a practitioner’s professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with these Bylaws, the Rules and Regulations or any other Department requirements, the President and Chief Executive Officer, together with the Department Chairman responsible for supervision of such practitioner, may terminate any or all of such practitioner’s temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VI. In the event of any such termination, the practitioner’s patients then in the Hospital shall be assigned to another practitioner by the Department Chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

5.7-4 RIGHTS OF THE PRACTITIONER

A practitioner shall not be entitled to the procedural rights afforded by Article VII because his/her request for temporary privileges is refused or because all, or any portion, of his/her temporary privileges are terminated.
5.8 EMERGENCY PRIVILEGES

A. For the purposes of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any member of the medical staff (and properly supervised residents) to the degree permitted by his/her license, regardless of department, staff status or clinical privileges, shall be permitted to do, and shall be assisted by hospital personnel in doing everything possible to save the patient from such danger. A practitioner utilizing emergency privileges shall provide to the Medical Executive Committee or President of the Staff, in writing, a statement explaining the circumstances giving rise to the emergency. When the emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient.

5.9 DISASTER PRIVILEGES

1. Disaster privileges should only be implemented when the Hospital’s Emergency Management Program’s Incident Commander activates its disaster plan and is unable to handle immediate patient needs. Disaster privileges are used only when Practitioner’s outside the medical staff require privileges to treat patients in the Good Samaritan Health System due to a disaster in the community.

   a. During a disaster, the, Chief Executive Officer and/or the Medical Staff President may grant disaster privileges. If neither the CEO nor Medical Staff President is available to grant such privileges, the Vice President of Medical Affairs or the Department Chairperson of the department in which the practitioner would be granted privileges (or their respective designee(s)) shall be responsible for granting such privileges.

   b. The responsible individual(s) are not required to grant privileges to any practitioner, and is expected to make such decision on a case-by-case basis at his/her discretion.

   c. Disaster privileges may be granted by persons as described above upon presentation of a valid government issued photo identification (for example a driver’s license or passport) and at least one of the following:

      1) A current picture hospital ID card from a healthcare organization that clearly identifies professional designation

      2) A current license to practice
3) Identification indicating that the practitioner is a member of a Disaster Team,

4) Identification indicating that the practitioner has been granted authority by a government entity to provide patient care, treatment and services in disaster circumstances,

5) Affirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s

2. The Department Chairperson (or his/her designee) will have the responsibility of proctoring the activities of the practitioner(s) granted emergency privileges in his/her department.

3. The practitioner(s) granted disaster privileges must wear a name tag, or other form of identification, at all times in order for them to be readily identified by members of the Hospital staff.

4. Once the immediate situation is deemed under control by the Hospital, the primary source verification process of the practitioner(s) granted disaster privileges must be completed within 72 hours. This privileging process will be identical to the process for granting temporary privileges as set forth in Section 5.7.

5. Within 72 hours, the Hospital will determine whether the Practitioner’s privileges will be allowed to continue based on information obtained regarding the Practitioner’s professional performance.

6. The disaster privileges automatically expire when the Hospital determines that the disaster is over.

- Addition of 5.9 approved at MEC 12/17/2013; GMS 01/28/2014; BOT 02/24/2014
6.1 BASIS FOR REVIEW

The procedures provided in this Article shall be invoked whenever it appears that the activities or professional conduct of any member of the Medical Staff:
A. Jeopardize or may jeopardize the safety or best interests of a patient, visitor or employee, or the quality of care, treatment or services rendered or to be rendered at The Good Samaritan Hospital.
B. Present a question regarding the competence, character, judgment, ethics, stability of personality (including the ability to work cooperatively with others in the provision of safe patient care, treatment and services), adequate physical and mental health, moral character or qualification of the member or
C. Violate these Medical Staff Bylaws, or the requirements, policies or Rules and Regulation of the Departments or The Good Samaritan Hospital, including the Code of Conduct, or constitute conduct that is, or is reasonably likely to become disruptive to The Good Samaritan Hospital operations.

6.2 INITIATION

A request for an investigation of the conduct of a member of the Medical Staff raising a question under section 6.1 above may be made by any member of the Medical Staff, by the President and Chief Executive Officer, or by the Board of Trustees. Such a request must be in writing, submitted to the President of the Medical Staff, and supported by reference to specific activities or conduct alleged. The President of the Medical Staff will apprise the Medical Executive Committee of the request for investigation. After discussion of the request for an investigation, the Medical Executive Committee may determine either that an investigation will commence or that no further investigation is warranted, making appropriate record of its reasons for such decision. In either event the affected member of the Medical Staff will be notified in writing that a request for investigation has been made and that an investigation will or will not commence. Early in any investigatory process, the Medical Staff member will be afforded the opportunity to meet informally with the committee, officer, or Department Chair conducting the investigation. If, in the Medical Executive Committee’s view, more than sixty (60) days is needed for investigation, the Medical Executive Committee shall advise the affected Medical Staff member and specify an appropriate time for completion of the investigation.
6.3 INVESTIGATION
On recommendation of the President of the Medical Staff, the Medical Executive Committee may, itself, conduct any investigation it deems necessary or may assign this task to an appropriately charged officer, committee, or Department Chair. The investigative process shall not be deemed to be a “hearing” as that term is used in Article VII. If the responsibility for investigation is delegated by the Medical Executive Committee, the responsible investigator(s), shall report to the Medical Executive Committee as soon as practical and in such form or manner as the Medical Executive Committee shall require.

6.4 MEDICAL EXECUTIVE COMMITTEE ACTION
The Medical Executive Committee shall act as soon as is practical after the conclusion of any investigation. Action taken by the Medical Executive Committee following the conclusion of any investigation may include, but is not limited to, making a recommendation to the Board of Trustees to undertake one or more of the following actions:
A. No corrective action
B. Proposed corrective action:
   1. Letter of admonition, reprimand or warning
   2. Terms of probation including monitoring requirements or specific individual requirements of consultation
   3. Reduction or revocation of clinical privileges;
   4. Suspension of clinical privileges until completion of specific conditions or requirements;
   5. Limitation of prerogatives related to the practitioner’s delivery of safe patient care, treatment and services;
   6. Suspension of Medical Staff membership for a specific period of time or without limit of time;
   7. Revocation of Medical Staff membership; or
   8. Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall prevent the Medical Executive Committee from implementing a summary suspension or restriction of privileges at any time, in the exercise of its discretion pursuant to Section 6.6 below.

If the recommendation of the Medical Executive Committee is favorable to the practitioner, or constitutes an admonition, reprimand, or warning to the practitioner, it shall become effective as the final decision of the Board of Trustees and the practitioner and the Board of Trustees shall be notified in writing of such determination. If the Medical Executive Committee fails to undertake or delegate responsibility for an investigation as required by Section 6.3, or fails to take action as required by Section 6.4, and the Board of Trustees determines that its failure to do so is contrary to the weight of the evidence then available, the Board of Trustees may, after consulting with the Medical Executive Committee, direct the Medical Executive Committee to investigate or undertake such action. The Medical Executive Committee shall inform the Board of Trustees of its action in response to such a directive. If the Medical Executive Committee fails to act after a directive from the Board of Trustees, the Board of Trustees may, in accordance with these Bylaws, after written notice to the Medical Executive Committee, take
action directly against the Medical Staff member. The Board of Trustees shall inform the Medical Executive Committee in writing of any action it undertakes in accordance with this Section. Any action undertaken by the Board of Trustee in accordance with this Section shall comply with the requirements of Sections 6.1 through 6.4 in the same manner as if they had been undertaken by the Medical Executive Committee or its designee.

6.5 PROCEDURAL RIGHTS
Any actions or recommendations by the Medical Executive Committee or the Board of Trustees pursuant to Section 6.4 which constitute grounds for a hearing as set forth in Section 7.3 shall entitle the Medical Staff member to the rights specified in Article VII. In such cases, the President of the Medical Staff shall give the Medical Staff member written notice of the recommendation, the reasons for the proposed action, and of his or her right to request a hearing pursuant to the requirements in 7.4-1. A copy of the Bylaws detailing the hearing rights of the Staff member will also be provided to the affected Medical Staff member.

6.6 SUMMARY SUSPENSION

6.6-1 INITIATION OF SUSPENSION

A. Criteria for Initiation
A precautionary restriction or suspension of a practitioner’s membership or all or any portion of his or her clinical privileges may be imposed, without benefit of a prior hearing, whenever a practitioner’s conduct suggests that immediate action be taken to protect the life of any patient, or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present in the Hospital, or to the orderly operation of the Hospital. Any of the following persons shall have the authority to impose a precautionary restriction or suspension:

- President and Chief Executive Officer
- Chairman of Board of Trustees
- President of Medical Staff
- Executive Vice President and Chief Operating Officer
- Medical Director
- Chairman of practitioner’s department
- Chairman of Credentials Committee
B. Effect of Suspension
   Such precautionary suspension shall become effective immediately upon
   imposition. It shall be deemed an interim precautionary action and not a professional
   review action, and shall not imply any final finding of responsibility for the situation that
   caused the suspension. Therefore, the precautionary suspension will not be reported to the
   National Practitioner Data Bank.

C. Notification
   The person imposing the suspension shall immediately notify in writing
   the practitioner, the President and Chief Executive Officer, the President of the Medical
   Staff, the Medical Director, the Medical Executive Committee, and the Chairman of
   Credentials Committee, and will notify the Board of Trustees at its next meeting. Approp- 
   riate hospital departments will be notified by the Medical Affairs department.

D. Care of Practitioner's Patients
   In the event of any such precautionary suspension, the practitioner's patients then in the
   Hospital, whose treatment by the practitioner is terminated by the suspension, shall be
   assigned to another practitioner with appropriate privileges by the Department Chairman.
   The wishes of the patient shall be considered, where feasible, in choosing a substitute
   practitioner. It shall be the duty of all members of the Medical Staff to cooperate in
   reassignment of involved patients.

6.6-2 REVIEW OF THE SUSPENSION

A. Medical Executive Committee
   The Medical Executive Committee shall complete a review of the situation which resulted in
   the precautionary suspension as soon as practicable, but within 30 days after the effective
   date of the suspension. The review shall include an interview with the suspended Medical
   Staff member, if he or she so requests. The Committee shall recommend whether further
   professional review activity is indicated and whether the suspension should be continued,
   modified or terminated. The Committee shall give the Medical Staff member written notice
   of its recommendation and the reasons therefore, with a copy to the Board of Trustees.

B. Board of Trustees
   If the review of a summary suspension by the Medical Executive Committee is delayed
   for a period in excess of 30 days, the reasons for the delay shall be reported to the Board of
   Trustees, which shall recommend whether the suspension should be continued, modified or
   terminated.
6.6-3 MODIFICATION OR TERMINATION OF PRECAUTIONARY SUSPENSION

A. If the Medical Executive Committee recommends termination of the suspension, such action may be effected by the President and Chief Executive Officer, with the concurrence of the President of Medical Staff and the Department Chairman.

B. If the President and Chief Executive Officer declines to act on the recommendation of the Medical Executive Committee, or if the Medical Executive Committee recommends modification or continuation of the suspension, the matter will be referred to the Board for action. The suspension will be continued until final action by the Board.

C. Any action taken by the President and Chief Executive Officer or the Board of Trustees shall be promptly reported to the practitioner.

6.6-4 PROCEDURAL RIGHTS

If the precautionary suspension is not terminated by the President and Chief Executive Officer or the Board, following review by the Medical Executive Committee, the practitioner shall be entitled to the procedural rights as provided in Article VII.

6.7 AUTOMATIC SUSPENSION

6.7-1 LICENSE

A Medical Staff member whose license, certificate or other legal credential authorizing him or her to practice in this State is revoked, stayed, restricted, or suspended, or who is placed on probation by the State shall immediately and automatically have his or her Medical Staff membership or license be subjected to the same action, as appropriate. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the license, certificate or other legal credential was revoked, suspended, stayed, restricted, subject to probation or relinquished. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or may direct that an investigation be undertaken pursuant to Sections 6.2 and 6.3 as appropriate.

Unless terminated or amended as a result of such further investigation, such a revocation, stay, restriction, suspension or probation shall remain in effect until the affected staff member makes a request for reinstatement of his or her privileges, in accordance with Section 4.7. In the event a staff member whose license has been affected pursuant to this Section fails to submit a reappointment application for reinstatement of privileges within 90 days following the termination date of such revocation, stay, restriction, suspension or probation, all staff privileges shall immediately and automatically be terminated.
Whenever a Medical Staff member’s license, certificate or other legal credential authorizing him or her to practice in this State expires, he or she shall be automatically suspended from practice until he or she provides satisfactory evidence of license renewal.

6.7-2 **DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBER**

A Medical Staff member whose DEA certificate or number is revoked, suspended, stayed, restricted, subject to probation or voluntarily relinquished shall immediately and automatically have the same action applied to his or her right to prescribe, dispense, or administer medications covered by the certificate or number. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA certificate or number was revoked, suspended, stayed, restricted, subject to probation or relinquished. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or may direct that an investigation be undertaken pursuant to Sections 6.2 and 6.3 as appropriate. Unless terminated or amended as a result of such further investigation, such a revocation, suspension, stay, restriction or probation shall remain in effect until the affected staff member makes a request for reinstatement of his or her privileges, in accordance with Section 4.7. In the event a staff member whose license has been affected pursuant to this Section fails to submit a reappointment application for reinstatement of privileges within 90 days following the termination date of such revocation, suspension, stay, restriction or probation, all staff privileges shall immediately and automatically be terminated.

Whenever a Medical Staff member’s DEA certificate or number expires, his or her right to prescribe, dispense or administer medications covered by the certificate or number shall be automatically suspended until he or she provides satisfactory evidence of renewal.

6.7-3 **CONVICTION OF FELONY**

If any member of the Medical Staff shall be convicted of or plead guilty or nolo contendere to any felony, his or her Medical Staff privileges shall be immediately and automatically terminated.
6.7-4 **MEDICAL RECORDS**

An automatic suspension of a Medical Staff member’s privileges to admit patients, consult and schedule procedures (except with respect to his or her patients already admitted to the Hospital) shall, after seven (7) days warning of delinquency, be imposed for failure to complete medical records within guidelines established by the Medical Records Committee (see Rules and Regulations). Such suspension shall be considered to be a voluntary relinquishment of the practitioner’s admitting, consulting and scheduling privileges, and shall be effective until all delinquent medical records are completed, at which time the practitioner’s privileges shall be automatically reinstated. This relinquishment of privileges shall not apply to obstetrical and emergency admissions, and will not release the physician who is responsible to carry out his or her assignment on service should he or she be on service at the time suspension of privileges occurs. 

For the purpose of enforcing this Section 6.7-4, the following, without limitation, may be considered justified reasons for delay in completing medical records:

A. the attending physician or any other individual contributing to the record is ill, or otherwise unavailable, for a period of time due to circumstances beyond his or her control;

B. a practitioner is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis; or

C. a practitioner has dictated reports and is waiting for the Hospital personnel to transcribe them.

Practitioners who have received an automatic suspension three times in any 12-month period, pursuant to this Section 6.7-4, will receive a mandatory additional suspension of privileges for 24 hours. As with the previous suspensions, this will be considered a voluntary relinquishment of privileges.

6.7-5 **MALPRACTICE INSURANCE**

A practitioner who fails to maintain the amount of professional liability insurance, if any, required under Section 15.3 shall immediately have his or her privileges suspended. Such suspension shall be effective until such required insurance is obtained, and written evidence that such insurance has been reinstated has been provided to the Medical Affairs office by the practitioner. When the Medical Affairs office has received this evidence, the practitioner’s privileges shall be automatically reinstated.
6.7-6 STATE OR FEDERAL PROGRAM

A practitioner who has been sanctioned by or involuntarily excluded from Medicare, Medicaid, or another state or federally funded healthcare program shall immediately be suspended from practicing in the Hospital. Such suspension shall be effective until notification of reinstatement by such program has been provided to the Medical Affairs office. When the Medical Affairs office has received this notification, the practitioner’s privileges shall be automatically reinstated.

6.7-7 IMPOSITION AND NOTICE OF AUTOMATIC SUSPENSION / TERMINATION

Whenever a practitioner qualifies for an automatic suspension or termination pursuant to one or more of the provisions set forth in this Section 6.7, such suspension shall be imposed by the President and Chief Executive Officer or the Vice President of the Medical Staff, who shall provide written notice of such suspension/termination to the practitioner, the President and Chief Executive Officer, the President of the Medical Staff, the Medical Director, the Medical Executive Committee and the Chairman of Credentials Committee, and to the Board of Trustees at its next meeting. Appropriate Hospital departments will be notified by the Medical Affairs department.

6.7-8 CARE OF PRACTITIONER’S PATIENTS

In the event of an automatic suspension or termination, the practitioner’s patients then in the Hospital shall be assigned to another practitioner with appropriate privileges by the Department Chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. It shall be the duty of all members of the Medical Staff to cooperate in reassignment of involved patients.

6.7-9 PROCEDURAL RIGHTS

A practitioner under automatic suspension by operation of any subsection of this Section 6.7 shall not be entitled to the procedural rights provided in Article IX unless otherwise expressly provided.
The Good Samaritan Hospital; Lebanon, PA
Bylaws of the Medical Staff
Article VII
Interviews, Hearings and Appellate Review
Page 1 of 8

INTERVIEWS, HEARINGS AND APPELLATE REVIEW

7.1 INTERVIEWS

When the Medical Executive Committee or other relevant staff committee, or the Board or any appropriate committee thereof, receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner may be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

7.2 PREAMBLE AND APPELLATE REVIEW

7.2-1 INTRA-ORGANIZATIONAL REMEDIES

The procedures provided for in this Article VII are strictly quasi-judicial in nature and shall not be utilized to hold notice and comment type hearings or to make legislative determinations or determinations as to the substantive validity of Bylaws, Rules and Regulations. When a substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal to and appearance in an executive session (voting members only) of the Medical Executive Committee. Only after the Medical Executive Committee has denied said appeal may the petitioner appeal directly to The Good Samaritan Hospital Board of Trustees. Such appearance shall not be considered a “hearing” under this Article and shall be conducted in accordance with guidelines established by The Good Samaritan Hospital Board of Trustees. A final determination by The Good Samaritan Hospital Board of Trustees after such appeal shall be a condition precedent to the petitioner’s right to seek judicial review in a court of law.

7.2-2 EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a Medical Staff member’s membership, Staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against The Good Samaritan Hospital, or participants in the decision process.
7.2-3 **DEFINITIONS**

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

1. “Notice” refers to a written communication delivered personally to the required addressee or sent by the United States Postal Service, pursuant to Section 16.2 addressed to the required addressee at his/her address as it appears in the records of Medical Affairs.

2. “Petitioner” refers to the Medical Staff member, practitioner or applicant for privileges who has requested a hearing or appearance pursuant to Section 7.3 or 7.2-1, and

3. “Date of Receipt” of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received seventy-two (72) hours after being deposited, postage prepaid, in the United States mail.

7.3 **GROUNDS FOR HEARING**

Any one or more of the following actions, or recommendations or proposals for any one or more of such actions, shall constitute grounds for a hearing unless otherwise specified in these Bylaws:

A. Denial of Medical Staff membership

B. Denial of requested advancement in Medical Staff membership status

C. Denial of Medical Staff appointment

D. Demotion to lower Medical Staff category or membership status

E. Summary restriction or suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearing and appeals procedures

F. Expulsion from Medical Staff Membership

G. Denial of requested privileges
H. Reduction in privileges

I. Termination of privileges

J. Requirement of consultation or proctoring when the reviewing physician has the authority to supervise, direct, or transfer care from the physician being monitored

K. Any other action which requires filing a report pursuant to 42 U.S.C. Section 11101 et. seq. with the National Practitioner Data Bank

7.4 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which the Medical Executive Committee or Board of Trustee has, under these Bylaws, recommended or taken any of the actions constituting grounds for hearing as set forth in Section 7.3, the Medical Executive Committee or Board, as the case may be, shall give the affected Medical Staff member notice of the decision. Such notice shall include the basis for the action or proposed action.

7.5 HEARINGS

7.5-1 ADVERSE MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

When any practitioner receives notice of an adverse recommendation of the Medical Executive Committee, he or she shall be entitled, upon request, to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the practitioner, he or she shall then be entitled, upon request, to an appellate review by the Board of Trustees before a final decision is rendered.

7.5-2 ADVERSE BOARD DECISION

When any practitioner receives notice of an adverse decision by the Board of Trustees taken either contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed or the practitioner has not previously requested a hearing, or on the Board’s own initiative without benefit of a prior recommendation by the Medical Executive Committee, such practitioner shall be entitled, upon request, to a hearing by an ad hoc committee appointed by the Board of Trustees. If such hearing does not result in a favorable recommendation, the practitioner shall be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

7.5-3 PROCEDURE AND PROCESS
All hearings and appellate reviews shall be in accordance with the procedures and safeguards set forth in Sections 7.6 through 7.8 below.

7.6 REQUESTS FOR HEARING

7.6-1 NOTICE OF RIGHT TO HEARING

Any notice of action or proposed action given to a practitioner pursuant to the provisions of Section 7.4 above shall include notice of the practitioner’s right to request a hearing pursuant to Section 7.6-2.

7.6-2 HEARING REQUEST

The Petitioner shall have thirty (30) days following the date of receipt of notice to request a hearing. The request for a hearing must be in writing directed to the President of the Medical Staff if the practitioner is seeking a hearing on a recommendation made by the Medical Executive Committee, or to the President and CEO of the Hospital if he/she is seeking a hearing on action or proposed action of the Board of Trustees. If the Petitioner does not request a hearing within thirty (30) days, he/she shall be deemed to have waived his/her right to a hearing and accepted the recommendation or decision. It shall thereupon become the final action of the Medical Executive Committee or the Board, as the case may be, and if deemed the final action of the Medical Executive Committee shall be subject to review and decision on that basis by the Board of Trustees.

7.6-3 TIME, PLACE AND DATE FOR HEARING

The Vice President of Medical Affairs shall confirm a date for a hearing. Notice shall be given to the Petitioner of the time, place, and date of the hearing. The date of commencement of the hearing shall not be less than thirty (30) days from the date of receipt of the notice, provided that a hearing for a practitioner under supervision shall commence as soon as arrangements may reasonably be made.

7.6-4 NOTICE OF CHARGES

The Vice President of Medical Affairs shall advise the Petitioner in writing of the acts or omissions with which the petitioner is charged including if applicable, a list of the medical records or charts being questioned. The Vice President of Medical Affairs and the petitioner shall provide each other with a list of witnesses expected at the time to testify at the hearing. The Vice President of Medical Affairs and the Petitioner shall
notify each other of additions to the list. Witness lists must be exchanged at least ten (10) days prior to commencement of the hearing.

7.6-5 JUDICIAL REVIEW COMMITTEE

The ad hoc committee appointed by the Medical Executive Committee or Board of Trustees shall serve as the Judicial Review Committee for the hearing. The members selected to serve on the Judicial Review Committee shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level and shall not be engaged in direct economic competition with the Petitioner.

7.6-6 FAILURE TO APPEAR

Failure of the Petitioner to appear at the scheduled hearing without good cause and proceed to a hearing shall be deemed to constitute voluntary acceptance of the action or recommendation appealed from and waiver of any hearing rights, and it shall thereupon become the final recommendation of the Medical Executive Committee or the final action of the Board of Trustees, as applicable. Such final recommendation or action shall be subject on that basis alone to appellate review and decision by the Board of Trustees.

7.6-7 POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of the time beyond the times expressly permitted in these Bylaws for a hearing may be requested by any affected party and shall be permitted by the hearing officer, or the Vice President of Medical Affairs before appointment of a hearing officer, on a showing of good cause.

7.7 HEARING PROCEDURE

7.7-1 PRE-HEARING PROCEDURE

It shall be the duty of the Petitioner and the Medical Executive Committee or the Board, as the case may be, to raise any procedural objections before the hearing so that decisions concerning such matters may expeditiously be made. Any such objections, when so raised, shall be preserved for consideration at any appellate review hearing which may subsequently be requested.
7.7-2 **THE HEARING OFFICER**

The Vice President of Medical Affairs shall appoint an unbiased hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing and, preferably, have experience in Medical Staff matters. The hearing officer shall have the authority to (1) rule on questions of procedure; (2) rule on the admission and exclusion of evidence; (3) participate in the deliberation of the Judicial Review Committee as requested by the Committee; and (4) advise the Judicial Review Committee generally in the discharge of its functions.

7.7-3 **RECORD AND CONDUCT OF THE HEARING**

The Judicial Review Committee shall maintain a record of the hearing. The cost of the report shall be borne by the Hospital, but the cost of the transcript shall be borne by the party requesting it. The hearing need not be conducted by technical rules of law relating to examination of witnesses or production of evidence except that irrelevant or unduly repetitious evidence shall be excluded.

7.7-4 **RIGHTS OF THE PARTIES**

At a hearing, both sides shall have the right to representation by counsel or other person. If either the Petitioner or the Medical Executive Committee or the Board of Trustees, as the case may be, elects not to be represented by counsel, this fact will be noted and recorded by the hearing officer. Both sides may ask the Judicial Review Committee members questions relating to determining the case and to challenge for bias, and may call and examine witnesses, introduce exhibits, cross-examine witnesses, and otherwise rebut any evidence. The Petitioner may be called by the Medical Executive Committee or the Board, as the case may be, and examined as if under cross-examination.

7.7-5 **MISCELLANEOUS RULES**

Any relevant evidence including hearsay, shall be admitted if it is the sort of evidence on
which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her or its position and the Judicial Review Committee may request such a statement be filed following the conclusion of the presentation of oral testimony. The Judicial Review Committee may interrogate the witnesses or call additional witnesses at its discretion.

7.7-6 BURDEN OF GOING FORWARD AND BURDEN OF PROOF

The Medical Executive Committee or the Board of Trustees, as the case may be, must initially come forward with evidence in support of its decision. Subject to the foregoing, the Petitioner shall bear the ultimate burden of persuading the Judicial Review Committee by the substantial weight of evidence provided at the hearing, that the recommendation or decision of the Medical Executive Committee or Board, as the case may be, lacked foundation in fact or was otherwise arbitrary, capricious, or unreasonable.

7.7-7 ADJOURNMENT AND CONCLUSION

The hearing may be adjourned and reconvened at the convenience of the participants without special notice. Upon receipt of all oral and written evidence and argument, the hearing shall be closed. The Judicial Review Committee shall thereupon conduct its deliberations and render a decision based on the record produced at the hearing including oral testimony, written statements, and all exhibits entered into evidence.

7.7-8 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after the close of the hearing, the Judicial Review Committee shall render a written decision which shall contain findings of fact sufficient in detail to indicate the basis for the Judicial Review Committee's decision on each matter contained in the notice of charges. The decision shall be delivered to the Medical Executive Committee, the Vice President of Medical Affairs, the President and CEO, the Board of Trustees, and by delivery of registered or certified mail, to the Petitioner. The decision of the Judicial Review Committee shall be considered final, subject to the right of appeal as provided in Section 7.8.
7.8 **APPEALS**

7.8-1 **TIME FOR APPEAL**

Within thirty (30) days after the date of the notice of the Judicial Review Committee decision, either the Petitioner, or the body whose recommendation or decision prompted the hearing, may appeal to the Board of Trustees before a final decision is rendered. No Petitioner shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse recommendation or action. All requests for appeal shall be delivered to the President of the Medical Staff in writing either in person, or by certified mail, return receipt requested, and shall include a statement of the reasons for the appeal. If an appellate review is not requested within the thirty (30) day period, both sides shall be deemed to have accepted the decision of the Judicial Review Committee, and it shall be the final recommendation of the Medical Executive Committee or the final decision of the Board of Trustees, as the case may be.

7.8-2 **REASONS FOR APPEAL**

The reasons for appeal from the Judicial Review Committee decision shall be: (1) lack of compliance with the procedure required by these Bylaws at the hearing so as to deny the Petitioner a fair hearing; (2) the lack of substantive rationality of a Medical Staff Bylaw, Rule or Regulation relied upon by the Judicial Review Committee in reaching a decision and/or (3) action taken arbitrarily, unreasonably, or capriciously.
ALLIED HEALTH PROFESSIONALS

8.1 DEFINITIONS

A. **Independent Allied Health Professional** is an individual who:

1. is duly licensed by the appropriate professional licensing board of the Pennsylvania Department of State; and

2. is authorized by Pennsylvania law to provide specific patient services without direct physician supervision or in collaboration with and under the direction of a physician.

B. **Dependent Allied Health Professional** is an individual who:

1. is duly qualified by training, experience, and certification and/or licensure to provide specific patient care services either under the direct supervision of a physician member of the Medical staff, or in collaboration with and under the direction of a physician member of the Medical staff; and

2. is either employed by a member of the Medical Staff or by the Hospital.

8.2 QUALIFICATIONS

Only an Allied Health Professional (AHP) holding a license, certificate or other legal credential as required by state law, who meet the following criteria shall be eligible to provide specific services in the Hospital:

A. represents an area of practice deemed by the Board of Trustees to be appropriate and necessary to provide services in the Hospital, and

B. documents his/her experience, background, training, demonstrated ability, physical health status and, upon request of the Medical Executive Committee or of the Board, mental health status with sufficient adequacy to demonstrate that any patient treated by him/her will receive care of the generally recognized professional level of quality and efficiency, and that he/she is qualified to provide a needed service within the Hospital; and
C. is determined on the basis of documented references, to adhere strictly to the ethics of his/her respective profession, as applicable, and to work cooperatively with others;

Where appropriate, the Medical Executive Committee may establish particular qualifications required of members of a specific category of AHP, provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable law.

8.3. **PROCEDURE FOR SPECIFICATION OF SERVICE**

An application for specified services for an AHP shall be submitted and processed in the same manner as provided in Articles IV and V for clinical privileges, provided that the Credentials Committee and the Medical Executive Committee need not take any action on any such application unless so requested by a Department Chairman, and provided further that the Board may delegate to the President and Chief Executive Officer the authority to take action for it on any such applications from specific categories of AHPs.

A Dependent AHP shall be individually assigned to a member of the active staff in the department appropriate to his/her professional training and shall be subject in general to the same terms and conditions as specified in Sections 4.2 for Medical Staff appointments. This member of the active staff will be considered the "supervising physician" of the Dependent AHP.

1. With the initial application for credentialing, a Dependent AHP must include a copy of his/her written collaborative agreement with the supervising physician as required by the respective professional practice regulations of the Dependent AHP. The Dependent AHP must provide evidence that the written or collaborative agreement has been filed with the appropriate Pennsylvania professional licensing Board or has been approved by the appropriate Pennsylvania professional licensing Board. This agreement will become part of the permanent credentialing file of the Dependent AHP.

All subsequent changes to the initial written or collaborative agreement must be given to the Medical Affairs office. The Dependent AHP must again provide evidence that these changes have been filed with, or approved by, the appropriate Pennsylvania professional licensing Board.

2. At the time of a Dependent AHP’s initial appointment, and at the time of all subsequent reappointments of the Dependent AHP, the supervising physician must sign a “Supervising Physician’s Agreement” which will become part of the Dependent AHP’s permanent credentialing file.
8.4 PREROGATIVES

A. The prerogatives of an Independent AHP shall be to:

1. provide specified patient care services consistent with the limitations of applicable law;

2. take a patient history, conduct a physical examination, and write progress notes on Hospital charts;

3. write orders, subject to the limitations of his/her license if any;

4. serve on staff, department and Hospital committees as requested;

5. attend meetings of the staff and department to which he/she is assigned and Hospital education programs; and.

6. exercise such other prerogatives as shall, by resolution or written policy duly adopted by the staff or by any of its departments or committees and approved by the Medical Executive Committee and the Board, be accorded to AHPs as a group or to Independent AHPs, such as the right to vote on specified matters, to hold defined offices, or any other prerogatives for which medical education, training and experience, beyond that which an Independent AHP can demonstrate is not a prerequisite.

B. The prerogatives of a Dependent AHP shall be to:

1. provide specified patient care services under the supervision or direction of a physician member of the active Medical staff and consistent with the limitations of his/her collaborative agreement filed with the applicable Pennsylvania professional licensing board and applicable law;

2. take a patient history, conduct a physical examination, and write progress notes on Hospital charts – all of which must be countersigned by the supervising physician;

3. write orders, and give oral orders, subject to the limitations of his/her license if any, which must be countersigned by the supervising physician in a timely fashion as determined by federal or state regulations;
4. serve on staff, department and Hospital committees as requested;

5. attend meetings of the staff and department to which he/she is assigned and Hospital education programs; and

6. exercise such other prerogatives as shall, by resolution or written policy duly adopted by the staff or by any of its departments or committees and approved by the Medical Executive Committee and the Board, be accorded to AHPs as a group or to Dependent AHPs, such as the right to vote on specified matters, to hold defined offices, or any other prerogatives for which medical education, training and experience, beyond that which a Dependent AHP can demonstrate is not a prerequisite.

8.5 **MEMBERSHIP STATUS**

Except as otherwise set forth herein, AHPs are not eligible for membership on the Medical staff and, therefore, are not entitled to the rights and privileges of Medical staff membership, unless specifically provided for in these Bylaws.

8.6 **RESPONSIBILITIES**

Each AHP shall:

A. meet the same basic responsibilities as required by Section 3.7-2 for Medical Staff members;

B. retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services. When appropriate, arrangements for alternate coverage may be made through the supervising physician members of the Medical Staff who have ultimate responsibility for the patient's medical care;

C. satisfy the requirements set forth in Article XIII for attendance at meetings of the staff and of the department and committees of which he/she is a member;

D. pay 25% of the full medical staff dues;

E. maintain in force, either himself/herself or through his/her employer, professional liability insurance in not less than the minimum amounts as from time to time may be determined by the Medical Executive Committee and the Board of Trustees;

F. meet the responsibilities required by the Rules and Regulations of the relevant
Department, and those responsibilities specified in Section 3.7 of these Bylaws as are deemed by the Medical Executive Committee to be applicable to the limited scope of practice of the AHP;

G. participate, as appropriate, in patient care audits and other quality review, evaluation and monitoring responsibilities required of AHPs, and in discharging such other functions as may be required by the Medical Staff from time to time;

H. notify the Vice President of Medical Affairs in writing immediately upon receiving notice of any adverse action by a state licensing agency, another hospital or health care facility, professional society or law enforcement agency including conviction of a misdemeanor of felony; and the filing or service of any professional liability suit or arbitration proceeding against the AHP; and

I. abide by the Bylaws, Rules and Regulations of the Medical Staff, the Policies, Rules and Regulations of the Department in which he/she participates, and other policies of the Medical Staff and Hospital.

8.7 CORRECTIVE ACTION/TERMINATION

A. Independent Allied Health Professional

Individuals in this category will be held to the corrective action and fair hearing processes as outlined in Articles VI and VII.

B. Dependent Allied Health Professional

1. Suspension of Clinical Privileges

   a. A summary suspension of all or any portion of the clinical privileges may be imposed whenever a Dependent AHP’s conduct suggests that immediate action be taken to protect the life of any patient, or to reduce the substantial likelihood of immediate injury or damage to the health and welfare of patients, employees, and/or others associated with the Hospital, or to the orderly operation of the Hospital. The President and CEO of the Hospital, Chairman of the Board of Trustees, President of the Medical Staff, Medical Director, Chairman of the AHP’s department, or the Chairman of the Credentials Committee have the authority to impose such a suspension. Such suspension will be reviewed by the Medical Executive Committee which will recommend disposition of the case for final action by the Board.
The Good Samaritan Hospital; Lebanon, PA
Bylaws of the Medical Staff
Article VIII
Allied Health Professionals
Page 6 of 7

b. The Dependent AHP shall have procedural rights for this type of suspension, and for all other privilege restrictions, revocations, and/or application disapprovals only as defined in this Section 5.7. Articles VI and VII do not pertain to Dependent AHPs.

2. Clinical functions of Dependent AHPs employed by a member of the Medical Staff may be subject to automatic termination for any of the reasons listed in Sections 6.7-1 through 6.7-5, or for any of the following reasons:

a. termination of Medical Staff appointment of the employer or the termination or expiration of the employer’s registration with the appropriate Pennsylvania professional licensing board;

b. curtailment of the employer’s clinical privileges to the extent that the services of the AHP are no longer necessary or permissible to assist the employer;

c. termination of employment of the Dependent AHP;

d. recommendation of the Medical Executive Committee with the approval of the Board of Trustees.

3. Whenever a Dependent AHP terminates his/her employment with a physician member of the Medical Staff or a physician member terminates the employment of the Dependent AHP, the physician employer must provide immediate written notice of such termination to the President of the Medical Staff.

8.8.1 PROCEDURAL RIGHTS FOR DEPENDENT AHPs

When the Medical Executive Committee disapproves the application of a Dependent AHP or recommends the restriction, suspension, or revocation of the privileges of a Dependent AHP, the President of the Medical Staff will notify that Dependent AHP of the Committee’s action. This notification will include a general statement of the reasons for the Committee’s recommendation and will advise the Dependent AHP of his/her right to appear personally (with his/her medical staff physician employer, if applicable) before the Medical Executive Committee to discuss the recommendation.

A. The Dependent AHP must request such a meeting with the Medical Executive Committee in writing to the President of the Medical Staff within seven (7) calendar days of being notified of the Medical Executive Committee’s proposed action.
B. When a meeting is timely requested, the President of the Medical Staff shall give the Dependent AHP and his/her employer written notice informing them of the time and place of the meeting with the Medical Executive Committee. The meeting will take place within fifteen (15) calendar days from the date of this notification. The Dependent AHP requesting the meeting must appear in person at the designated time and place, and failure to do so waives any further procedural rights under this Article.

C. The objective of the meeting shall be to reach a fundamentally fair result with the safety, health, and welfare of patients, employees, and/or others associated with the Hospital being paramount in any decision.

D. The Medical Executive Committee will recommend its decision to the Board of Trustees which shall make a final determination of the issue.

E. All decisions of the Board are final. The Board will send written notice of its final decision to the Dependent AHP, the physician employer of the Dependent AHP (if applicable), and the President of the Medical Staff within five (5) calendar days of its decision.
CLINICAL ORGANIZATION OF THE MEDICAL STAFF

9.1 CLINICAL SERVICES

A. The Medical Staff of the Hospital shall be organized into Clinical Departments as follows:

- Anesthesia
- Cardiovascular Medicine
- Family Medicine
- Medicine
- Obstetrics & Gynecology
- Pediatrics
- Radiology
- Surgery
- Emergency Medicine

Clinical Departments may be created, eliminated, subdivided, or combined in accordance with changes in the Departments of the Hospital, with the concurrence of the Medical Executive Committee and the Board of Trustees.

9.2 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff shall be assigned membership in at least one Clinical Department, but may also be granted membership and/or clinical privileges in other Clinical Departments.

9.3 FUNCTIONS OF DEPARTMENTS

Each Clinical Department is charged with the responsibility for implementing and conducting specific monitoring, review and evaluation activities that contribute to the preservation and improvement of the quality of safe patient care, treatment, and services provided in the Department.

To carry out this responsibility, each Department shall

A. Participate in patient studies for the purpose of reviewing and evaluating the quality of care within the Department. Each Department shall review all clinical work performed under its jurisdiction whether or not any particular practitioner whose work is subject to such review is a member of that Department. Family practitioners shall be subject to review by each Department in which they exercise clinical privileges.
B. Establish guidelines for the granting of clinical privileges and the performance of specified services within the Department and submit the recommendations required under Articles IV and V regarding the specific privileges each staff member or applicant may exercise and the specified services each allied health professional may provide.

C. 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, evaluation and monitoring activities.

D. Monitor on a continuing and concurrent basis, adherence to:

1. Staff and Hospital policies and procedures;
2. Requirements for alternate coverage and for consultations;
3. Sound principles of clinical practice; and
4. Regulation designed to promote patient safety.

E. Coordinate the patient care provided by the Department’s members with nursing and ancillary patient care services and with administrative support services.

F. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:

1. Findings of the Department’s review, evaluation and monitoring activities, actions taken thereon, and the results of such action;
2. Recommendations for maintaining and improving the quality of care provided in the Department and the Hospital;
3. Recommendations for purchase of new equipment; and
4. Such other matters as may be requested from time to time by the Medical Executive Committee.

G. Meet at least quarterly for the purpose of receiving, reviewing and considering patient care audit findings and the results of the Department’s other review, evaluation and monitoring activities and staff functions.

H. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

I. Specify emergency service responsibility.
J. Develop Department Rules and Regulations and Policies.

K. Oversee adherence by members of the Department to a) Medical Staff Bylaws, Policies and Rules and Regulations, and other requirements of the Department; b) sound principles of clinical practice; and c) regulations designed to promote patient safety.
10.1  GENERAL OFFICERS OF THE STAFF

10.1-1 IDENTIFICATION

The general officers of the staff shall be:
A. President
B. Vice President
C. Immediate Past President
D. Secretary
E. Treasurer

10.1-2 OTHER OFFICIALS OF THE STAFF

Other officials may include a medical director, department chairmen, a director of medical education, academic chiefs, and such other officials as may be selected pursuant to these Bylaws. Any such official must become and remain a member of the staff and be subject to these Bylaws, the Staff Rules and Regulations, and all other policies of the Hospital.

10.1-3 QUALIFICATIONS

General officers must be members of the active staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and Vice President must be practitioners with demonstrated qualifications on the basis of training, experience and ability to direct the medico-administrative aspects of Hospital and Staff activities.

10.1-4 NOMINATIONS

A. By Nominating Committee: The staff nominating committee shall convene one (1) month prior to the Annual Meeting and shall submit to the staff secretary one or more qualified nominees for each office. The names of such nominees shall be reported to the staff at least fifteen (15) days prior to the Annual Meeting.

B. By Other Means: Nominations for any office may be made from the floor at the time of election.
10.1-5 **ELECTION**

Officers shall be elected at the Annual Meeting of the staff in each even numbered year. Only staff members accorded the prerogative to vote for the general staff officers under Article III shall be eligible to vote. If requested, voting shall be by secret written ballot and by written and signed proxy. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

10.1-6 **EXCEPTIONS**

Sections 10.1-4 and 10.1-5 shall not apply to the office of Immediate Past President. The President shall, upon the completion of his/her term of office in that position, immediately succeed to the office of Immediate Past President.

10.1-7 **TERM OF OFFICE**

Each officer shall serve a two (2) -year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office. Each Officer may succeed themselves if appropriately elected at the General Medical Staff Meeting in each even numbered year.

10.1-8 **REMOVAL OF ELECTED OFFICERS**

Except as otherwise provided herein, removal of a staff officer may be initiated by the Board acting upon its own recommendation or by a two-thirds (2/3) vote of the members of the staff eligible to vote for staff officers. Removal may be based only upon failure to perform the duties of the position held as described in these Bylaws, or for violation of the basic responsibilities of individual staff membership (Section 3.7).

10.1-9 **VACANCIES IN ELECTED OFFICES**

Vacancies in offices, other than that of President, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of President, the Vice President shall become President and serve out the remaining term.
10.2 **DUTIES OF GENERAL OFFICERS**

10.2-1 **PRESIDENT**

The President shall serve as the Chief Medical Officer of the Hospital. As the principal elected official of the staff, the President shall:

A. Enforce the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

B. Develop, implement and perform oversight of the Medical Staff performance improvement activities within the Hospital, including quality improvement, credentialing and privileging, patient safety and utilization management.

C. Call, preside at, and be responsible for the agenda of, all general meetings of the Medical Staff.

D. Serve as Chairman of the Medical Executive Committee, as a staff member of the Joint Conference Committee, and as an ex-officio member of all other staff committees.

E. Assist 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;

F. Appoint in consultation with the Medical Executive Committee, the member of all Medical Staff committees and designating the Chairs and Vice Chairs of the committees, unless otherwise provided by these Bylaws.

G. Represent the Medical Staff to the Board of Trustees, outside licensing and accreditation agencies and the public.

H. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the President and Chief Executive Officer and other officials of the staff;

I. In the interim between Medical Executive Committee meetings, perform those responsibilities of the Medical Executive Committee that, in his/her reasonable opinion must be accomplished prior to the next regular or special meeting of the Medical Executive Committee.

J. Serve as an ex officio member of the Board of Trustees with vote.
10.2-2 **VICE PRESIDENT**

The vice president shall:

A. In the absence, temporary or permanent, of the President, assume all the duties and have the authority of the President.

B. Be responsible for the Bylaws review and revision function.

C. Be a member of the Medical Executive Committee, and a Medical Staff representative to the Joint Conference Committee.

D. Be an ex-officio member of the Board of Trustees, without vote.

E. Perform such additional duties as may be assigned to him/her by the President, Medical Executive Committee, or the Board.

F. Shall preside as Chairman of Performance Improvement and Monitoring Committee, with the responsibility to report on these performance monitoring activities to the Medical Executive Committee.

10.2-3 **IMMEDIATE PAST PRESIDENT**

The Immediate Past President shall be a member of the Medical Executive Committee and a Medical Staff representative to the Joint Conference Committee, and shall perform such other advisory duties as are assigned to him/her by the President, Medical Executive Committee, or the Board. He/she shall be an ex officio member of the Board of Trustees without vote.

10.2-4 **SECRETARY**

The Secretary shall be a member of the Medical Executive Committee, a Medical Staff representative to the Joint Conference Committee, and an ex-officio member without vote of all other staff committees. His/her duties shall be to:

A. give proper notice of all staff meetings in order of the appropriate authority;

B. prepare accurate and complete minutes for all meetings; and

C. perform such other duties as ordinarily pertain to his/her office.
10.2-5 **TREASURER**

The duties of the Treasurer shall be to:

A. supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments or application fees; and

B. perform such other duties as ordinarily pertain to this office.

10.3 **OTHER OFFICIALS OF THE STAFF**

10.3-1 **DEPARTMENT CHAIRMEN**

A. Qualification: Each Chairman shall be a member of the active staff, shall be board certified or have affirmatively established comparable competence through the credentialing process, have demonstrated ability in at least one of the clinical areas covered by the Department and shall be willing and able to faithfully discharge the functions of his/her office.

B. Selection and Appointment: The Department Chairman shall be elected by the Department members themselves prior to the annual meeting of the medical staff, with the appointment being subject to Board approval.

C. Term of Office: A Department Chairman shall serve a two (2)-year term commencing upon his/her appointment. He/she shall serve until the end of his/her term and until his/her successor is chosen, unless he/she shall sooner resign or be removed from office.

D. Vacancy: Upon a vacancy in the office of Department Chairman, the Vice Chairman of the Department shall be come Department Chairman until a successor is appointed.

E. Responsibilities:

Each Department Chairman shall:

1. Determine and manage the clinical and administrative activities within his/her Department, and particularly for quality review and evaluation functions delegated to the Department;
2. Develop and implement departmental programs and Rules and Regulations, in cooperation with the Vice President of Medical Affairs and consistent with the provisions of Article IX and Article XII, for on-going monitoring of practice, credentials review and privileges delineation, continuing medical education, and utilization review;

3. Be a member of the Medical Executive Committee, give guidance on the overall medical problems of the Hospital, and make specific recommendations and suggestions regarding his/her department;

4. Maintain continuing review of the professional performance of all practitioners with clinical privileges and of all allied health professionals with specified services in his/her Department and report regularly thereon to the Medical Executive Committee;

5. Transmit to the appropriate authorities as required by Article IV and V, his/her Department’s recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners in his/her Department;

6. Appoint such committees as are necessary to conduct the functions of the Department and designate a chairman and secretary for each;

7. Enforce the Hospital and Medical Staff Bylaws, Rules and Regulations and Policies within his/her department, including initiating corrective action and investigation of clinical performance and ordering consultations to be sought when necessary;

8. Implement within his/her department actions taken by the Medical Executive Committee and by the Board;

9. Participate in every phase of administration of his/her department, through cooperation with the nursing service and the Hospital administration, in matters affecting patient care, including personnel, supplies, equipment, space needs, special regulations, standing orders and techniques;

10. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee, the President and Chief Executive Officer or the Board; and
11. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital,

12. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the President of the Staff, the Medical Executive Committee, or the Board.

10.3-2 VICE CHAIRMAN OF DEPARTMENT

A. The Vice Chairman shall be elected at the time and in the manner as specified for the Chairman in Section 10.3-1B.

B. The Vice Chairman shall perform the various functions of the Chairman during his/hers absence, and any other function designated by the Chairman.

C. The Vice Chairman’s term of office shall coincide with that of the Chairman.

D. The Vice Chairman shall represent the Department on the Medical Staff’s Performance Improvement and Monitoring Committee.

10.3-3 MEDICAL DIRECTOR/VICE PRESIDENT OF MEDICAL AFFAIRS

A. Shall be an employee of the Hospital, appointed by the President and CEO, with the advice of the medical staff, through the Medical Executive Committee.

B. Shall be a member of the Active Medical Staff.

C. Shall not be a member of a specific staff department.

D. Responsibilities:

1. Member of the Medical Executive Committee and such other staff committees as shall be deemed appropriate;

2. Assist the officers of the medical staff in conducting staff affairs, including governance, quality assurance, medical education and credentialing.

3. Act as liaison between the medical staff, administration and Hospital Board of Trustees; and
4. If a full-time hospital employee, shall not have responsibilities or privileges for patient care.

10.3-4 MEDICAL DIRECTOR OF LABORATORIES

A. Shall be an employee of the Hospital appointed by the President and Chief Executive Officer, with the advice of the Medical Staff, through the Medical Executive Committee.

B. Shall be a member of the active medical staff

C. Shall be a Board Certified or Board Eligible Pathologist

D. Responsibilities:

1. shall be a member of the Performance Improvement and Monitoring Committee and such other staff committees as shall be deemed appropriate

2. direct all of the divisions of the Laboratory Department
MEDICAL EXECUTIVE COMMITTEE

11.1 DESIGNATION AND SUBSTITUTION

The organized medical staff delegates authority in accordance with law and regulation to the Medical Executive Committee to carry out medical staff responsibilities. The Medical Executive Committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The Medical Executive Committee has the primary authority for activities related to self-governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners through the medical staff process.

The Medical Executive Committee may, by resolution, establish a staff committee to perform one or more of the required staff functions. Whenever these Bylaws require a function to be performed by, or that a report or recommendation be submitted to:

A. a named medical staff committee but no such committee exists, the Medical Executive Committee shall itself perform such function or receive such report or recommendation, or shall assign the function to a new or existing committee of the staff or to the staff as a whole; or

B. the Medical Executive Committee, but a standing or special committee has been formed to perform the function; the committee so formed shall act in accordance with the authority delegated to it.

11.2 COMPOSITION

11.2-1 MEMBERSHIP

The Medical Executive Committee shall consist of the President, Vice President, Immediate Past President, Secretary, Chairmen of the Departments of Anesthesiology, Cardiovascular Medicine, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Pediatrics, Radiology, and Surgery, the Vice President for Medical Affairs, and two members-at-large, all of whom shall be voting members. The following persons from hospital administration shall be ex officio members without vote: the President and Chief Executive Officer, and the Vice Presidents. Other licensed independent practitioners may be included in the composition as appropriate.
If a dual position is held by one of the above Medical Executive Committee members, an additional member-at-large shall be appointed in order that the committee shall consist of sixteen (16) members.

11.2-2 Elected Membership

All members of the organized medical staff are eligible for membership in the Medical Executive Committee. All physician members of the Committee must be active members of the Medical Staff in good standing, and is Board Certified (or have affirmatively established comparable competence through the credentialing process). The procedure for electing the two (2) members-at-large from the active medical staff to service on the Medical Executive Committee shall be as follows:

A. Nominations
   The Nominating Committee will solicit names of eligible nominees from the Medical Staff. The Nominating Committee will then review the list of nominees, determine whether they are eligible to serve on the Medical Executive Committee and are willing to do so, and then submit a list of nominees to the Medical Executive Committee.

   The Medical Executive Committee, after receiving recommendations from the Nominating Committee, shall submit to the Medical Staff a list of qualified nominees for the elected positions on the Medical Executive Committee.

B. Election

   The elected members-at-large shall be those individuals receiving the highest number of votes of the eligible voting members of the Medical Staff voting in the election.

C. Term of Office

   The two (2) elected members-at-large shall each serve two (2) year terms. They may be re-elected. In order to provide an on-going rotation, one (1) such member shall be elected one year and one (1) the next.
11.2-3 REMOVAL FROM OFFICE

A. A member of the Medical Executive Committee may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office, gross neglect or malfeasance in office, or serious acts of moral turpitude.

B. Elected members-at-large of the Medical Executive Committee may be removed from office when:

1. A petition calling for a vote on removal signed by at least seventy-five (75) of the eligible voting members of the Medical Staff is presented to the Vice President of Medical Affairs; and

2. Two-thirds (2/3) of the eligible voting members of the Medical Staff responding to the official request for a vote, vote for an elected member’s removal.

C. Appointed members of the Medical Executive Committee may be removed from the Medical Executive Committee by:

1. A petition calling for a vote on removal signed by at least fifty percent (50%) of the eligible voting members of the Medical Executive Committee is presented to the Vice President of Medical Affairs; and

2. Two-thirds (2/3) of the eligible voting members of the Medical Executive Committee responding to the official request for a vote, vote for an appointed member’s removal.

11.2-4 VACANCIES IN OFFICE

If an elected member-at-large of the Medical Executive Committee is unable to complete the elected term of office, the Nominating Committee shall recommend a replacement to the Medical Executive Committee, who shall then appoint a replacement to complete the remainder of the term.

11.3 QUORUM

Fifty percent (50%) of the voting membership, but no less than eight (8), of the Medical Executive Committee shall be considered a quorum.
11.4 **MANNER OF ACTING**

Except as otherwise specified in these Bylaws, action of the Medical Executive Committee may be taken by a majority of the voting members present at a meeting at which a quorum is present, and at a meeting at which a quorum is initially present, the Medical Executive Committee may take action notwithstanding the withdrawal of members, if any action is approved by at least the majority of the required quorum for such a meeting.

11.5 **MEETINGS**

The Medical Executive Committee shall meet at least once a month and shall maintain a permanent record of its proceedings and actions. Members shall be required to attend at least fifty percent (50%) of the meetings unless excused by the President.

11.6 **DUTIES AND RESPONSIBILITIES**

The purpose, duties and responsibilities of the Medical Executive Committee shall be to, without limitation:

A. Provide a forum for the Medical Staff to assess the quality, appropriateness and efficacy of treatment services. The Committee will review the quality and appropriateness of care, treatment and services provided by members of the Medical Staff. The Committee will be responsible for overseeing the Peer Review Process for the Medical Staff.

B. Identify opportunities for improvement in quality of care and clinical performance in both the inpatient and outpatient settings.

C. Review or delegate to other appropriate Committees or Departments, review of matters involving quality of care and clinical performance, and ensuring that appropriate action is taken for identified problems.

D. Receive and act upon reports and recommendations from the Departments, Committees and officers of the Staff, including those reports and recommendations concerning patient care studies and other performance improvement and monitoring functions, and the discharge of their delegated administrative responsibilities, and recommend to the Medical Staff specific programs and systems to implement these functions.

E. Set objectives with Department Chairmen for establishing, maintaining, and enforcing professional standards within the Hospital for the continuing improvement of the quality of care rendered in the Hospital, and assist in developing programs to achieve these objectives.
F. Recommend to the Board of Trustees all matters relating to Medical Staff structure and mechanisms used to review credentials and to delineate clinical privileges for appointments and reappointments, recommend individuals for Medical Staff membership and clinical privileges.

G. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff Members, including investigation, corrective or review measures with regard to matters involving a practitioner referred by 1) the President or other Staff Member, 2) the President and Chief Executive Officer, or 3) the Board.

H. Request evaluations (focused review) of practitioners when there is doubt about an applicant’s ability to perform privileges.

I. Act upon reported concerns and reviews about a practitioner and initiate corrective action or termination when necessary, in accordance with the provisions of Article VI.

J. Be accountable to the Board of Trustees for the quality of medical care and the organization of performance improvement activities of the Medical Staff, including the mechanism used to conduct, evaluate and revise such activities, and reporting of outcomes of the medical Staff performance improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards.

K. Develop and maintain methods for the protection and care of patients and others in the event of internal and external disaster.

L. Represent and act on behalf of the Medical Staff during and in the interval between meetings, subject to such limitations as may be imposed by these Bylaws.

M. Coordinate the activities of and policies adopted by the staff, departments and committees.

N. Make recommendations on medico-administrative and Hospital management matters.

O. Assist in obtaining and maintaining accreditation.

P. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.

Q. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.
R. Serve as Bylaws Committee, which shall maintain the appropriate Bylaws, Rules and Regulations, and other organizational documents pertaining to the medical staff and:

1. Conduct an annual review of the Bylaws, the Rules and Regulations, procedures and forms promulgated in connection therewith;

2. Submit recommendations to the Staff and to the Board for changes in these documents.

3. Act upon all matters as may be referred to the Bylaws Committee by the Board, the Joint Conference Committee, the Departments, the President of the Staff, the President and Chief Executive Officer and the Committees of the Staff.

S. Serve as Medical Staff Equipment/Facilities Committee, which shall:

1. Review and determine the priorities on staff departmental requests for equipment;

2. Serve as liaison between Staff, Administration and Board regarding the purchase of all equipment and improvement of facilities, especially as they pertain to the care, treatment and services provided to, and general welfare of Hospital patients.

T. Collaborate with Administration and Hospital personnel in enforcing the Compliance Program.

U. Serve as Nurse Practitioner Oversight Committee.

V. Provide a forum for conflict resolution. The conflict management process shall include meeting with involved parties as early as possible to identify the conflict; gather information regarding the conflict; working with the parties to manage and, when feasible, resolve the conflict with the objective of protecting patient safety and enhancing quality of care.
COMMITTEES OF THE MEDICAL STAFF

12.1 PARTICIPATION OF INTER-DISCIPLINARY HOSPITAL COMMITTEES

Staff functions and responsibilities relating to liaison with the Board and Hospital Administration shall be discharged by the appointment of Medical Staff members to such Hospital committees as are established to perform those functions.

12.2 OPERATION OF STAFF COMMITTEES

12.2-1 COMPOSITION AND APPOINTMENT

A staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of members of the active staff and may include, where appropriate, allied health professionals and representation from Hospital administration, nursing service, medical records service, pharmaceutical service, social service, and such other Hospital departments as are appropriate to the functions to be discharged.

Unless otherwise stated in these Bylaws, each committee shall include a broad representation of the Medical Staff; however, committees shall consist of an appropriate number of individuals to be of an effective, yet manageable, size.

Unless otherwise specifically provided in these Bylaws, the Medical Staff committee members, chairmen and vice chairmen shall be appointed by the President of the Staff, and the Administrative Staff committee members shall be appointed by the President and Chief Executive Officer of the Hospital. The President and the Secretary of the staff shall serve as ex-officio members without vote on all committees, unless otherwise expressly provided herein.

All Medical Staff committees shall operate in accordance with the Hospital-Corporate bylaws and the written policies of the Hospital and the Medical Staff.

12.2-2 TERM AND PRIOR REMOVAL

Unless otherwise specifically provided herein, a member of a Medical Staff committee shall serve a term of two (2) years, coinciding with the term of the President of the Staff, unless he/she shall sooner resign or be removed from the committee.
A Medical Staff committee member, other than one serving ex-officio, may be removed by the President or by a majority vote of the Medical Executive Committee.

An Administrative Staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until his/her successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee.

An Administrative Staff committee member may be removed by action of the President and Chief Executive Officer of the Hospital.

12.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.

12.2-4 MEETINGS

A 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, but no less often than twice a year.

12.2-5 RECORDS AND REPORTS

Each committee shall periodically report a summary of its activities to the Medical Executive Committee and Board of Trustees.

Each Committee shall keep a record of the minutes of each of its meetings including an attendance roster. A copy of the minutes, approved by the membership and signed by the committee chair, shall be submitted to the Medical Affairs Department and will be kept on file.

12.3 STAFF FUNCTIONS

Provision shall be made in these Bylaws, either through assignment to the departments, to staff committees or to inter-disciplinary Hospital Committees, for the effective performance of the staff functions specified in this Section 12.3, of all other staff functions required by these Bylaws and of such other staff functions as the Medical Executive Committee or the Board shall reasonably require.

Each committee may, with the approval of the President of the Medical Staff, form subcommittees, task forces, or ad hoc committees as appropriate to carry out the charge of the committee. All such groups shall be considered committees of this Medical Staff.
The functions of the Medical Staff shall include, without limitation, to:

A. Conduct, coordinate and review patient care studies and monitoring activities, including tissue, blood usage and antibiotic reviews and analysis or autopsy reports.

B. Conduct, coordinate and review, or oversee, the conduct of utilization review activities.

C. Conduct, coordinate and review credentials investigations and recommendations regarding staff membership and grants of clinical privileges and specified services.

D. Monitor and evaluate care provided in and develop clinical policy for special care areas such as critical care unit, patient care support services such as radiology, laboratory respiratory therapy, physical medicine and anesthesia, and emergency, outpatient, home care, and other ambulatory services.

E. Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs, and supervise the Hospital’s professional library services.

F. Review the completeness, timeliness and clinical pertinence of patient medical and related records.

G. Develop and maintain surveillance over drug utilization policies and practices.

H. Prevent, investigate and control Hospital-acquired infections and monitor the Hospital's Infection Control Program.

I. Plan for response to disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.

J. Supervise and train medical and dental students and graduate trainees.

K. Direct staff organizational activities, including Staff Bylaws review and revision, staff officer and committee nominations, liaison with the Board and Hospital Administration, and review and maintenance of Hospital accreditation.

L. Coordinate the care provided by practitioners with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.
12.4 **STAFF COMMITTEES**

12.4-1 **CANCER COMMITTEE**

Members of this committee shall include, but are not limited to, physician representation from: diagnostic radiology, pathology, general surgery, medical oncology, radiation oncology and a cancer liaison physician. Also, non-physician membership includes, but is not limited to: Cancer Program Administrator, representatives from Oncology Nursing, Social Work/Case Management, Tumor Registry, and Performance Improvement.

The responsibilities of the committee are goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities throughout the Hospital. The Committee shall follow the requirements outlined in the most current Commission on Cancer Program Standards.

The Committee will meet at a minimum on a quarterly basis and will report to the Medical Staff at least annually.

12.4-2 **CREDENTIALS COMMITTEE**

Members of the Committee can be any medical staff member in good standing duly appointed by the President of the Medical Staff. In addition, all Department Chairmen by virtue of their office are voting members of the Committee. The Department Chairman may appoint a designee to attend in their absence with full voting privilege on Committee business. The VPMA is an ex-officio Committee member with voting privileges. Ex-officio members without vote will include the President, the Vice President for Nursing Services, and a member of the Board of Directors. The duties involved in conducting, coordinating, and reviewing credentials investigations are to:

1. Review and evaluate the qualifications of each applicant for initial appointment, or modification of appointment for clinical privileges and, in connection therewith, to obtain and consider the recommendations of the appropriate Department Chairmen.

2. Review and evaluate the qualifications of each Allied Health Professional applying to perform specified services and, in connection therewith, to obtain and consider the recommendations of the appropriate departments.

3. Conduct a personal interview of all new applicants except those applicants applying for coverage privileges.
4. Submit reports to the Medical Executive Committee in accordance with Articles IV and V on the qualifications of each applicant for staff membership or particular clinical privileges and of each limited health professional for specified services. Such reports shall include recommendations with respect to appointment, staff category, department affiliation, clinical privileges or specified services, and special conditions attached thereto.

5. Consider monthly the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

12.4-3 CRITICAL CARE COMMITTEE

This Committee shall be co-chaired by the Medical Directors of CVU and ICU and shall have physician representation from the Department of Anesthesia, Department of CV Medicine, Department of Emergency Medicine, Department of Medicine and the Department of Surgery. Other members of the Committee include representatives from CVU, ICU, 3 South, Respiratory Therapy, Education Services, Administration and Quality

The duties of this Committee shall be to:
A. Monitor;
   a) Patient care treatments and services provided in the CVU, ICU, 3 South and 2 East telemetry
   b) Code blue and CAT Team utilization;
   c) Protocols, outcomes, processes and procedures related “a” and “b”.

B. Develop appropriate criteria for admission and discharge in CVU/ICU, 3 South and 2 East telemetry as well as provide oversight for appropriate care.

C. Review quality of care treatment and services provided in CVU/ICU, 3 South and 2 East telemetry

D. Make recommendations and implement evidence-based clinical protocols, policies, procedures and process improvements related to critical care and cardiac services provided in affected areas.
12.4-4 PERFORMANCE IMPROVEMENT AND MONITORING COMMITTEE

This is a multi-disciplinary committee with representation from the Medical Staff and various hospital departments. The responsibilities of the Committee shall be to:

A. Review and offer recommendations regarding the following functions:

1. Food and nutrition
   a. Review the content and availability of diet therapy in the Hospital
   b. Periodically review and approve the dietary manual.

2. Health information management
   a. Review completeness, timeliness and clinical pertinence of patient medical and related records
   b. Review and approve medical record format
   c. Approve procedures regarding delinquency in completion of records
   d. Exercise general oversight over policies regarding record storage and availability.
   e. Monitor the quality of medical histories and physical examinations.

3. Infection control/employee health
   a. Monitor the Hospital’s infection control and employee health programs
   b. Investigate prevention and control of infections, both Hospital-acquired and exogenous

4. Laboratory and hematology
   a. Blood and blood-component usage
   b. General oversight of laboratory policies pertinent to patient care

5. Operative and invasive procedures
   a. Tissue reports
   b. Autopsy performance and reports

6. Utilization management - review general policies and problem areas

B. Review patient safety and patient satisfaction data.

C. Review publicly reported data, including Core or Quality Measures.
D. Review each clinical department's performance improvement reports.

E. Review trended, de-personalized data from Medical Staff Department peer review.

F. The Chairman of this Committee shall be the Vice President of the Medical Staff, with responsibility to report on these performance monitoring activities to the Medical Executive Committee.

12.4-5 **JOINT CONFERENCE COMMITTEE**

A committee of the Board of Trustees, this is a joint committee of Board, staff and administration. It shall consist of the President, Vice President, Immediate Past President, Secretary and two members of the Medical Executive Committee appointed by the President, at least an equal number of representatives of the Board of Trustees, and the President and Chief Executive Officer, and other hospital Vice Presidents as ex officio members. The Medical Staff representatives will be spokesmen for the Medical Staff on this committee. This committee shall be a medico-administration liaison committee and the official point of contact among the Medical Staff, the Board and the President and Chief Executive Officer of the Hospital.

12.4-6 **MATERNITY AND NEWBORN COMMITTEE**

1. This committee shall have representation from the Departments of Obstetrics/Gynecology, Pediatrics, and Family Medicine, Anesthesia, and Nursing Service.

2. Duties include coordination of activities and problem-solution in the labor, delivery, and post-partum areas and in the nursery.
12.4-7 **MEDICAL EDUCATION/LIBRARY COMMITTEE**

This committee is responsible for the duties involved in organizing continuing education programs and supervising the Hospital's professional library services, including to:

1. Develop and plan, and/or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to patient care study.

2. Evaluate, through the patient care evaluation function, the effectiveness of the educational programs developed and implemented.

3. Analyze, on a continuing basis, the Hospital's and Staff's library needs.

4. Act upon continuing education recommendations from the Medical Executive Committee, the Departments, or other committees responsible for patient care monitoring and evaluation functions.

5. Maintain a record of education activities and submit periodic reports to the Medical Executive Committee concerning these activities, specifically including their relationship to the findings of the patient care audit and other quality review, evaluation and monitoring functions.

12.4-8 **NOMINATING COMMITTEE**

This committee shall consist of the three (3) living and available Immediate Past Presidents of the Medical Staff. The duty of this committee is to present to the staff qualified candidates for elective positions in the staff organization (when nominations are made other than by a staff-wide nominating ballot), including to:

1. Consult with members of the Staff and Administration concerning the qualifications and acceptability of prospective nominees.

2. Submit, at the appropriate times as provided in these Bylaws, one or more nominations for:

   A. each elective office of the staff to be filled;

   B. each of the Member-at-Large positions on the Medical Executive Committee; and
C. such other elective positions as may be required by these Bylaws.

12.4-9 GRADUATE MEDICAL EDUCATION COMMITTEE

This committee shall be multi-disciplinary, with representation from the Medical Staff, Hospital staff, and residency program(s).

1. Duties - meet regularly to advise and review concerning the following matters:

   A. Establishment of and compliance with institutional policies affecting graduate medical education.

   B. Compliance with requirements of the appropriate Residency Review Committee of the Accreditation Council for Graduate Medical Education.

   C. Enhancement and implementation of policies and procedures for selection, evaluation, promotion, and dismissal of residents.

   D. Establishment and implementation of policies and procedures for selection, evaluation, promotion, and dismissal of residents.

   E. Establishment and implementation of institutional policies and procedures for residents and faculty, regarding discipline and adjudication of grievances, which maintain fairness and due process.

   F. Appropriate and equitable funding for resident positions, benefits and support services.

   G. Appropriate working conditions and duty hours of residents.

   H. Ethical, socio-economic, medical/legal, and cost-containment issues affecting graduate medical education.

2. Membership (all with vote except as noted) - should ordinarily consist of at least the following:

   A. Residency director (chairman)

   B. Full-time teaching faculty - two

   C. Clinical teaching faculty - one

   D. Chairman of Medical Staff Department of Family Medicine
E. Resident physician - one

F. Professor and Chairman of Penn State Department of Family and Community Medicine

G. Vice President for Medical Affairs

H. Director, Quality and Risk Management

I. Residency Secretary (ex-officio without vote)

J. Administrative Director of Residency Center (ex-officio without vote)

12.4-10 MEDICAL STAFF AND ALLIED HEALTH PROFESSIONAL HEALTH COMMITTEE

1. Duties:

A. Investigating and evaluating all complaints, allegations, or concerns ("referrals") regarding the potential impairment of a physician of the Hospital medical staff or an allied health professional ("AHP") credentialed at the Hospital.

B. Reporting such impaired physician or AHP to the Physician Health Program (PHP) of the Pennsylvania Medical Society, when appropriate.

C. Serving as a contact with the PHP for monitoring purposes of any Physician or AHP reported to that program by this Committee.

2. Composition:

A. President of the Medical Staff (Chairperson).
B. Psychiatrist who is knowledgeable in addictive disorders;
C. Vice President, Medical Affairs at the Hospital;
D. Chairperson of the Department in which the affected physician has privileges. (This committee member is considered a temporary member, and is only a member for those cases affecting physicians of his/her department.);
E. Supervising physician of the AHP (when an AHP is in question)

3. This committee will meet as needed when issues of a physician’s or AHP’s impairment, or potential impairment, have been called to its attention.

4. This committee is a subcommittee of the Medical Executive Committee and will
report its activities to the Medical Executive Committee on an annual basis (or more frequently as necessary).

5. Procedures:

A. All physicians and AHPs will be allowed to self-refer to the Medical Staff and Allied Health Professional Health Committee if they feel they have an impairment problem. Self-referral may be made to any of the permanent members, the physician’s or AHP’s Department Chairman, or the AHP’s supervising physician (in the case of an AHP).

If a physician or AHP self-refers to a committee member other than the Chairman, that committee member must report the referral to the Chairman within 48 hours of receiving the referral.

B. Referral (in verbal or written form) of any physician or AHP will also be allowed by any employee of The Good Samaritan Health System should the employee suspect an impairment problem. Employees may contact any of the permanent committee members, appropriate Department Chairman, or specific AHP’s supervising physician with their concerns.

C. Information to be provided to a committee member shall include, but is not limited to:

1. Physician’s or AHP’s name;
2. Date(s) of observation of unusual behavior;
3. Description of unusual behavior;
4. Did the person referring the physician or AHP confront the physician or AHP regarding this behavior? If so, what was the response of the physician or AHP?
5. Did the physician or AHP have any possible signs of substance abuse (e.g. alcohol on the breath)?

D. When a referral is received by this committee from an employee of The Good Samaritan Health System, the committee will investigate and evaluate that referral to decide the validity of the referral, and whether the physician or AHP in question should be reported to the Physician Health Program.

1. The physician or AHP in question will be interviewed by a member(s) of the committee as part of the committee’s investigation/evaluation. The committee will decide who is/are most appropriate for this interview. The committee member(s) who conduct the interview will then report findings from the interview to the committee.
2. The Chairman of the committee (and any other committee members deemed necessary by the Chairman) will interview the person who referred the physician or AHP to the committee.

3. Confidentiality of all findings, as well as the identity of both the physician or AHP in question and the person who referred the physician or AHP to the committee, will be maintained during all steps of an investigation and evaluation.

E. If a physician or AHP is seeking a referral to the PHP, or, after completion of the appropriate investigation/evaluation of an independent referral, it is the committee’s finding that the Physician or AHP in question needs to be referred to the PHP; the committee Chairman will contact the PHP for purposes of reporting the specific physician or AHP.

F. PHP’s plan of monitoring the physician or AHP will be reviewed by the committee. Additions to the plan may be made by the committee if deemed necessary for the safety of patients and staff at the Hospital.

1. Additions to the plan may consist of, but are not limited to:
   a. Peer review of the physician’s or AHP’s cases;
   b. Proctoring of the physician or AHP;
   c. Co-signature of orders by another physician in a like specialty.

2. The committee may assist the PHP in monitoring any physician or AHP who has been referred by the committee to the PHP.

3. The committee may ask a PHP participant for a copy of his/her PHP agreement to be given to the committee Chairman for the committee’s confidential file.

G. Monitoring will continue until the PHP is able to verify that the impairment for which the affected physician or AHP was referred to the program:

1. No longer exists, and

2. No longer impacts the quality of patient care provided by the specific physician or AHP (as confirmed by means decided upon by the committee).
H. Should the PHP withdraw its advocacy of any participating physician or AHP for cause, the committee understands that the PHP will notify those entities listed in the agreement, including the Medical Staff and Allied Health Professional Health Committee.

In such cases of advocacy withdrawal by the PHP, the committee will make its own recommendation regarding advocacy to both the administration and Medical Executive Committee. All confidentiality requirements and Hospital due process protocols are to be followed and met at all times.

I. If at any time during the investigation/evaluation phase of a referral to the committee, or during the diagnoses, treatment, or rehabilitation phase of the PHP process it is determined that the affected physician or AHP is unable to safely perform the privileges he/she has been granted, the matter will be forwarded by this committee to the Medical Executive Committee for appropriate disciplinary action (pursuant to mandated state and federal reporting requirements).

1. When a physician or AHP self-refers to the committee, or during the time period of the investigation of a referral from a staff member (and through to the termination of the monitoring period), all of any portion of the clinical privileges of the physician or AHP in question may be required to be suspended in order to maintain the safety of patients, employees, or other persons present in the Hospital, or the orderly operation of the Hospital.

2. If the Medical Staff and Allied Health Professional Health Committee deem such a suspension necessary, the Chairman of the Health Committee will invoke the summary suspension process as defined in Article VI of these Bylaws.

J. All discussions, reports, and minutes by the committee shall be considered confidential. All committee minutes, materials gathered in the course of a committee investigation/evaluation, and copies of reports (including periodic reports from the PHP) shall be kept in locked files in the Medical Affairs Office. None of this material should be reproduced and/or disseminated beyond the members of the committee.
12.4-11 PHARMACY AND THERAPEUTICS COMMITTEE

This committee shall be responsible for developing and maintaining surveillance over drug utilization policies and practices, including to:

1. Assist in the formulation of broad professional policies regarding the evaluation, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital.

2. Advise the Medical Staff and the Hospital’s pharmacy department on matters pertaining to the choice of available drugs.

3. Make recommendations concerning drugs to be stocked on the nursing floors and by other services.

4. Develop and review periodically a formulary or drug list for use in the Hospital.

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

6. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

7. Perform such other duties as assigned by the President of the Medical Staff or the Medical Executive Committee.

8. Maintain a record of all activities relating to the pharmacy and therapeutics function, and submit period reports and recommendations to the Medical Executive Committee and Departments concerning the drug utilization policies and practices in the Hospital.
12.4-12 UTILIZATION REVIEW COMMITTEE

This committee must review professional services provided to determine medical necessity and promote the most efficient use of available health facilities and services.

1. Establish and carry out programs of admission certification and continued stay review of all patients in accordance with applicable state and federal laws and regulations.

2. Assure coordination between concurrent review activities, quality assurance, risk management activities and reimbursement agencies.

3. Assist in the selections and ongoing modification of criteria and standards

4. Recommend changes in Hospital procedures, medical staff practices or continuing education programs as indicated on analysis of review findings.

5. Act on any topics referred to by Medical Staff Administration or other Hospital committees.

6. Address potential over utilization or under utilization issues.

7. Determination that admission or continued stay is not medically necessary is made by one of the UR Committee if the physician concurs with determination or fails to present their views when afforded the opportunity (must be made by two members in all other cases).

8. Before determination is not medically necessary, UR Committee must consult the Physician responsible for the care and afford opportunity to present their views.

12.4-13 ROBOTICS COMMITTEE

Members of this Committee shall include, but are not limited to physician representation from: general surgery, gynecologic surgery, urology, cardiothoracic surgery and anesthesia. Also, non-physician membership includes, but is not limited to: OR Manager, representatives from performance improvement, risk management and nursing.

This Committee is charged with the responsibility for recommending, implementing and conducting specific monitoring review and evaluation activities that contribute to the preservation and improvement of the quality of patient safety, treatment and services provided by the Robotics Program.
WellSpan Good Samaritan Hospital; Lebanon, PA
Bylaws of the Medical Staff
Article XII
Committees of the Medical Staff
Page 16 of 16

- Addition of 12.4-12 approved at MEC 05/21/2013; GMS: 05/28/2013; BOT 07/23/2013
- Addition of 12.4-13 approved at MEC 07/15/2014; GMS 09/23/2014; BOT 10/21/2014
- Revisions to 12.4-3 approved at MEC 11/17/2015; GMS 01/19/2016; BOT 01/26/2016
- Revisions to 12.4-2 approved at MEC 03/15/2016; GMS 05/17/2016; BOD 05/24/2016
MEETINGS

13.1 GENERAL STAFF MEETINGS

13.1-1 REGULAR MEETINGS

A regular annual meeting of the Medical Staff shall be held each year in the month of May. Additional regular meetings shall be held in January and September.

13.1-2 ORDER OF BUSINESS AND AGENDA

The order of business at a regular meeting shall be determined by the President. The Agenda shall include at least:

A. Reading and acceptance of the minutes of the last regular Staff meeting and of the Executive Committee, Joint Conference Committee and special meetings held since the last regular meeting;
B. Communications;
C. Old Business;
D. Administrative reports from the Committees;
E. New Business;
F. Departmental reports;
G. Election of officers and of representatives to staff and Hospital committees when required; and
H. For the Good of the Order.

13.1-3 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, the Medical Executive Committee, or not less than ten (10) members of the Active Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.
13.2 **COMMITTEE AND DEPARTMENT MEETINGS**

13.2-1 **REGULAR MEETINGS**

Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

13.2-2 **SPECIAL MEETINGS**

A special meeting of any committee or department may be called by, or at the request of, the Chairman thereof, the Board, the President of the Medical Staff, or by one-third of the group’s current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 **NOTICE OF MEETINGS**

Written or printed notice stating the place, day and hour of any special meeting, or of any regular committee or department meeting not held pursuant to resolution, shall be delivered either personally or by mail to each person entitled to be present there, at his/her last known business address, not less than two (2) days before the date of such meeting. In an emergency situation, verbal notification may be substituted for written notice and the two-day period may be waived.

13.4 **QUORUM AND PROXY**

The presence of 50 percent (50%) of the voting members of the Active Medical Staff in person, or by proxy, at any regular meeting shall constitute a quorum for the purposes of amendment to the Bylaws. The majority of members present shall be sufficient for the transaction of all other business at regular or special staff and departmental meetings.

Every member of the Medical Staff entitled to vote may vote on matters either in person or by proxy. Every proxy shall be executed in writing by the member and may be revoked at will. A majority of the voting members of a department or committee, but not less than two (2) members, shall constitute a quorum at any meeting of such department or committee.
13.5 **MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a department or committee by a writing, setting forth the action so taken, signed by a majority of members entitled to vote thereat.

13.6 **MINUTES**

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Medical Executive Committee and made available to the staff. A file of the minutes of each meeting shall be maintained in accordance with Hospital policy for retention of documents.

13.7 **ATTENDANCE REQUIREMENTS**

13.7-1 **REGULAR ATTENDANCE**

Each member of a staff category required to attend meetings under Article III shall be required to attend:

A. At least 50 percent (50%) of all general Medical Staff meeting duly convened pursuant to these Bylaws; and

13.7-2 **ABSENCE FROM MEETINGS**

Any member who is compelled to be absent from any Medical Staff meeting shall provide to the regular presiding officer thereof the reason for such absence. Unless excused, failure to meet the attendance requirements of Section 13.7-1 may be grounds for any of the corrective actions specified in Article VI.

Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application and any such applications shall be processed in the same manner as an application for initial appointment.
13.7-3 **SPECIAL APPEARANCE**

A Practitioner whose patient’s clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified. The Chairman of the meeting shall give the Practitioner at least ten (10) days advance written notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice in involved, the special notice shall be given and shall include a statement of the issue involved and that the Practitioner’s appearance is mandatory.

Failure of a Practitioner to appear at any meeting with respect to which he/she was given such special notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner’s clinical privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or of the Board or through corrective action, if necessary.
CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

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

A. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5-2.

B. MALICE means the dissemination of knowing falsehood or of information with a reckless disregard for whether or not it is true or false.

C. PRACTITIONER means a staff member, or applicant, or an allied health professional.

D. REPRESENTATIVE means the Hospital Board and any director or committee thereof; the President and Chief Executive Officer of the Hospital; or the Medical Staff through any member, officer, department or committee thereof authorized to perform specific information gathering or disseminating functions.

E. THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges or providing specified patient care services within this Hospital, a practitioner:

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

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

C. acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, staff membership and the continuation of such membership, or to his/her exercise of clinical privileges or provisions of specified patient services at this Hospital.
14.3 CONFIDENTIALITY OF INFORMATION

Current federal and state law provides that information derived through peer review activities is confidential. Therefore, information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient’s file or of the general hospital records, but it may be placed in the Confidential (peer review) section of the practitioner’s personnel file.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

No representative of the Hospital or Medical Staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

14.4-2 FOR PROVIDING INFORMATION

No representative of the Hospital or Medical Staff and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other facility providing health care, or organization of physicians concerning a practitioner or limited health professional who is, or has been, an applicant to, or member, of the staff, or who did or does exercise clinical privileges or provide specified services at this Hospital, provided that such representative or third party acts in good faith and without malice.
14.5 **ACTIVITIES AND INFORMATION COVERED**

14.5-1 **ACTIVITIES**

The confidentiality and immunity of peer review activities provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with activities of this or any other facility providing health care or organization of physicians, but not limited to:

A. applications for appointment, clinical privileges or specified services;

B. periodic appraisals for reappointment, clinical privileges or specified services;

C. corrective action;

D. hearings and appellate reviews:

E. patient care studies;

F. utilization reviews; and

G. other Hospital, department, committee or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

14.5-2 **INFORMATION**

The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

14.6 **RELEASES**

Each practitioner shall, upon request of a Hospital representative, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.
14.7 **CUMULATIVE EFFECT**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof and, in the event of conflict, the applicable law shall be controlling.
GENERAL PROVISIONS

15.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner or allied health professional in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. Once the amended Rules and regulations have been approved by the Board of Trustees, copies will be forwarded to all members of the medical staff and others who have clinical privileges.

15.2 DEPARTMENTAL RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee and the Board, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or other policies of the Hospital. A permanent file of current department rules and regulations shall be maintained by the President.

15.3 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by resolutions of the Medical Staff and of the Board and consistent with existing State and Federal laws.
15.4 **STAFF DUES**

Subject to the approval of the Board, the Medical Staff shall have the power to set the amount of annual dues for each category of staff membership, and to determine the manner of expenditure of funds received.

15.5 **FORMS**

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the Medical Executive Committee.

15.6 **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 not intended to limit or define the scope or effect of any provision of these Bylaws.

15.7 **TRANSMITTAL OF REPORTS**

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the President and Chief Executive Officer of the Hospital.
ADOPTION AND AMENDMENT OF BYLAWS

16.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board, by-laws and amendments thereto which shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and the community. Such by-laws and amendments shall be effective when approved by the Board. Once the amended bylaws and/or rules and regulations have been approved by the Board of Trustees, copies will be forwarded to all members of the medical staff and others who have clinical privileges.

- The Medical Executive Committee is authorized to act on behalf of the Medical Staff regarding amendments to the Bylaws which may be necessary to meet State or federal requirements, or are merely clerical in nature.

16.2 METHODOLOGY

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

16.2-1 MEDICAL STAFF

a. Affirmative vote of a majority of the staff members eligible to vote on this matter at a meeting at which a quorum is present, either in person or by proxy.

(Example: 100 staff members---->quorum = 51 members----> 26 votes passes amendment)

OR

b. Affirmative vote of a majority of a sufficient number of staff members eligible to vote on this matter which would constitute a quorum, but which vote was recorded at Department meetings, either in person or by proxy.

(Example: 100 staff members------->51 members attend Department meetings = quorum of staff -------> 26 votes passes amendment)

c. Provided that written notification of the proposed changes has been given at least 14 days in advance of the meeting.

AND

16.2-2 BOARD

The affirmative vote of the majority of those members of the Board attending a meeting at which a quorum is present.