BYLAWS

of the

MEDICAL STAFF

Sacred Heart Hospital
Allentown, Pennsylvania
June 2016
<table>
<thead>
<tr>
<th>Revised</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 1986</td>
<td></td>
</tr>
<tr>
<td>June 1987</td>
<td></td>
</tr>
<tr>
<td>June 1988</td>
<td></td>
</tr>
<tr>
<td>December 1988</td>
<td></td>
</tr>
<tr>
<td>June 1989</td>
<td></td>
</tr>
<tr>
<td>December 1989</td>
<td></td>
</tr>
<tr>
<td>June 1990</td>
<td></td>
</tr>
<tr>
<td>December 1990</td>
<td></td>
</tr>
<tr>
<td>June 1991</td>
<td></td>
</tr>
<tr>
<td>June 1992</td>
<td></td>
</tr>
<tr>
<td>June 1993</td>
<td></td>
</tr>
<tr>
<td>December 1993</td>
<td></td>
</tr>
<tr>
<td>June 1994</td>
<td></td>
</tr>
<tr>
<td>December 1994</td>
<td></td>
</tr>
<tr>
<td>June 1995</td>
<td></td>
</tr>
<tr>
<td>June 1996</td>
<td></td>
</tr>
<tr>
<td>June 1997</td>
<td></td>
</tr>
<tr>
<td>June 1999</td>
<td></td>
</tr>
<tr>
<td>June 2002</td>
<td></td>
</tr>
<tr>
<td>December 2002</td>
<td></td>
</tr>
<tr>
<td>June 2004</td>
<td></td>
</tr>
<tr>
<td>December 2004</td>
<td></td>
</tr>
<tr>
<td>June 2005</td>
<td></td>
</tr>
<tr>
<td>December 2006</td>
<td></td>
</tr>
<tr>
<td>June 2007</td>
<td></td>
</tr>
<tr>
<td>December 2008</td>
<td></td>
</tr>
<tr>
<td>December 2009</td>
<td></td>
</tr>
<tr>
<td>June 2010</td>
<td></td>
</tr>
<tr>
<td>June 2011</td>
<td></td>
</tr>
<tr>
<td>June 2012</td>
<td></td>
</tr>
<tr>
<td>June 2013</td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td></td>
</tr>
<tr>
<td>June 2016</td>
<td></td>
</tr>
</tbody>
</table>
# Table of Contents

BYLAWS OF THE MEDICAL STAFF – TABLE OF CONTENTS

**PREAMBLE** .......................................................................................................................... 10

**ARTICLE I - DEFINITIONS** ................................................................................................. 11

**ARTICLE II - NAME** ............................................................................................................. 13

**ARTICLE III - PURPOSES** .................................................................................................. 13

**ARTICLE IV – EXCLUSION OF PATIENTS’ THIRD PARTY BENEFICIARY RIGHTS** ................. 13

**ARTICLE V – MEDICAL STAFF MEMBERSHIP** .................................................................... 14

   Section 1 – Eligibility for Medical Staff Membership .......................................................... 14

   Section 2 – Qualifications for Membership ........................................................................ 14

   Section 3 – Other Considerations ...................................................................................... 15

   Section 4 – Basic Responsibilities of Medical Staff Membership ....................................... 15

   Section 5 – Conditions and Duration of Appointment ....................................................... 16

   Section 6 – Medical Staff Categories ................................................................................ 17

      Part 1 – Active Medical Staff .......................................................................................... 17

      Part 2 – Courtesy Medical Staff .................................................................................... 18

      Part 3 – Consulting Staff Category ................................................................................ 18

      Part 4 – Affiliate Staff .................................................................................................... 19

      Part 5 – Limited Duty Staff ............................................................................................ 19

      Part 6 – Honorary Medical Staff .................................................................................... 19

**ARTICLE VI – ALLIED HEALTH PROFESSIONALS** .......................................................... 20

   Section 1 - Definitions ..................................................................................................... 20

   Section 2 – Status of Allied Health Professionals ............................................................. 20

   Section 3 – Clinical Privileges and Functions .................................................................. 20

   Section 4 – General Principles ....................................................................................... 21

   Section 5 – Initial Application ......................................................................................... 22

   Section 6 – Reappointment ............................................................................................. 22

   Section 7 – Procedural Rights ......................................................................................... 22
Section 8 – Precautionary Suspensions .................................................................................. 23
Section 9 – Automatic Suspension/Revocation Procedure .................................................. 23
Section 10 – Disclosure ........................................................................................................ 24

ARTICLE VII – ORGANIZATION AND OPERATION OF THE MEDICAL STAFF ............................................... 25

Section 1 – General ............................................................................................................. 24
  Part 1 – Medical Staff Year .............................................................................................. 24
  Part 2 – Dues and Assessments ....................................................................................... 24

Section 2 – Officers of the Medical Staff ........................................................................... 25
  Part 1 – Officers ............................................................................................................. 25
  Part 2 – Selection of Officers ......................................................................................... 25
  Part 3 – Duties of Officers .............................................................................................. 26

Section 3 – Meetings of the Medical Staff ....................................................................... 28
  Part 1 – Annual Staff Meetings ...................................................................................... 28
  Part 2 – Semi-Annual Staff Meetings ........................................................................... 28
  Part 3 – Special Staff Meetings ...................................................................................... 28
  Part 4 – Notice of Special Meetings .............................................................................. 28
  Part 5 – Actions and Voting ........................................................................................... 28
  Part 6 – Agenda ............................................................................................................. 28

Section 4 – Department and Committee Meetings ............................................................ 29
  Part 1 – Department Meetings ....................................................................................... 29
  Part 2 – Committee Meetings ....................................................................................... 29
  Part 3 – Special Department and Committee Members ................................................. 28
  Part 4 – Minutes ............................................................................................................ 29

Section 5 – Provisions Common to All Meetings ............................................................... 30
  Part 1 – Notice of Meetings ........................................................................................... 30
  Part 2 – Attendance Requirements .............................................................................. 30
  Part 3 – [Reserved] ....................................................................................................... 30
Part 4 – Environment and Infection Control Committee ...................................................... 38
Part 5 – Medical Executive Committee .............................................................................. 39
Part 6 – Nominating Committee ......................................................................................... 41
Part 7 – Pharmacy and Therapeutics Committee ................................................................. 41
Part 8 – Medical Care Evaluation Committee ..................................................................... 42
Part 9 – Procedure Review Committee ............................................................................... 43
Part 10 – Cancer Committee .............................................................................................. 43
Part 11 – Graduate Medical Education Committee ............................................................ 45
Part 12 – Joint Conference Committee .............................................................................. 45
Part 13 – Radiation Safety Committee ............................................................................... 46
Part 14 – Utilization Documentation Management Committee ........................................ 46

Section 3 – Creation of Standing Committees .................................................................... 46

Section 4 – Special Committees .......................................................................................... 46

ARTICLE X – APPOINTMENT TO THE MEDICAL STAFF ..................................................... 47

Section 1 – Requirements for Appointment ........................................................................ 47

Part 1 – Eligibility, Qualifications, Basic Responsibilities and Conditions and Duration .......... 47

Section 2 – Application for Initial Appointment andClinical Privileges ................................ 47

Part 1 – Application Form .................................................................................................. 47

Part 2 – Terms of Application ............................................................................................ 48

Part 3 – Release and Immunity from Liability ..................................................................... 49

Part 4 – Burden of Providing Information .......................................................................... 50

Section 3 – Description of Initial Clinical Privileges ............................................................ 50

Part 1 – Delineation of Clinical Privileges ......................................................................... 50

Part 2 – Dental Privileges .................................................................................................. 51

Part 3 – Podiatry Privileges ............................................................................................... 51

Section 4 – Procedure for Initial Appointment ..................................................................... 52

Part 1 – Processing of Application ...................................................................................... 52
Part 2 – Credentials Committee Reports .................................................................................. 53
Part 3 – Action on the Application .......................................................................................... 53
Section 5 – Procedure for Temporary Clinical Privileges ....................................................... 54
   Part 1 – Temporary Privileges for Applicants .................................................................... 54
   Part 2 – Temporary Privileges for Non-Applicants ............................................................. 54
   Part 3 – Special Requirements ............................................................................................ 55
   Part 4 – Locum Tenens ......................................................................................................... 55
   Part 5 – Termination of Temporary Clinical Privileges ....................................................... 55
Section 6 – Emergency Clinical Privileges ........................................................................... 56
   Part 1 – Emergency Privileges for Nonmembers ............................................................... 56
   Part 2 – Emergency Privileges for Members ..................................................................... 56
   Part 3 – Termination of Emergency Privileges ................................................................. 56
   Part 4 – Definition of “Emergency” ...................................................................................... 56
   Part 5 – Disaster Preparedness Credentialing ..................................................................... 56
Section 7 – Telemedicine Privileges ..................................................................................... 57
Section 8 – Confidentiality of Peer Review Credentialing Documents and Material ............. 58
   Part 1 – Introduction ........................................................................................................... 58
   Part 2 – Contents of Credentials Files ............................................................................... 58
   Part 3 – Access Procedures for Peer Review Credentialing Documents and Materials ....... 59
Section 8 – Medico-Administrative Officer .......................................................................... 60
ARTICLE XI – MEDICAL STAFF CODE OF CONDUCT GUIDELINES ................................ 60
ARTICLE XII – ACTIONS AFFECTING MEDICAL STAFF MEMBERS ............................. 61
Section 1 – Procedure for Reappointment ............................................................................. 61
   Part 1 – Completion of Reappointment Form .................................................................... 61
   Part 2 – Factors to be Considered ....................................................................................... 61
   Part 3 – Department Procedures ....................................................................................... 62
   Part 4 – Credentials Committee Procedures ..................................................................... 62
ARTICLE XIII

Section 1 – General Terms ................................................................. 68

Part 1 – Title and Definitions .......................................................... 68

Part 2 – Interpretation ................................................................... 69

Section 2 – Hearing Process ............................................................ 69

Part 1 – Initiation of Hearing .......................................................... 69

Part 2 – Request for Hearing .......................................................... 71

Part 3 – Parties Rights and Duties ..................................................... 71

Part 4 – Notification of Hearing ....................................................... 72

Part 5 – Fair Hearing Procedure ..................................................... 72

Part 6 – Effect of Hearing Committee Report .................................. 74

Section 3 – Appellate Review Process ............................................. 75

Part 1 – Request for Appellate Review ........................................... 75

Part 2 – Notification of Time and Place for Appellate Review .............. 75

Part 3 – Appellate Review Procedure .............................................. 76

Part 4 – Appellate Review Action .................................................... 77

Section 4 – Miscellaneous .............................................................. 77
ARTICLE XIV – RULES AND REGULATIONS .............................................................................................................. 78
Section 1 – Medical Staff Rules and Regulations ................................................................................................. 78
Section 2 – Medical Staff Policies ........................................................................................................................... 78
Section 3 – Applicable Hospital Rules and Regulations ......................................................................................... 79
ARTICLE XV – AMENDMENTS .............................................................................................................................. 79
ARTICLE XVI – ADOPTION ................................................................................................................................... 79
PREAMBLE

WHEREAS, the Sacred Heart Hospital, a Roman Catholic Institution bound by its charter as approved by the Bishop of Allentown, is a nonprofit corporation organized under the laws of the Commonwealth of Pennsylvania with the purpose of operating a hospital to provide health care, health education, and health research; and

WHEREAS, the Medical Staff is that organized body whose members possess the education, knowledge, expertise, and competence to provide, monitor and evaluate the quality and appropriateness of medical care; to define for the Board of Directors the proper quality of medical care standards which will apply to all practitioners that treat patients in Sacred Heart Hospital; to judge the qualifications of applicants to the Medical Staff and to delineate the privileges of said individuals; and to judge the qualifications of Allied Health Professionals; and

WHEREAS, the Board of Directors of Sacred Heart Hospital has the ultimate responsibility and authority for the conduct of the Hospital and wishes to delegate to the Medical Staff, the duties, responsibilities, and authority for: monitoring the quality and appropriateness of medical care in the Hospital; making recommendations to the Board of Directors concerning an applicant's appointment or a Member's reappointment to the Medical Staff; recommending the clinical privileges such applicants or Members shall enjoy in the Hospital; evaluating the qualifications of Allied Health Professionals; and for investigating and recommending action in questions of clinical competence, patient care, professional ethics or infractions of these Bylaws or of applicable hospital rules or of Medical Staff Rules and Regulations; now therefore be it,

RESOLVED, that these Bylaws are adopted in order to provide for the organization of the Medical Staff of Sacred Heart Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board, and relations with applicants to and Members of the Medical Staff and others holding or seeking delineated clinical privileges, and are not subject to waiver by contract between the Hospital and other parties, or otherwise. These Bylaws constitute a contract between the Medical Staff and the Hospital and are mutually binding. These Bylaws and clinical privileges accorded under these Bylaws will be binding upon the Hospital and Medical Staff of any successor in interest in this Hospital. Affiliation with other hospitals, healthcare systems or similar entities shall not in and of itself affect these Medical Staff Bylaws; and

be it further

RESOLVED, that in recognizing that the best interests of patients are served by concerted and cooperative efforts, the Board of Directors, by approving these Bylaws, agrees that it and its administrative staff will develop its patient care policies in consultation with the Medical Staff and agrees to provide the assistance, resources, and cooperation necessary for the Medical Staff to effectively fulfill its duties and responsibilities to the Hospital.
ARTICLE I – DEFINITIONS

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

1) “Administration” or “administrative staff” mean the personnel employed by the Hospital, including the Chief Executive Officer, who, under the direction of the Board, are responsible for carrying out the day-to-day management of the Hospital’s operations.

2) “Allied Health Professionals” or “AHPs” are individuals, other than Medical Staff Members, who are duly qualified by training, experience or certification and/or licensure to provide specific patient care services in collaboration with and under the direct supervision of an active Member of the Medical Staff. For the purposes of these Bylaws, Psychologists duly licensed by the appropriate licensing Boards of the Pennsylvania Departments of State and/or Health and authorized by Pennsylvania law to provide specific patient care services without direct physician supervision are also AHPs.

3) "Attending" means the Medical Staff Member who admits the patient, unless the patient is transferred to another service via a formal written transfer.

4) “Board” or “Board of Directors” means the Board of Directors of the Sacred Heart Hospital.

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

6) “Clinical privileges” or “privileges” mean the authority recommended by the medical Staff and granted by the Board to an individual to provide medical/surgical and other patient care services in the Hospital, including the access to equipment, facilities and personnel necessary to practice in the individual’s specialty. Such approved clinical privileges shall be within defined limits based on the individual’s license or certification, education, training, experience, demonstrated competence and judgment.

7) “Dentist” means an individual who is fully licensed by the Pennsylvania Examining Board of Dental Council to practice dentistry in all its phases.

8) “Hospital” means the Sacred Heart Hospital, Allentown, Pennsylvania, and its extensions.

9) "Hospital rules" or "Applicable Hospital Rules" means such rules or such regulations adopted or proposed by the Hospital as described in Section 3 of Article XIV.

10) "Impaired" means the inability to practice the practitioner’s profession with reasonable skill, care and diligence due to a physical or mental disability including, but not limited to, deterioration through the aging process, loss of motor or sensory skills or abuse of drugs or alcohol.

11) “Joint Conference Committee” means the Committee composed of the Chief Executive Officer and representatives of both the Medical Staff and the Board of Directors as described in these Bylaws.

12) “Medical Executive Committee” or “MEC” means the Medical Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Board.
13) "Medical Staff Member" or “Member” means any physician, dentist or podiatrist who individually satisfies the requirements for Medical Staff membership as set forth in the Bylaws.

14) "Medical Staff Rules and Regulations" means rules and regulations adopted by the Medical Staff as described in Section 1 of Article XIV.

15) "Medical Staff Secretary" means an individual, hired and salaried by the Hospital, who is assigned the responsibility to provide administrative and clerical support to the Medical Staff. The Medical Staff Secretary (not to be confused with the Secretary of the Medical Staff as defined in Section 2 of Article VII) may also be responsible for other administrative and clerical functions when Medical Staff duties and responsibilities are fulfilled. The President of the Medical Staff shall have the authority to determine the priority of the Medical Staff Secretary's workload. The Hospital shall provide, at one location, the office space, equipment, and furnishings necessary for the Medical Staff Secretary to adequately perform his/her Medical Staff responsibilities.

16) "Patient Encounters" means any continuing uninterrupted management of any patient inclusive of, but not limited to admissions, consultations or OP/SPU procedures in the Hospital. This does not include care of patients by Emergency Care Unit, Pathology, Radiology, or Nuclear Medicine physicians or care of patients in physicians' offices.

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

18) "Podiatrist" means an individual who is fully licensed by the Pennsylvania Board of Podiatry Examiners.

19) "Practitioner" includes members of the Medical Staff and Allied Health Practitioners.

20) "President of the Medical Staff" means that Member elected to that position by the Medical Staff according to election procedures set forth in these Bylaws or another Member acting in his/her stead as provided for in Article VII.

21) “Telemedicine” means the provision of clinical services to patients by practitioners from a distance via electronic communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine” for the purposes of these Bylaws.

22) "Vice-President for Medical Affairs" means an administrative position of the Hospital to be occupied by a physician, duly licensed in the Commonwealth of Pennsylvania. In the event there is no Vice-President for Medical Affairs, the duties shall be assigned to the President of the Medical Staff or his/her designee.
ARTICLE II – NAME

The name of this organization shall be the Medical Staff of the Sacred Heart Hospital of Allentown, Pennsylvania, an unincorporated association.

ARTICLE III – PURPOSES

The purposes of the Medical Staff of Sacred Heart Hospital are:

1) To monitor and evaluate the quality and appropriateness of medical care in the Hospital and to take action and make recommendations to the Board so that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive quality medical care to the fullest extent possible, consistent with available resources, manpower, and facilities;

2) To make recommendations to the Board and set standards concerning the appointment or reappointment of an applicant to the Medical Staff of the Hospital;

3) To recommend the classifications for Allied Health Professionals and to recommend the nature and extent of clinical privileges to be granted to applicants in any categories established by the Board;

4) To ensure an acceptable level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each such person may exercise in the Hospital and through an ongoing review and evaluation of the performance of each such person in the Hospital, reports of these evaluation activities to be presented to the Board for periodic review;

5) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized by the Board;

6) To establish and maintain specific rules and regulations for self-government of the Medical Staff and to govern actions and professional responsibilities of the Members of the Medical Staff;

7) To establish procedures whereby issues concerning the Medical Staff and the Hospital may be discussed both within the Medical Staff and with the Board and the Chief Executive Officer through the Medical Executive Committee and the Joint Conference Committee;

8) To support, evaluate and promote programs associated with community health needs;

9) To participate in a spirit of mutual cooperation with the Board of Directors and the Chief Executive Officer in all appropriate projects where the unique qualifications of the Medical Staff are an essential ingredient; and

10) To develop mechanisms, through its quality assurance program, to ensure the provision of one level of patient care in the Hospital.

ARTICLE IV – EXCLUSION OF PATIENTS’ THIRD PARTY BENEFICIARY RIGHTS

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

Section 1 – Eligibility for Medical Staff Membership

Membership on the Medical Staff of the Sacred Heart Hospital is a privilege, which shall be extended by the Board, except as otherwise provided, only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Such individuals (except for members of the Consulting or Honorary staff) must be eligible for assignment to appropriate departments of the Medical Staff.

Medical Staff membership requires a continuous obligation to immediately notify the Medical Staff Office in writing of a change in any of the qualifications of Medical Staff Membership listed in Section 2 below.

Neither Medical Staff membership nor particular clinical privileges shall be denied on the basis of sex, race, religion, color, age, disability or national origin or on the basis of any other criterion unrelated to: the delivery of quality patient care; professional ability and judgment; moral character and ethical conduct; ability to work cooperatively with others; community need; or availability of adequate facilities or supportive services.

Section 2 – Qualifications for Membership

A) Only physicians, dentists and podiatrists licensed to practice in the Commonwealth of Pennsylvania, who can document their background, experience, training, demonstrated competence, good reputation, and upon request of either the Credentials Committee or the Medical Executive Committee, the status of their physical and mental health, with sufficient adequacy to assure the Medical Staff and the Board that they are capable of treating patients according to generally recognized professional standards of quality of medical care, shall be qualified to apply for membership on the Medical Staff.

B) As of July 1, 1999, only physicians, dentists and podiatrists who are Board certified or Board admissible shall be qualified to apply for membership on the Medical Staff. All physicians, dentists and podiatrists who apply for initial appointment after July 1, 1999 must be or become Board certified in accordance with their respective Board and/or Subspecialty Board requirements; in all events, such individuals must be Board certified within five (5) years of becoming Board admissible. Those physicians, dentists and podiatrists who apply for reappointment to the Medical Staff after July 1, 1999 must comply with any Board re-certification requirements and/or Maintenance of Certification or Osteopathic Continuous Certification requirements, if applicable. Those physicians, dentists and podiatrists who apply for reappointment to the Medical Staff after July 1, 1999, and who were members of the Medical Staff prior to July 1, 1999, shall be exempt from the requirements of this subsection. As used herein, the terms Board certified or Board re-certified shall mean, respectively, board certified or board re-certified within the physician, dentist or podiatrist’s subspecialty. Acceptable board certification is from American Board of Medical Specialties, the American Osteopathic Boards, the American Board of Oral and Maxillofacial Surgery, or the American Board of Foot and Ankle Surgery. For Podiatrists requesting non-surgical privileges only, Board certification by the American Board of Podiatric Medicine is acceptable.
C) General Dentistry, Endodontics, Orthodontics, Pedodontics, Periodontics and Prosthodontics – Members of these divisions shall not be required to be board certified, but shall be required to show evidence of satisfactory completion of a training program in general dentistry and, for the subspecialists only, a training program in the appropriate subspecialty; such training programs must be approved by the American Dental Association.

D) No physician, dentist or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that the individual (i) is duly licensed to practice medicine, dentistry or podiatry in this or in any other state; (ii) is a Member of any professional organization; (iii) had in the past, or presently has, such privileges at another hospital; or (iv) is a Member of a group practice whose members have previously been granted Medical Staff appointment and clinical privileges at this Hospital.

E) Applicants for Medical Staff membership must be able to demonstrate, on the basis of documented references, their adherence to the Code of Ethics of their respective specialty, their ability to work cooperatively with others and their willingness to participate in the discharge of Medical Staff responsibilities.

F) Members of the Medical Staff must pledge that they will not receive from, or pay to, any practitioner, either directly or indirectly, any part of a fee received for professional services.

G) Members of the Medical Staff shall properly inform all patients as to the identity of an operating surgeon, or any other medical practitioner providing treatment or consultative services.

H) If necessary, a Member of the Medical Staff shall delegate the responsibility for diagnosis or care of hospitalized patients only to another medical practitioner that is qualified to undertake this responsibility.

Section 3 – Other Considerations

In addition to the applicant's qualifications, the Hospital must consider its ability to provide facilities and supportive services for the applicant and the applicant’s patients. The Hospital must also consider the patient care needs for additional physicians, dentists or podiatrists with the applicant's qualifications.

Section 4 – Basic Responsibilities of Medical Staff Membership

Each Member of the Medical Staff shall:

A) Assure that one level of care is provided to each patient according to generally recognized professional standards of quality and provide for continuous care for their patients;

B) Comply with any regulations of the applicable state licensing board;

C) Abide by the Medical Staff Bylaws and by all other lawful standards, policies, and applicable rules of the Medical Staff and the Hospital;

D) Discharge such staff, department, service, committee and Hospital functions for which the Member is responsible by appointment, election or otherwise;
E) Prepare and complete in a manner established by the Medical Staff, the medical and other required records for all patients the Member admits or in any way provides care to in the Hospital;

F) Show evidence of adequate professional liability insurance coverage as may be required by the Board;

G) Abide by the ethical principles established by the applicable professional society or organization;

H) Comply with the Ethical and Religious Directives for Catholic Health Facilities as approved by the United States Conference of Catholic Bishops and all subsequent directives that may from time to time be promulgated, subject to the interpretation of the then current Bishop of Allentown;

I) Immediately report in writing to the President of the Medical Staff any of the following: notification of conviction of a felony; any change in state licensure, certification or registration status; any voluntary or involuntary revocation, resignation, suspension, limitation, non-renewal or reduction of privileges at another hospital facility; any change in medical professional liability coverage; or, any trial court judgment or settlement.

J) Supply current DEA (if applicable), State License, and Malpractice Insurance information to the Medical Staff Office within one (1) month of request for such delinquent information. Failure to supply this pertinent information will result in automatic suspension and relinquishment of privileges until such information is supplied. This automatic suspension and relinquishment shall not be subject to review under the Fair Hearing Plan.

Section 5 – Conditions and Duration of Appointment

A) Initial appointments and reappointments to the Medical Staff shall be made by the Board after consideration of a Medical Staff recommendation as provided in these Bylaws.

B) Initial appointments and reappointments shall be for a period of not more than two (2) years.

C) Appointments to the Medical Staff shall confer on the Member only such clinical privileges as have been granted by the Board, in accordance with these Bylaws.

D) Every application for staff appointment shall be signed by the applicant and shall contain the applicant’s specific acknowledgment of every Medical Staff Member's obligations to provide continuous care and supervision of patients, to abide by these Bylaws, Medical Staff Rules and Regulations, applicable Hospital rules and to accept assignments to clinical services, committees, and consultations.

E) These Bylaws and the Rules and Regulations do not apply to matters involving the appointment of hospital-based exclusive providers of physician services or the terms or conditions of their contractual arrangements. These matters, including the identity and selection of the physician-provider shall be governed by the terms of the respective contract for services; provided, however, that each hospital-based exclusive provider of physician services must meet and maintain all of the requirements for Medical Staff membership as a pre-requisite to the execution and continuance of any contractual relationship with the Hospital. Decisions to renew or to terminate contracts for the exclusive provision of hospital-based physician services shall not be subject to appeal through the Hearing and Appellate Review processes stated in these Bylaws.
F) These Bylaws and the Rules and Regulations do not apply to matters involving the appointment, terms or conditions of contractual arrangements between the Hospital and Medical Staff Members, employed or contracted to discharge administrative responsibilities within the Hospital, including but not limited to, Department Chairs; provided, however, that all such Members serving in medical/administrative capacities within the hospital must meet and maintain all the requirements for Medical Staff membership as a prerequisite to the execution and continuance of any contractual or employment relationship with the Hospital.

Section 6 – Medical Staff Categories

The Medical Staff shall be divided into the following categories: Active, Courtesy, Consulting, Affiliate, and Honorary.

Part 1 – Active Medical Staff

A) The Active Medical Staff shall consist of Medical Staff Members who regularly admit or otherwise provide service to patients in the Hospital, who are located closely enough to the Hospital to provide continuous care to their patients, who assume all the functions and responsibilities of membership on the Active Medical Staff, including the transaction of Medical Staff business and, where appropriate, emergency service care, clinical service coverage for inpatients and consultation assignments, and who shall attend service patients in the Hospital as assigned by Department procedures.

B) Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff committees, and shall be required to pay dues.

C) In order to remain on the Active Staff, an individual must be willing to assume reasonable service assignments, Medical Staff committee appointments, and other Medical Staff and Hospital responsibilities set forth in these Bylaws and the Medical Staff Rules and Regulations. Failure to faithfully fulfill such assigned responsibilities may result in the termination of Medical Staff membership. In such a situation, the individual must reapply to be considered for membership. The individual’s reappointment shall be granted only after the demonstration, to the satisfaction of both the Medical Executive Committee and the Board, that the individual is willing and able to discharge the above responsibilities. Any action to terminate, suspend, or in any way limit Medical Staff membership will be carried out in accordance with procedures set forth in Article XII of these Bylaws. The term “reasonable service” includes:

1) Acceptance of clinical service appointments and responsibilities as required by the chairperson of the department of which the individual seeks appointment.

2) Service on the Medical Executive Committee, other Medical Staff committees and Board committees.

3) Acceptance of emergency call responsibilities and care of service patients as designated by department chairpersons and specified in the Medical Staff Rules and Regulations. Any exemption for an individual or specialty group must be approved by the CEO or designee and President of the Medical Staff or designee. Where the hospital determines that there is an insufficient number of specialists to adequately provide for call coverage in a given specialty, the hospital shall make arrangements for transfer to a local institution.
D) Each Active Staff Member must assume and carry out responsibility, within the Member’s area of professional competence, for the daily care and supervision of each patient under the Member’s care in the Hospital, or arrange for a suitable alternative practitioner to provide the necessary care and supervision during the Member’s absence or unavailability.

E) Upon attaining the age of 65, Active Staff Members may be exempt from service assignments, committee appointments, emergency call and/or care of service patients. In order to obtain this (these) exemption(s), Active Members must request the exemption(s) desired and the reasons for the exemption(s) in a letter addressed to the Subdivision Chief (if applicable) and the Department Chairperson. The Department Chairperson shall make a recommendation to the Credentials Committee, which will evaluate each request independently and pass its recommendations to the Medical Executive Committee and the Board for their respective approval. If there is disagreement regarding the approval of the requested exemption, the Medical Executive Committee shall make the final decision to approve or disapprove the request.

**Part 2 – Courtesy Medical Staff**

The Courtesy Staff shall consist of Medical Staff Members who are eligible to be Members of the Active Staff, but chose instead Courtesy Staff status wherein they may only have twelve (12) patient encounters during any given year. Persons appointed to the Courtesy Staff must comply with all requirements of these Bylaws with the exception that they are eligible but not required to attend meetings of the Medical Staff or of their departments. They may accept committee appointments if they wish, but they may not vote, serve as a chairperson, or hold an elected office of the Medical Staff. Members of the Courtesy Staff must pay dues.

**Part 3 – Consulting Staff Category**

Staff Members in this category shall be recognized medical or dental specialists who, by virtue of special skills and limited availability, do not limit their work to any one hospital or to this community alone, and are appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients and in the administration of clinical departments. Appointment to the Consulting Staff does not entitle the Member to admit patients, serve on staff committees, to vote or to hold an office of the Medical Staff. Members of the Consulting Staff may, but are not required to, attend meetings of the Medical Staff. Members of the Consulting Staff are not required to pay dues. Medical Staff Members who are approved for telemedicine services will be appointed to the Consulting Staff Category.

As the Hospital sponsors a General Practice Residency Training Program in Dentistry, it is both desirable and necessary to have a committed teaching faculty. We currently have a limited number of dentists qualified by virtue of their training or admission privileges within the Department of Surgery, Subdivision of Oral and Maxillofacial/Dentistry to provide a well-balanced training program. Therefore, it is necessary to extend teaching privileges to Members of the Dental Community who have neither a need for, nor a desire to admit patients to the Sacred Heart Hospital, but rather to provide a resource for training the Dental Residents. These dentists will be credentialed in the same fashion as other Members, but limited to procedures performed in the outpatient Dental Unit, according to their Delineation of Privileges.
Appointments to the Dental Teaching Staff do not entitle the Member to admit patients, serve on Medical Staff Committees, to vote or to hold an office of the Medical Staff. Members of the Dental Teaching Staff may, but are not required to attend meetings of the Medical or Dental Staff. Members of the Dental Teaching Staff are not required to pay dues.

**Part 4 – Affiliate Staff**

The Affiliate Staff shall consist of Medical Staff Members who do not intend to admit or care for patients in the Hospital, including those Members who seek appointment or reappointment as an Active or Courtesy Staff Member, but who have not practiced medicine or continued training or education for one (1) year or more prior to seeking appointment or reappointment. Such Affiliate Staff Member shall be eligible to apply for Active or Courtesy Staff Membership, but such eligibility shall not entitle the Member to such staff category merely by virtue of the Member’s Affiliate Staff Membership. The Affiliate Staff shall not have clinical privileges. Affiliate Staff may visit their patients in the hospital, and may review the charts of their patients including all results of tests and examinations. They may observe procedures including surgeries with the specific consent of the Member performing such procedures. Affiliate Staff Members are not required to pay dues. Members of the Affiliate Staff must comply with all requirements of these Bylaws. They are eligible but not required to attend meetings of the Medical Staff or of their Departments. They may be appointed to Committees but may not vote, may not serve as a Chairperson, and may not hold an elected office of the Medical Staff.

**Part 5 – Limited Duty Staff**

A) The Limited Duty Staff shall be appropriate for those Members with specific privileges and written position description approved by the Department Chair and Medical Staff President, limited to scheduled service as determined by the Department Chair. These individuals will not be permitted to treat patients outside the terms of their contractual agreement.

B) Limited Duty Staff Members may:

1) Not serve on any committee of the medical staff but may be appointed as an adjunct without vote at the discretion of the President
2) Not vote at Medical Staff meetings (including Department, Division, etc.)
3) Not hold office on the Medical Staff

C) Limited Duty Staff Members are exempt from the board certification requirements of these Bylaws.

**Part 6 – Honorary Medical Staff**

The Honorary Staff shall consist of former Active Members of the Medical Staff who are no longer clinically active in the Hospital. Non-appointees to the Medical Staff who are of outstanding reputation in medically related fields may be designated Members of the Honorary Staff. Persons appointed to the Honorary Staff shall not be eligible to attend patients, to vote, hold office, or serve on a standing Medical Staff committee, but they may be appointed to special committees. The Honorary Staff Members may, but are not required to, attend Medical Staff meetings, but they are not required to pay dues.
ARTICLE VI - ALLIED HEALTH PROFESSIONALS

Section 1 – Definitions

For the purpose of these Bylaws, Allied Health Professionals ("AHPs") are individuals, other than Medical Staff Members, who are duly qualified by training, experience or certification and/or licensure to provide specific patient care services in collaboration with and under the direct supervision of an active member of the Medical Staff. For the purpose of these Bylaws, Psychologists duly licensed by the appropriate licensing Boards of the Pennsylvania Departments of State and/or Health and authorized by Pennsylvania law to provide specific patient care services without direct physician supervision are also AHPs.

Section 2 – Status of Allied Health Professionals

Allied Health Professionals are not Members of the Medical Staff and are not entitled to the procedural rights delineated in Article XIII of these Bylaws. Allied Health Professionals shall, however, be entitled to the procedural rights described in this Article.

Section 3 – Clinical Privileges and Functions

A) Each Allied Health Professional may exercise only those privileges on the clinical privilege sheet approved by the Board of Directors.

B) Prescriptive privileges of all Physician Assistants and Nurse Practitioners are subject to the State Board of Medicine regulations as well as the Allied Health Professional’s current collaborative or supervision agreement on file with the state.

C) All individuals desiring to exercise privileges within Sacred Heart Hospital must be appointed to the Allied Health Professional Staff under the supervision of a Medical Staff Member, unless otherwise provided for in these Bylaws.

D) If an Allied Health Professional Staff member is supervised by more than one clinical practice, each clinical practice must make individual application for privileges for that member.

E) Although hospital privileges may be granted to AHPs to assist in the direct care and evaluation of patients, the supervising Medical Staff Member has the ultimate responsibility for the care of the patient and responsibility for the professional and practice-related activities of the AHP.

F) Allied Health Professionals shall not have admitting privileges to Sacred Heart Hospital, with the exception of nurse midwives.

G) Medical Staff Members may not delegate to AHPs the duty to independently initiate orders except in the case of Nurse Practitioners, Physician Assistants, and Nurse Midwives acting within the scope of their practice and their approved privileges.

H) The Medical Staff Member using the services of an AHP assumes the responsibility for that person. Procedures performed by an AHP in the Hospital’s operating rooms must be directed and supervised by the surgeon in charge of the operation. It is the responsibility of the supervising Medical Staff Member to ensure that the AHP is kept current in all the privileges he or she wishes to perform.
I) Each Chairperson of the Department to which the AHP is assigned shall be responsible for evaluating the AHP and making recommendations on the continuation, expansion, reduction, or termination of clinical privileges and functions. In making these recommendations, each Chair shall take into account applicable state licensing statutes and regulations; recognized education, training, certification and/or licensure; experience, demonstrated competence and judgment; use of Hospital facilities; available facilities and resources; and patient care needs of the community.

Section 4 – General Principles

A) Allied Health Professionals shall comply with aspects of the Medical Staff Bylaws and Rules and Regulations, department rules and regulations, and Hospital policies that logically pertain to that individual and the individual must agree in writing, prior to the exercise of the individual’s services, to comply with the applicable requirements set forth in aforementioned documents.

B) All AHPs granted privileges at Sacred Heart Hospital must adhere and abide by all rules and regulations as set forth by the appropriate state board, state law or other regulatory agencies.

C) Each AHP must maintain and provide proof of current liability coverage in, at least, the minimum amount as required by Sacred Heart Hospital and state law.

D) Each AHP shall maintain and provide proof of licensure and/or certification as required by Sacred Heart Hospital and/or state law.

E) The membership and privileges of all AHPs shall be reviewed and granted at a maximum of every two (2) years.

F) At all times, each AHP shall wear the hospital-issued photo ID badge with his/her appropriate professional or technical title (e.g. RN, CRNP, CRNA, etc.)

G) The AHP is assigned to the Department and Subdivision (if applicable) of their supervising Medical Staff Member with whom they perform the majority of their responsibilities.

H) The AHP will be terminated or suspended if the supervising Medical Staff Member(s) cease(s) to be a Member of the Medical Staff or if the supervising Medical Staff Member(s) cease(s) to supervise the AHP. This termination shall be considered an automatic voluntary resignation not entitling the AHP to any procedural rights under the Bylaws of the Medical Staff.

I) At no time shall any AHP represent, imply, or lead a patient to believe that he or she is a Medical Staff Member.

J) The Credentials Committee may require an impartial physical or mental examination of an applicant and shall require that the results be made available for consideration in a manner consistent and in accordance with applicable law with respect to confidentiality. For Allied Health Professionals with clinical privileges who are 70 years of age and older at the time of initial application, and annually thereafter, completion of an Allied Health Professional Staff Health Evaluation Form by a physician is required.
K) Allied Health Professionals may be appointed to serve on Medical Staff committees and may attend meetings of their assigned department and/or the Medical Staff, if specifically invited by the appropriate department chairperson or the President of the Medical Staff.

Section 5 – Initial Application

A) An applicant shall submit an application, provided by the Hospital, documenting education, training, experience and background, together with evidence of current licensure status and references from two (2) practitioners who are familiar with the applicant’s character, education, and clinical competence.

B) Each applicant, by applying for Allied Health Professional Staff privileges, expresses his or her willingness to appear for interviews in regard to the application; authorizes the Hospital to consult other health professionals and hospitals with which the applicant has been associated; and consents to the Hospital’s inspection of all records and documents that concern the application process. The applicant also releases from any liability all representatives of Sacred Heart Hospital for their acts performed in connection with evaluating the applicant and his/her credentials; and releases from liability all persons and organizations who provide information to Sacred Heart Hospital concerning the applicant’s competence, qualifications and education.

C) The completed application will be processed in accordance with the Allied Health Professional Staff Credentialing Policy.

D) Upon approval of an applicant, the supervising Medical Staff Member will arrange for the orientation of the Allied Health Professional to Sacred Heart Hospital and its policies. The supervising Medical Staff Member is responsible for ensuring that the Allied Health Professional Staff member is oriented to specific issues of concern, such as operating room policies and procedures.

Section 6 – Reappointment

A) Reappointment is a privilege, not a right, and the burden of proof is on the Allied Health Professional and his/her supervising Medical Staff Member to demonstrate his/her competence for reappointment and reassignment of privileges to be performed. The ongoing monitoring of Quality Assurance and Improvement activities will be considered. All AHPs will be requested to respond to any queries resulting from quality assessment activities.

B) The completed application will be processed in accordance with the Allied Health Professional Staff Credentialing Policy.

Section 7 – Procedural Rights

Any affected AHP shall be provided with written notice of a negative recommendation by the Medical Executive Committee relating to appointment, reappointment, or reduction or termination of clinical privileges. When the negative recommendation is related to the AHP’s professional competence or professional conduct and may require a report to the National Practitioner Data Bank, the affected AHP shall have thirty (30) days from receipt of the notice to request a review and reconsideration of the negative recommendation (the “Review”) by filing a written request for a Review with the Vice President Medical Affairs. The Medical Executive Committee shall undertake the Review at the first or second regularly scheduled monthly meeting of the Medical Executive Committee immediately following the
receipt of the request. The affected AHP and the Medical Staff shall have the opportunity to present written information to the Medical Executive Committee. The Medical Executive Committee will render a decision after review of the written information or appoint an ad hoc committee to further investigate the matter. The ad hoc committee (if any) will submit its written report to the Medical Executive Committee for action by the Medical Executive Committee. Upon conclusion, the recommendation will be forwarded to the Board of Directors for final action.

Section 8 – Precautionary Suspensions

A) Whenever immediate action must be taken in the best interest of patient care or whenever the failure to take immediate action may result in imminent danger to the health of any individual, the President of the Medical Staff, the Chairperson of any Department, the Chief Executive Officer, or the Medical Executive Committee shall each have the authority to impose a precautionary suspension of the clinical privileges of an AHP, and such precautionary suspension shall become effective immediately upon imposition.

B) When a precautionary suspension has been imposed by any individual or entity other than the Medical Executive Committee, the Medical Executive Committee shall review the suspension at the next regularly scheduled monthly meeting of the Medical Executive Committee. Upon completion of the review, the Medical Executive Committee shall continue, modify or terminate the precautionary suspension.

C) When the Medical Executive Committee imposes a precautionary suspension, the affected AHP shall be entitled to the Procedural Rights Section of this Article.

Section 9 – Automatic Suspension/Revocation Procedure

A) Automatic suspension/revocation of the clinical privileges of an AHP shall occur under the following circumstances:

1) License:

   a) Revocation – Whenever an AHP’s license, certificate or other legal credential so authorizing him or her to practice in the Commonwealth of Pennsylvania is revoked by the appropriate State Board of Licensure, his or her clinical privileges shall immediately and automatically be revoked.

   b) Restriction – Whenever an AHP’s license, certificate or other legal credential authorizing him or her to practice in this Commonwealth is restricted by the appropriate State Board of Licensure, his or her clinical privileges shall be immediately and automatically restricted.

   c) Suspension – Whenever an AHP’s license, certificate or other legal credential is suspended by the appropriate State Board of Licensure, his or her clinical privileges shall be automatically suspended, effective upon and at least for the term of the suspension imposed by the State Board of Licensure.

2) Failure to maintain adequate malpractice insurance as required by the law of the Commonwealth of Pennsylvania.
3) Whenever an AHP is excluded from any Federal health care programs his or her clinical privileges shall immediately and automatically be revoked; provided however, that such clinical privileges may be reinstated upon action of the Medical Executive Committee and the Board of Directors at their sole discretion in the event that they conclude that the AHP is no longer excluded from any Federal health care programs. For purposes of this subsection, an excluded AHP shall refer only to an AHP who has been excluded from any Federal health care program as part of a formal sanction. An excluded practitioner shall not include a “nonparticipating” AHP or an AHP who has “opted out” of any Federal health care program (i.e. a professional who voluntarily elects not to participate in any Federal health care program or an AHP who wishes to terminate his or her participating agreement with Federal health care but fails to take such action during the participating enrollment period).

4) The clinical privileges of AHPs (except psychologists duly licensed by the appropriate licensing Boards of the Pennsylvania Departments of State and/or Health and authorized by Pennsylvania law to provide specific patient care services without direct physician supervision) shall be automatically suspended or terminated whenever the AHP’s supervising practitioner:

   a) has his or her clinical privileges or Medical Staff membership suspended or terminated;
   
   b) ceases to be a Member of the Medical Staff; or
   
   c) ceases to supervise the AHP.

B) Suspension, restriction or revocation of clinical privileges pursuant to 1 - 4 above shall not be subject to a Review under the Procedural Rights Section of this Article. Consideration for reinstatement of clinical privileges shall occur only after the AHP has, in the case of exclusion (except as otherwise provided in 3 above), been reinstated to the Federal health care programs from which he or she has been excluded, has reapplied for clinical privileges, the incident which led to the suspension or revocation has been investigated, and the application reviewed by the appropriate credentialing individuals and committees pursuant to these Bylaws.

Section 10 – Disclosure

A) Content of Application/Reapplication: All applications and reapplications for clinical privileges shall be in writing, signed by the applicant, and submitted on the form prescribed by the Board of Directors. Each AHP is required to disclose the information that would be provided by an applicant to the Medical Staff under these Bylaws.

B) Ongoing Disclosure: Each AHP has an ongoing affirmative duty to immediately report to the Hospitals the occurrence of any event that would be reportable by an applicant to the Medical Staff under these Bylaws. Such events include, but are not limited to loss, reduction or suspension of any license or certification, and the initiation of any investigation, lawsuit, or other action against the AHP which relates in any way to the practice of health care. It is also the responsibility of each AHP to inform the Medical Staff Office of a separation from their group practice, change in supervising physician, or a change in their written/collaborative agreement.
ARTICLE VII – ORGANIZATION AND OPERATION OF THE MEDICAL STAFF

Section 1 – General

Part 1 – Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the first day of July and ends on the 30th day of June each year.

Part 2 – Dues and Assessments

All persons appointed to the Medical Staff (except Consulting, Affiliate and Honorary Staff) shall pay annual staff dues and assessments as established by the Medical Staff. Dues collected and other funds received by the Medical Staff shall be placed in such accounts or depositories as the Medical Executive Committee shall direct. Disbursement of Medical Staff funds shall be solely determined by action of the Medical Staff or the Medical Executive Committee, unless specifically restricted by action of the Medical Staff.

Section 2 – Officers of the Medical Staff

Part 1 – Officers

The officers of the Medical Staff shall be the President, President-elect, Immediate Past President, Secretary and Treasurer.

Part 2 – Selection of Officers

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

B) Nominations - Nominations for officers of the Medical Staff shall be presented by the Nominating Committee at the Medical Staff meeting prior to the end of the current two-year term and at any other meeting at which an election is being held. The Nominating Committee’s slate of nominees shall be sent to all voting Members of the Medical Staff at least fifteen (15) days prior to an election. Nominations from the floor are permitted at the time of elections. This procedure will be followed in all Medical Staff elections.

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

D) Term - Each officer shall hold office for a two (2) year term commencing on the first day of the Medical Staff year following the officer’s election, unless the officer shall sooner die, resign, or be removed from office. All officers may be reelected, but the President and President-elect may not hold their respective offices for more than two (2) consecutive terms.
E) **Disqualification and Removal** - Failure of an officer to maintain the status of a Member of the Active Medical Staff shall immediately disqualify that person from holding such office and shall be deemed to create a vacancy therein. The Medical Executive Committee may, by a two-thirds (2/3) vote at a meeting in which a quorum has been established, remove any officer of the Medical Staff for conduct detrimental to the interests of the Hospital, or if the officer is suffering from a physical or mental infirmity rendering the officer incapable of fulfilling the duties of the office, providing that notice of the meeting at which such action takes place shall have been given in writing to such officer by overnight mail with signature required at least ten (10) days prior to the date of such meeting. The officer in question shall be afforded the opportunity to speak in the officer’s own behalf prior to the taking of any vote on the officer’s removal. Any officer may also be removed from office by a majority vote of all Members of the Medical Staff eligible to vote and present at a meeting of the Medical Staff, provided the above mentioned notice and opportunity to appear before the Medical Staff to speak on the officer’s own behalf is afforded the officer in question. Any such removal from office shall not entitle such officer to the procedural rights afforded by Article XIII and shall not affect the officer’s Medical Staff membership status or clinical privileges.

F) **Vacancies** - When the office of the President is vacated prematurely, the President-elect shall immediately assume the office of President for the remainder of the current Medical Staff Year. If the President-elect is unable to succeed to the office of President or is unable to serve out the remainder of the current Medical Staff Year for any reason, the authority and duties of the President will be temporarily assumed by the Immediate Past President, the Secretary or the Treasurer, in that order of succession until the next regular Medical Staff Meeting at which time any prematurely vacated offices shall be filled by vote of the membership following the procedures set forth above in Parts 2B and C of Section 2 this Article. Filling a vacancy will not count against the maximum number of consecutive terms as described in Section D above.

**Part 3 – Duties of Officers**

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

1) Act on behalf of the Medical Staff in cooperation with the Vice-President for Medical Affairs and the Chief Executive Officer in matters of mutual concern;

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

3) Serve as a member and as Chairperson of the Medical Executive Committee;

4) Appoint committee chairpersons and members, in consultation with the Vice-President for Medical Affairs, to all standing, special, and multi-disciplinary Medical Staff committees, except as otherwise specified in these Bylaws;

5) Serve as an ex-officio member of all other Medical Staff committees;

6) Present the activities, opinions, policies, concerns, needs and grievances of the Medical Staff to the Chief Executive officer and to the Board;

7) Report the policies and decisions of the Board of Directors to the Medical Staff;
8) Be the spokesperson for the Medical Staff in its external professional and public relations;

9) Serve as an ex-officio member with vote of the Board if so elected by the Board; and

10) Be a member of the Joint Conference Committee.

B) President-elect - The president-elect shall:

1) Assume all the duties and have the authority of the President in the President’s absence or disability. Should both the President and the President-elect be unavailable in an emergency, the authority and duties of the President will be temporarily assumed by the Immediate Past President, the Secretary or the Treasurer in that order of succession;

2) Automatically succeed the President when the President fails to serve for any reason;

3) Serve as an ex-officio member with vote of the Board if so elected by the Board;

4) Be a member of the Joint Conference Committee;

5) Be a member of the Credentials Committee; and

6) Perform such other duties as may be assigned by the President of the Medical Staff or the Medical Executive Committee.

C) Immediate Past President – The Immediate Past President shall:

1) Be a member of the Medical Executive Committee, and Chairperson of both the Nominating Committee and the Credentials Committee;

2) Act as advisor to the President; and

3) Perform such additional or special duties as shall be assigned by either the President or the Medical Executive Committee.

D) Secretary – The Secretary shall:

1) Keep accurate and complete minutes of all staff and Medical Executive Committee meetings;

2) Call meetings on order of the President, attend to all correspondence, and perform such other duties as may pertain to the office; and

3) Be a member of the Medical Executive Committee.

E) Treasurer – The Treasurer shall:

1) Collect and be custodian of staff dues and funds, and make disbursements authorized by the Medical Staff, the Medical Executive Committee or their designees. The Treasurer shall issue a report at each regular meeting of the Medical Staff and of the Medical Executive Committee, specifying the amount and location of all balances and itemizing all receipts and disbursements occurring since the previous meeting;
2) Be a member of the Medical Executive Committee.

Section 3 – Meetings of the Medical Staff

Part 1 – Annual Staff Meetings

The Medical Staff shall hold its Annual Meeting at least ten (10) days before the end of the Medical Staff year. All Members of the Medical Staff are entitled to attend all Medical Staff meetings; however, voting rights shall be determined by staff category.

Part 2 – Semi-Annual Staff Meetings

The Medical Staff shall meet semi-annually, on dates set at the beginning of the Medical Staff year by the President, for the purpose of reviewing and evaluating department and committee reports and recommendations, and to act on any other matters placed on the agenda by the President. The June meeting shall be the annual meeting.

Part 3 – Special Staff Meetings

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the Medical Executive Committee, or a petition signed by not less than twenty (20) Members of the Active Staff. In the event it is necessary for the staff to act on a question without being able to meet, the voting members may be notified with the question and their votes returned to the President of the Medical Staff. Such a vote shall be binding so long as the question receives an affirmative vote by a majority of the staff eligible to vote.

Part 4 – Notice of Special Meetings

A written notice stating the place, day, hour and purpose for any special meeting of the Medical Staff shall be sent to each Member eligible to vote, not less than fifteen (15) days before the date of such meeting and may be posted at various locations in the Hospital. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Part 5 – Actions and Voting

For any action to move forward, it must receive one-half (1/2) of the votes cast by the voting Members who are present at the time of such vote and who do vote.

Part 6 - Agenda

The agenda at any regular meeting of the Medical Staff shall be determined by the President based on the business to be considered.
Section 4 – Department and Committee Meetings

Part 1 – Department Meetings

Members of each department shall meet as a department at least quarterly but may meet more often at the discretion of the chairperson of the department. The time and place of the meetings shall be set by the chairperson of the department. The purpose of the meeting will be to review and evaluate the clinical work of the Department and to discuss any other matters concerning the Department. The agenda for the meeting and its general conduct shall be set by the chairperson.

Part 2 – Committee Meetings

All committees shall meet at least quarterly unless a greater or fewer number is specified by law or in these Bylaws, at a time set by the Chairperson of each committee. The agenda for the meetings and its general conduct shall be set by the chairperson of the committees.

Part 3 – Special Department and Committee Meetings

A) A special meeting of any department or committee may be called by or at the request of the department or committee chairperson, by the President of the Medical Staff, or by petition signed by not less than one-fourth of the members of the department or committee involved. Written notice stating the place, day and hour of any special meeting shall be given to each member of the department or committee not less than seven (7) days before the time of such meeting. No business shall be transacted at any special meeting except that business stated in the notice calling the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

B) In the event that it is necessary for a department or committee to act on a question without being able to meet, the voting members of the concerned department or committee may be presented with the question, in person or by mail, and their written vote returned to the chairperson of the department or committee. Such a vote shall be binding so long as the question receives an affirmative vote by a majority of the department or committee members eligible to vote.

Part 4 – Minutes

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of the members, of the recommendations made, and of the votes taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the Medical Executive Committee unless otherwise specified for certain committees in Article IX. Each department and each committee shall maintain a permanent file of the minutes of each of its meetings.
Section 5 – Provisions Common to All Meetings

Part 1 – Notice of Meetings

Written notice specifying date, time and location of all meetings of the Medical Staff, of departments and of committees shall be sent to each designated member of these groups at least five (5) days prior to a given meeting. With the exception of special meetings of the Medical Staff, no further notification is required. Announcements of such meetings may also be posted at suitable locations within the Hospital. The presiding officers should consider the professional constraints of each member when determining the time and dates of meetings.

Part 2 – Attendance Requirements

A) Each Member of the Active Staffs is strongly encouraged to attend all meetings of the Medical Staff, and of the departments and committees to which the Member has been assigned, appointed or elected. The semi-annual General Staff meeting is held twice per year and Department meetings shall be held at least quarterly.

B) Members of the Courtesy, Consulting, Affiliate and Honorary Staffs are welcome to attend and participate in department and general staff meetings, but shall not be required to do so unless their clinical work is scheduled for discussion.

Part 3 – [Reserved]

Part 4 – Voting

Any individual who attends a meeting in more than one capacity shall only be entitled to one vote.

Section 6 – Committee Meetings - Quorum

The presence of one-third (1/3) of the total membership of the committee members eligible to vote at any regular or special committee meeting is required in order for the meeting to proceed, unless otherwise stated in these Bylaws. For any action to move forward, it must receive one-half (1/2) of the votes cast by the voting members who are present at the time of such vote and who do vote.

Section 7 – Vice-President for Medical Affairs

The position of Vice-President for Medical Affairs shall be filled by a physician appointed by the Board and employed by the Hospital. Although this office is part of the Hospital administration and not interposed between the Medical Staff and the Board, the Vice-President for Medical Affairs may from time to time represent the authority of the Hospital in matters relating to individual members or groups of Members of the Medical Staff. The Vice President for Medical Affairs of the Medical Staff shall be a Member, and be subject to and required to comply with these Bylaws and the Medical Staff Rules and Regulations. In the event there is no Vice-President for Medical Affairs of the Medical Staff, the duties shall be assigned to the President of the Medical Staff, or his/her designee. The specific duties shall be determined by the Board and shall include but not be limited to the following:
A) be an ex-officio member of the Medical Executive Committee and all other committees of the Medical Staff;

B) monitor activities of the Medical Staff;

C) provide day to day liaison between the Medical Staff and the administration of the Hospital;

D) present and explain the policies of the Hospital to the Medical Staff;

E) monitor and interpret to the Board and the Medical Staff changing requirements of outside regulatory authorities and of accrediting organizations;

F) be responsible for monitoring the overall quality of patient care and reporting possible deficiencies to the Chief Executive Officer, the Board and the Medical Executive Committee;

G) be the coordinator of the research, educational, and pre and post graduate training activities of the Medical Staff;

H) coordinate all review, evaluation and audit activities of the various departments and committees of the Medical Staff; and

I) receive, review and appropriately distribute and file all minutes and other reports of the Medical Staff and its various departments, and committees.

**ARTICLE VIII – CLINICAL DEPARTMENTS AND SUBDIVISIONS**

**Section 1 – Departments and Subdivisions**

**Part 1 – Creation and Elimination**

From time to time, circumstances may present the desirability of altering the structure of departments and subdivisions. Accordingly, upon recommendation of the Medical Executive Committee and the approval of the Board, new departments or subdivisions may be established, and existing ones may be eliminated, rearranged, combined or separated.

**Part 2 – List of Departments and Subdivisions**

The Medical Staff Shall be divided into the following departments:

A) Anesthesia to include Pain Management

B) Emergency Medicine

C) Family Practice

D) Internal Medicine to include these subdivisions:
   1) Cardiology
   2) Dermatology
   3) Gastroenterology
4) Hematology and Medical Oncology

5) Nephrology

E) Neurosciences to include Neurosurgery, Neurology, Sleep

F) Obstetrics and Gynecology

G) Pathology, Anatomical and Clinical

H) Pediatrics to include Neonatology and other non-surgical pediatric subspecialties

I) Psychiatry

J) Radiology to include Nuclear Medicine

K) Radiation Oncology

L) Surgery to include these subdivisions:
   1) Colon-rectal Surgery
   2) General Surgery
   3) Neurosurgery
   4) Ophthalmology
   5) Oral and Maxillofacial Surgery including Dentistry
   6) Orthopedic Surgery
   7) Otolaryngology and Head and Neck Surgery
   8) Plastic Surgery
   9) Podiatry
   10) Urology
   11) Vascular Surgery

Section 2 – Functions of Departments

Part 1 – Criteria and Rules and Regulations

Each department shall establish in writing its own criteria for the delineation and assignment of clinical privileges and its Rules and Regulations. These requirements shall be consistent with these Bylaws and shall become effective when approved by the Medical Executive Committee. Clinical privileges shall be based upon demonstrated education, training and experience within the field covered by the department.
Part 2 – Medical Care Evaluation

Each department shall establish a medical care evaluation process responsible for conducting a concurrent review of the quality and appropriateness of all patient care. Such review shall be ongoing, and shall contribute to the continuing education of every practitioner and to the assurance of quality patient care.

Such review shall be directed toward important aspects of patient care as defined by clinical indicators established at the department level. In conjunction with the Hospital Quality Assurance Program, each department shall collect, organize, and evaluate data, take actions to improve care where necessary, and assess the effectiveness of actions taken. This review is accomplished by monitoring and evaluating volume indicators and untoward occurrences, and by conducting focused reviews of important aspects of care.

Each department shall conduct the following: surgical case review for the indications and appropriateness of all procedures, blood usage review, drug usage evaluation, and medical record review. Each department shall also participate in the pharmacy and therapeutics function of the Medical Staff. Additionally, each department shall participate in the hospital-wide monitors of utilization review, infection control, and safety and risk management.

Section 3 – Department Chairperson

Part 1 – Qualifications

The chairperson of each department, at the time of appointment, shall be a Member of the Active Staff and shall be qualified by training, experience, and administrative ability for the position. The chairperson must be certified by an American Specialty Board, unless this requirement shall be waived by the Department and the Board of Directors upon recommendation of the Medical Executive Committee.

Part 2 – Appointment

The chairperson of each department shall be appointed by the Board of Directors for a one (1) year term and may be reappointed on an annual basis thereafter. If deemed necessary, the Board of Directors may appoint an adhoc Advisory Committee to make the recommendation.

During the process of appointing department chairpersons, the Board may also appoint a qualified member of each department to serve as assistant chairperson of the department.

Part 3 – Removal

The removal of a chairperson or subdivision chief during a term of office may be initiated by two-thirds (2/3) of the members of the department present and eligible to vote. If this action is approved by a majority of the Medical Executive Committee, it shall be referred to the Board for its consideration. The Board may remove any department chairperson or subdivision chief at any time it deems such action to be appropriate.

Part 4 – Requirement for Employed Chairperson

In the case where the chairperson of the department or service is hired by the Hospital, all of the statements in these Bylaws applicable to other chairpersons also apply to the Hospital-hired chairperson with the exception that the terms and provisions of his/her employment agreement, namely, salary, etc., shall be determined by the Board.
Part 5 - Assistant Chairperson

The assistant chairperson of each department, as appointed by the Board, shall assume such duties as may be assigned by the chairperson of the department. The assistant chairperson shall assume the position of chairperson in the event the position is vacated, for whatever reason.

Part 6 – Subdivision Chief

The department subdivisions listed in Part 2 of Section 1 of this Article having four (4) or more members are encouraged to have a subdivision chief approved by the Board of Directors annually. If so organized, the subdivision chief shall be responsible for evaluating patient care and shall report, through the department chairperson, to the Medical Executive Committee. A subdivision chief may be reappointed.

Section 4 – Function of Department Chairperson

Each chairperson shall:

A) Be responsible for all department professional and administrative activities;

B) Be a member of the Medical Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the department in order to assure quality patient care. The Chairperson shall attend a minimum of eight (8) Medical Executive Committee meetings per year.

C) Be an ex-officio member of all committees in his/her own department, giving guidance and help when needed.

D) Maintain ongoing surveillance of the professional performance of all individuals with delineated clinical privileges in the department, and report and recommend thereon to the Credentials Committee and/or the Medical Executive Committee when appropriate;

E) Oversee and facilitate peer review within the department in accordance with the Professional Practice Plan;

F) Assure that quality and appropriateness of patient care within the department are monitored and evaluated on an ongoing basis;

G) Participate as required in the quality assessment and performance improvement, risk management and utilization management programs to enhance processes and safe outcomes of care;

H) Recommend criteria for clinical privileges to the Medical Staff;

I) Transmit to the Credentials Committee recommendations concerning appointment, reappointment, and delineation of clinical privileges for all individuals in and applicants to the department. Recommendations regarding reappointment and/or clinical privileges shall be based upon results of the ongoing monitoring of the quality and appropriateness of care;

J) Be responsible for enforcement within the department of these Bylaws and the Rules and Regulations of the Medical Staff and of the department;
K) Be responsible for implementation within the department of actions taken by the Board and the Medical Executive Committee;

L) Be responsible for the establishment, implementation, and effectiveness of any teaching, education, and research program in the department;

M) Be responsible for the general administration of the department, reporting and recommending to the Hospital management when necessary concerning matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

N) Assist the Hospital management in the preparation of annual reports and budget planning pertaining to the department as may be requested by the Chief Executive Officer; and

O) Assign such duties to other members of the department as deemed appropriate.

Section 5 – Assignment to Departments

The Medical Executive Committee shall make the recommendations for department assignment of the Medical Staff Members and other approved practitioners with practice privileges based upon the advice received from the specific department(s) through the Credentials Committee.

Any Member of the Medical Staff may have privileges in the clinical services of one or more departments on a basis of training and experience. Such a Member shall be subject to all of the rules of each department or service to which the Member is assigned.

ARTICLE IX – COMMITTEES OF THE MEDICAL STAFF

Section 1 – Appointment

Part 1 – Committee Chairperson

A) The appointment of all committee chairpersons, unless otherwise provided for in these Bylaws, will be made by the President of the Medical Staff. All chairpersons shall be selected from among members of the Active Staff.

B) All material handled by Committees are considered “peer review” material, as that term is defined under applicable state and federal law.

Part 2 – Members

Members of each committee shall be appointed bi-annually by the President of the Medical Staff. Committee members are required to attend 75% of the scheduled meetings per year, unless otherwise stated.
Section 2 – Committees of the Medical Staff

The following committees are organized by the Medical Staff to carry out the functions that are solely those of the Medical Staff, including those involving "peer review," which do not require interaction at the committee level with other units of the Hospital organization. The membership on these committees is limited to those individuals who are Medical Staff Members in the appropriate categories unless otherwise specified. These committees include but are not limited to:

- Bylaws Committee
- Cancer Committee
- Credentials Committee
- Continuing Medical Education Committee
- Environment and Infection Control Committee
- Medical Executive Committee
- Library Committee
- Medical Care Evaluation Committee
- Nominating Committee
- Pharmacy and Therapeutics Committee
- Procedure Review Committee

Part 1 – Bylaws Committee

A) Composition - The Bylaws Committee shall consist of seven (7) or more members of the Medical Staff appointed by the President of the Medical Staff and representing different departments. The chairperson of the Committee shall be appointed by the President of the Medical Staff.

B) Duties - The Bylaws Committee shall:

1) Review the Bylaws of the Medical Staff at least annually and recommend amendments thereto to the Medical Executive Committee.
2) Receive and consider all recommendations for changes in these Bylaws by the Board, the Joint Conference Committee, the Medical Executive Committee, the departments, the President of the Medical Staff, the Chief Executive Officer, committees of the Medical Staff and any member of the Medical Staff.
3) Coordinate the activities associated with the review and revision of the Rules and Regulations of the Medical Staff by assisting and advising the Medical Executive Committee.

C) Meetings, Reports and Recommendations - The Bylaws Committee shall meet at least twice per year, or as often as necessary, to fulfill its duties. It shall maintain a permanent record of its activities, and it shall report its recommendations to the Medical Executive Committee.

Part 2 – Credentials Committee

A) Composition - The Credentials Committee shall consist of the two (2) most recent Past Presidents of the Medical Staff who are still Members of the Active Staff, the President Elect of the Medical Staff, three (3) additional Members appointed by the President of the Medical Staff, and seven (7) Members of the Active Staff not serving on the Medical Executive Committee. The most recent Past President shall be the chairperson of the committee. As applicable, the Department chairpersons shall be consulted on the credentials of applicants.
B) **Duties** - The duties of the Credentials Committee shall be:

1) To review the credentials of all applicants, to make such investigations of and interview applicants as may be necessary and to make recommendations for appointment and delineation of clinical privileges in compliance with these Bylaws;

2) To make a report to the Medical Executive Committee on each applicant for Medical Staff appointment and clinical privileges, including specific considerations of the recommendations from the departments in which such applicant requests privileges;

3) To review, as questions arise, all information available regarding the ethics and professional and clinical competence of persons who are currently Members of the Medical Staff, their care and treatment of patients and case management, and to make recommendations to the Medical Executive Committee for the granting, reduction or withdrawal of promotions, privileges, reappointments and changes in the assignment of Members to the various departments;

4) To review reports on specific Members of the Medical Staff that are referred by the Medical Executive Committee and by the President of the Medical Staff, matters that concern the clinical privileges of Medical Staff Members and to make such recommendations as provided by these Bylaws;

5) To review reports on specific Members of the Medical Staff that are referred to the Credentials Committee, regarding matters that are related to suspected disruptive behavior or conduct. If the Credentials Committee believes corrective action may be warranted, such recommendation shall be made to the Medical Executive Committee as provided by these Bylaws;

6) To review reports on specific Members of the Medical Staff that are referred to the Credentials Committee, regarding Medical Staff Members who may be experiencing physical, mental or emotional instability and/or may be suffering from dependence of alcohol or drugs, and to provide peer counseling and support in directing such Members to appropriate medical treatment. If the Committee believes formal action may be warranted, such recommendation shall be made to the Medical Executive Committee as provided by these Bylaws; and

7) To review all applicants to the Allied Health Practitioner category as detailed in Article VI of these Bylaws.

C) **Meeting, Reports and Recommendations** - The Credentials Committee shall meet as often as necessary to accomplish its duties but at least six (6) times a year, and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the Medical Executive Committee.

D) **General Considerations**:

1) **Conflict of Interest** - In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or a member of the staff which comes before the Credentials Committee, that member of the Credentials Committee shall not participate in the discussion or voting on the matter and shall absent himself/herself from the meeting during that
time, although the member may be asked to answer any questions concerning the matter before leaving.

2) All members of the Credentials Committee shall faithfully comply with the stipulations of Article X of these Bylaws concerning the confidentiality of credentialing materials and discussions.

**Part 3 – Continuing Medical Education Committee**

A) **Composition** - The Continuing Medical Education Committee shall consist of at least three (3) Active Members of the Medical Staff, one of which will be a representative from the Family Practice Department. Representatives from the departments of Nursing (education), Library, Quality Improvement and Risk Management shall be invited to meetings, as necessary.

B) **Duties** - The Continuing Medical Education Committee shall be responsible for:

1) Coordinating educational programs among departments;

2) Developing and planning programs of continuing medical education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to evaluation findings;

3) Reviewing all program applications to be approved for Category I credit;

4) Annually reviewing CME mission statement based on the past year’s activities;

5) Conducting annual needs assessment for the program;

6) Reviewing evaluations after conferences have been held for overall needs assessment and sending summaries to Program Directors;

7) Preparing quarterly/annual reports to the Medical Staff and Board regarding CME activities; and

8) Planning the ongoing CME activities yearly.

9) Make recommendations on the operation of the Hospital’s library service and recommend purchase or deletion of periodicals, books, textbooks and other educational materials, such as audiovisual aids.

C) **Meetings, Reports and Recommendations** - The Continuing Medical Education Committee shall meet as often as necessary to accomplish its duties but at least three (3) times a year. It shall maintain a permanent record of its proceedings and actions and it shall report its recommendations to the Medical Executive Committee.

**Part 4 – Environment and Infection Control Committee**

A) **Composition** - The Environment and Infection Control Committee shall be composed of at least two Members from the Active Staff, and a microbiologist, an infection surveillance officer, a representative from the Hospital’s administration, a liaison member of a local or state health department, ad hoc members to represent Central Services, Plant Operations, Environmental Services, Dietary and Pharmacy, and an employee health nurse.
B) **Duties** - The duties of the Environment and Infection Control Committee shall be to supervise infection control in all phases of Hospital activity and to be responsible for the surveillance, review and analysis of Hospital infections. It shall have the authority to initiate written policies and procedures for the promotion of a preventive and corrective program to minimize infection hazards, to initiate cultures where evidence of infection hazards exists, to institute any appropriate control measures or studies when it is believed that a danger to any patient or personnel exists, and to notify physicians of the need for cultures.

C) **Meetings, Reports and Recommendations** - The Environment and Infection Control Committee shall meet monthly or as often as necessary to accomplish its duties. It shall maintain a permanent record of its proceedings and actions and it shall report its recommendations to the Medical Executive Committee.

**Part 5 – Medical Executive Committee**

A) **Composition:**

1) The Medical Executive Committee shall consist of the officers of the Medical Staff, including the immediate Past President, the chairperson of each department, six (6) members elected at-large from the Medical Staff, a hospitalist member of the Medical Staff and the Director of the Family Practice Residency. The Chief Executive Officer and the Vice-President for Medical Affairs shall be ex-officio members of the Medical Executive Committee without vote.

2) The six (6) Medical Executive Committee members at-large shall be elected at the appropriate Medical Staff meeting. Of the nominees who shall be presented by the Nominating Committee and any others nominated from the floor, the six (6) receiving the largest number of votes shall be elected.

3) The hospitalist member may be represented at each committee meeting by any one of the current hospitalist Medical Staff Members.

4) The President of the Medical Staff shall be the chairperson of the Medical Executive Committee.

5) The Director of the Nursing Service and members of the Board, or anyone invited by the President, may attend meetings of the Medical Executive Committee and participate in the discussions, but without vote.

B) **Duties** – The duties of the Medical Executive Committee shall be:

1) To represent and to act on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;

2) To coordinate the activities and general policies of the various departments;

3) To receive, review, evaluate and act upon reports and recommendations of the Medical Staff's quality review committees relevant to the performance of any individual Member(s) of the Medical Staff;
4) To implement policies of the Medical Staff which are not the responsibility of the departments;

5) To provide liaison within the Medical Staff and to the Chief Executive Officer and the Board on behalf of the Medical Staff;

6) To recommend action to the Chief Executive Officer on matters of a medico-administrative and Hospital management nature;

7) To ensure that the Medical Staff is kept abreast of The Joint Commission program and informed of the accreditation status of the Hospital;

8) To receive and evaluate the recommendations of the Credentials Committee concerning applications and reapplications for membership on the Medical Staff and to make recommendations to the Board on all actions relating to Medical Staff appointments, reappointments, staff category, department assignments and clinical privileges;

9) To take all reasonable steps to ensure proper professional and ethical conduct and the enforcement of applicable Hospital Rules and of these Bylaws and the Medical Staff Rules and Regulations in the best interests of patient care and of the Hospital on the part of all Members of the Medical Staff and to make recommendations to the Board on actions described in Article XII;

10) To consider situations involving questions of the clinical competence, patient care and treatment or case management of any individual Member of the Medical Staff for appropriate action;

11) To be responsible to the Board for the general quality of medical care rendered to patients in the Hospital;

12) To determine minimum continuing education requirements for Members of the Medical Staff;

13) To assist in the implementation of quality improvement by identifying and removing barriers to progress;

14) To monitor the activities of the quality improvement process;

15) To assist the Hospital in developing Medical Staff Member understanding of the quality improvement process and techniques; and

16) To support ongoing efforts to develop quality improvement in policy and planning activities.

C) Meetings, Reports and Recommendations – The Medical Executive Committee shall meet once a month, but not less than ten (10) times per year or more often if necessary to transact pending business. The Secretary shall maintain reports of all meetings, which reports shall include the minutes of the various committees and departments of the Medical Staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Chief Executive Officer routinely as prepared, and a monthly report of actions of the Medical Executive Committee shall be communicated to all departments. Recommendations of the Medical Executive Committee shall be transmitted to the Board by the President of the Medical Staff as the committee deems appropriate or as otherwise required by these Bylaws.
D) **Conflict of Interest** - In any instance in which a member of the Medical Executive Committee has a conflict of interest in any matter involving another Member of the Staff which comes before the Medical Executive Committee, or in any instance where a member of the Medical Executive Committee brought the complaint against that member, that Medical Executive Committee member shall not participate in the discussion or voting on the matter and shall absent himself/herself from the meeting during that time, although the member may be asked and may answer any questions concerning the matter before leaving.

E) **Attendance Requirements** - All Medical Staff Members of the Medical Executive Committee shall attend a minimum of 8 Medical Executive Committee meetings per year.

F) **Quorum** - The presence of fifty-one percent (51%) of the total membership of the Medical Executive Committee members eligible to vote at any meeting is required in order for the meeting to proceed. For any action to move forward, it must receive one-half (1/2) of the votes cast by the voting members who are present at the time of such vote and who do vote.

**Part 6 – Nominating Committee**

A) **Composition** - The Nominating Committee shall be composed of the three (3) most recent Past Presidents and two (2) Members of the Medical Staff appointed by the President. The chairperson of the Committee shall be the most recent Past President.

B) **Duties** - The Nominating Committee shall present at the appropriate annual meeting one (1) or more nominees for each of the offices of President-Elect, Secretary, Treasurer and a slate of six (6) nominees for the at-large membership of the Medical Executive Committee. The committee shall also adopt procedures, not inconsistent with these Bylaws, to govern Medical Staff elections.

C) **Meetings, Reports and Recommendations** - The Nominating Committee shall meet as often as necessary to accomplish its purpose, but at least every two (2) years.

**Part 7 – Pharmacy and Therapeutics Committee**

A) **Composition** - The Pharmacy and Therapeutics Committee shall consist of at least four (4) representatives of the Medical Staff, one (1) from the nursing service and one (1) from the Hospital management, the Director of Pharmacy, the clinical microbiologist, and other members of the Hospital staff which are deemed necessary by the chairperson or the Committee. The Director of Pharmacy shall be a physician designated by the President of the Medical Staff.

B) **Duties** - The duties of the Pharmacy and Therapeutics Committee shall be to examine and survey all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist the Director of Pharmacy in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

1) Serve as an advisor group to the Medical Staff and the pharmacist on matters pertaining to the choice of available drugs;
2) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

3) Develop and review periodically a formulary for use in the Hospital;

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

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

6) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs, in concert with the Institutional Review Committee;

7) Review all cases of suspected untoward drug reactions;

8) Review all drug usage in the Hospital; and

9) Make recommendations concerning drugs for which automatic stop orders are necessary.

C) Meetings, Reports and Recommendations - The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a quarterly report thereof to the Medical Executive Committee.

Part 8 – Medical Care Evaluation Committee

A) Composition - The Medical Care Evaluation Committee shall be composed of five (5) or more Members of the Medical Staff, one (1) of whom shall be the President-Elect of the Medical Staff who shall be its Chairperson; at least two (2) of the members shall have served as Members of the Active Staff for at least ten (10) years each. The Vice-President for Medical Affairs shall be an ex-officio member.

B) Duties - The duties of the Medical Care Evaluation Committee shall be to:

1) Receive, review, evaluate and act upon reports and recommendations of Medical Staff Departments and quality improvement committees relevant to the performance of any individual Member of the Medical Staff;

2) Make recommendations relevant to the performance of an individual Member of the Medical Staff, whenever appropriate, to the Medical Executive Committee;

3) Receive, review, evaluate and correlate the minutes and reports of the Departments of the Medical Staff to the extent that such department minutes and reports are concerned with peer review, or audit activities or any other quality issues deemed necessary by the Medical Care Evaluation Committee;

4) Receive, review, evaluate and correlate the minutes and reports of surveys, reviews, ad hoc committees, standing committees, or any other source generating information considered important to the purpose of the Medical Care Evaluation Committee as decided by that Committee; and
5) Submit a written report of its evaluation and recommendations to the Medical Executive Committee as necessary.

C) Meetings, Reports and Recommendations - The Medical Care Evaluation Committee shall meet as needed to fulfill its duties. It shall keep a permanent record of its activities. A written report of its evaluation and recommendations shall be submitted as required to the Medical Executive Committee.

**Part 9 – Procedure Review Committee**

A) Composition - The Procedure Review Committee shall be composed of a collaboration of representatives from each major department that encounters procedures placing a patient at risk. In addition to special members selected by the department and standing committee, Procedure Review Committee membership consists of a committee chairperson, Vice President for Medical Affairs, and representatives of the Medical Staff from the Departments of Internal Medicine, Surgery and Anesthesia. Other specialists will be invited as needed.

B) Duties - The Procedure Review Committee shall review requests for procedures which are new to the facility and/or new procedural technology. The Procedure Review Committee shall recommend to the Credentials Committee whether the procedure should be performed at the hospital and if so, the appropriate privileging criteria, including involved specialty(ies), education and training for practitioners who wish to perform the procedure.

C) Meetings, Reports and Recommendations - The Procedure Review Committee shall meet at the discretion of the Chairperson, shall maintain a permanent record of its findings, proceedings and actions and shall make a report thereof to the Medical Executive Committee and relevant individual department reports.

**Part 10 – Cancer Committee**

The Cancer Committee is a standing committee of the medical staff. The committee has the authority and responsibility for planning, initiating, implementing, evaluating and improving all cancer-related activities in the hospital.

A) Composition - The Cancer Committee shall consist of at least the following Members of the Medical Staff: a radiation oncologist, medical oncologist, surgeon, pathologist, radiologist, pain management physician, cancer liaison physician, and any additional members appointed by the President of the Medical Staff, who shall also designate its chairperson. Non-Medical Staff members should include representatives from Administration, Social Service, Nursing, Cancer Registry, and Quality Improvement.

B) Duties - The Cancer Committee shall:

1) Periodically review the spectrum of care for cancer patients admitted to the Hospital, including diagnosis, treatment, rehabilitation, follow-up and end-result reporting;

2) Advise the Chief Executive Officer on matters concerning personnel, facilities, equipment and space, relating to the Hospital's cancer program;

3) Oversee the professional aspects of the operation of the Cancer Registry.
4) Develop and evaluate the annual goals and objectives for the clinical, quality improvement and community outreach activities related to cancer; 

5) Promote a coordinated, multidisciplinary approach to patient management; 

6) Ensure that educational and consultative cancer conferences cover all major sites and related issues; 

7) Ensure that an active, supportive care system is in place for patients, families, and staff; 

8) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes; 

9) Promote clinical research; 

10) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting; 

11) Perform quality control of registry data; 

12) Encourage data usage and regular reporting; 

13) Ensure content of the annual report meets requirements; 

14) Publish the annual report by November 1 of the following year; 

15) Uphold medical ethical standards; and 

16) Analyze patient outcomes and disseminate the results of the analysis to the Medical Staff and Administration annually. This report must include the following:
   
   a) Diagnostic Evaluation 
   b) Treatment modalities 
   c) Prognostic factors 
   d) Survival data by American Joint Committee on Cancer Manual for Staging of Cancer (AJCC) 
   e) Comparison with NCDB Benchmarks and other comparative data 

C) Meetings, Reports and Recommendations - The Cancer Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee.
The Medical Staff shall participate in the maintenance and improvement of professional standards throughout the Hospital by maintaining representation on all multi-disciplinary committees which relate to the quality of care rendered to patients. The Members of the Medical Staff shall be assigned to these committees on a bi-annual basis by the President of the Medical Staff. Minutes of all meetings of multi-disciplinary committees shall be submitted to the Medical Executive Committee. These committees are committees of the Medical Staff. These committees include but are not limited to:

- Accreditation Committee
- Critical Care Committee
- Disaster Committee
- Graduate Medical Education Committee
- Joint Conference Committee
- Operating Room Committee
- Radiation Safety Committee
- Utilization Documentation Management Committee

The composition and duties of the following committees are specified since they are not described in these Bylaws and may not be described in any Hospital documents.

**Part 11 – Graduate Medical Education Committee**

A) **Composition** - The Graduate Medical Education Committee shall be comprised of directors of each residency program, the administrator responsible for the residencies, Medical Staff representatives from specialties which have an interest in the residency programs, and members of ancillary departments, as necessary. The chairperson of the committee shall be appointed by the President of the Medical Staff.

B) **Duties** - The Graduate Medical Education Committee shall:

1) Supervise all graduate medical education programs;
2) Aid program directors in formulating a plan of education for all residents;
3) Assist in matters of discipline and governance of the residents; and
4) Aid program directors in the recruitment, selection and appointment of residents.

**Part 12 – Joint Conference Committee**

A) **Composition** – The Joint Conference Committee shall consist of three (3) Members appointed by the President of the Medical Staff and three (3) representatives appointed by the Board and the Chief Executive Officer.

B) **Duties** – The Joint Conference Committee shall be a forum for discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care. The Joint conference Committee shall:

1) Provide medico-administrative liaison with the Board and the Chief Executive Officer;
2) Review and consider issues that may arise in the planning and operation of the Hospital that affect the relationship between the Board, its administration and the Medical Staff;
3) Advise the Board and the Medical Executive Committee relative to proposed changes in the Board’s Bylaws and these Bylaws and the Medical Staff Rules and Regulations; and

4) Resolve any conflict that may arise between the Medical Executive Committee and the Medical Staff.

C) Meeting – The Joint Conference Committee shall meet at the request of either the Chairperson of the Board, the President of the Medical Staff or the Chief Executive Officer.

Part 13 – Radiation Safety Committee

The Medical Staff shall participate in the Hospital's radiation safety activities and shall designate Medical Staff Members to serve on the Hospital's Radiation Safety Committee as necessary and appropriate to meet Joint Commission, the State and federal regulatory requirements.

Part 14 – Utilization Documentation Management Committee

A) Composition – Medical Staff Members will be requested by the Hospital to participate in the Hospital's medical record review and utilization review activities as such activities relate to professional evaluation functions necessary and appropriate to patient care appraisal, to maximize proper use of facilities and services, and to meet Joint Commission, State and federal regulatory requirements.

B) Duties - The Utilization Documentation Management Committee shall supervise the maintenance of medical records at the required standard of completeness. It shall recommend for discipline any Member of the Medical Staff whose medical records practices fail to comply with necessary record keeping requirements. And it shall participate in the development and approval of the Hospital’s Utilization Management Plan.

C) Meeting – The Utilization Documentation Management Committee shall meet at least quarterly. A written report of its evaluation and recommendations shall be submitted as required to the Medical Executive Committee.

Section 3 – Creation of Standing Committees

The Medical Executive Committee may, by resolution, without amendment of these Bylaws, establish a Medical Staff committee to perform one or more staff functions. In the same manner the Medical Executive Committee may by resolution dissolve or rearrange an established Medical Staff committee's structure, duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

Section 4 – Special Committees

Special committees may be created and their members and chairpersons shall be appointed by the President of the Medical Staff as required. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.
ARTICLE X – APPOINTMENT TO THE MEDICAL STAFF

Section 1 – Requirements for Appointment

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

The requirements for appointment are set forth in Sections 1, 2, 3 and 4 of Article V of these Bylaws.

All persons practicing medicine, dentistry and podiatry in Sacred Heart Hospital, unless specifically exempted by these Bylaws, must first have been granted membership on the Medical Staff.

Section 2 – Application for Initial Appointment and Clinical Privileges

Part 1 - Application Form

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms prescribed by the Board after consultation with the Medical Executive Committee. These forms shall be obtained from the Chief Executive Officer or the Chief Executive Officer’s designee. The application shall require detailed information concerning the applicant’s professional qualifications including:

A) The names of at least two practitioners, as appropriate, who have had recent, extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant’s present professional competence and ethical character. Written reference should be made to the applicant’s medical/clinical knowledge, technical/clinical skills, clinical judgment, patient care, communication skills, interpersonal skills and systems-based practice. Letters of reference should only be received from peers who do not have a current or planned business relationship with the applicant.

B) A listing of all hospitals where the applicant has held appointment and or privileges and information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been denied, revoked, restricted, suspended, reduced, not renewed or voluntarily withdrawn to avoid an investigation or disciplinary action at any other hospital or health care facility;

C) Information as to whether membership in local, state, or national medical societies or the applicant’s license to practice any profession in any state, or the applicant’s federal license to prescribe and administer controlled substances has ever been voluntarily relinquished, suspended, modified, terminated or denied. The submitted application shall include a copy of all of the applicant’s current licenses to practice, as well a current D.E.A. license, if issued, along with a description of any restrictions or pending investigations related to licenses or memberships held, and a statement as to whether any license has been voluntarily relinquished.

D) Information relative to board certification status with appropriate national specialty board;

E) Any information contained in the National Practitioner Data Bank regarding the applicant;

F) Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;

G) Information concerning the applicant’s malpractice experience;

H) A consent to release of information from present and past malpractice insurance carriers;
I) A request for the specific clinical privileges desired by the applicant;

J) Information on the applicant’s physical or mental health;

K) Information as to whether the applicant has ever been convicted of a felony;

L) Information from managed care organizations including but not limited to the background and competence of the applicant;

M) Information from hospitals at which the applicant had clinical privileges including but not limited to the background and competence of the applicant; and

N) Such other information as the Board, Medical Executive Committee or the Credentials Committee may require.

Part 2 – Terms of Application

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

A) The applicant’s specific acknowledgment of the obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the applicant has responsibility;

B) A statement that the applicant has received and read a copy of these Bylaws and of such Rules and Regulations of the Medical Staff that are in force at the time of the applicant’s application and has agreed to be bound by the terms thereof in all matters relating to consideration of the application whether or not the applicant is granted appointment to the Medical Staff;

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

D) A statement of a willingness to appear for personal interviews in regard to the application;

E) A statement that the applicant will abide by generally recognized ethical principles applicable to the profession; and

F) A statement whereby the applicant agrees that when an adverse ruling is made concerning appointment to the Medical Staff, staff status or clinical privileges, the applicant will exhaust the administrative remedies offered by these Bylaws before taking legal action.

G) A statement whereby the applicant represents that the information provided in or attached to the application is complete and accurate with the understanding that any misrepresentation, misstatement, or omission from the application, whether intentional or not- is discovered, the application will not be processed. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the hospital may immediately terminate the applicant’s appointment and privileges.
Part 3 – Release and Immunity from Liability

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

A) To the fullest extent permitted by law, the applicant or Member extends absolute immunity and release from liability to the Medical Staff, Hospital Administration, the Board and their designated representatives from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures involving the applicant or Member performed, made or received in good faith and without malice, by the Medical Staff, Hospital Administration, the Board and their designated representatives, or from any third party concerning activities relating to but not limited to:

5) Applications for appointment or clinical privileges, including temporary privileges;
6) Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
7) Proceedings affecting clinical privileges or staff membership;
8) Summary suspension;
9) Hearings and appellate reviews;
10) Medical care evaluation/quality assurance;
11) Utilization reviews;
12) Other Hospital, department, service or committee activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a physician, dentist or podiatrist; and concerning matters or inquiries relating to an applicant’s or Member’s professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on the individual’s competence or the individual’s quality of patient care, or the orderly operation of this or any other hospital or health care facility, including otherwise privileged or confidential information.

B) Any act, communication, report, recommendation, or disclosure, with respect to any such applicant or Member performed or made in good faith and without malice and at the request of a designated representative of the Medical Staff, Hospital Administration or the Board or any other hospital or health care facility, for the purposes set forth in A. above, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to Members of the Medical Staff, Hospital Administration, the Board and their designated representatives and to any third parties who supply information to any of the foregoing authorized to receive, release or act upon same.

C) The Medical Staff, the Board and their designated representatives are specifically authorized to consult with the management and Members of the medical staffs of other hospitals, health care facilities or institutions with which the applicant or Member has been associated, and with others who may have information bearing on his/her competence, character and ethical qualifications.
D) The Medical Staff, Hospital Administration, the Board and their designated representatives are specifically authorized to inspect all records and documents that may be material to an evaluation of either the applicant’s or Member’s professional qualifications or competence to perform the clinical privileges requested or currently possesses, as well as moral and ethical qualifications or stability as they may directly or indirectly affect the individual’s competence, patient care or the good operation of this Hospital or any other health care facility.

E) The applicant or Member specifically releases from any liability, the Medical Staff, Hospital Administration, the Board and their designated representatives for statements made or acts performed in good faith and without malice in evaluating the applicant for any of the purposes or reasons set forth in this Part.

F) As used in this Part the terms "Medical Staff," the "Board" and their "designated representatives" mean the Medical Staff, any of its Members having any direct or indirect responsibility for obtaining, evaluating or acting upon applicant's or Member's credentials and all other information that may be pertinent to qualification for membership and the Hospital, the Board, its members and its appointed representatives, the Chief Executive Officer and the Chief Executive Officer’s subordinates and any lawyer or other outside consultant and their associates who may be retained by the Board or the Medical Staff.

G) As used in this Part, the term "third party" means all individuals or government agencies, organizations, associations, partnerships, corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Medical Staff, Hospital Administration, the Board or their designated representatives.

Part 4 – Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. The absence of requested information shall constitute an incomplete application which shall not be processed until such time as the applicant fulfills the responsibility to provide the requested information or cause it to be provided. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. If the application is not completed within ninety (90) days of receipt, the application will be considered withdrawn unless a written request for extension is approved. The applicant may request and submit a new application at any time thereafter along with the submission of the current application fee.

Section 3 – Description of Initial Clinical Privileges

Part 1 – Delineation of Clinical Privileges

A) Each Member appointed to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal of the applicant's qualifications by the chairperson of the department in which such privileges are sought. Recommendations of the clinical department in which privileges are sought shall be forwarded to the
Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

B) Dental privileges may be granted to qualified dentists to perform procedures in the out-patient dental unit only. Such dentists shall be credentialed as in paragraph A, immediately above, and shall be Members of the Consulting Staff as in Article V, Section 6, Part 3 of these Bylaws. Such dentists shall be Members of the Dental Teaching Staff at Sacred Heart Hospital.

**Part 2 – Dental Privileges**

A) The scope and extent of surgical procedures that a dentist who is a Member of the Medical Staff may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a Member of the Medical Staff before dental surgery shall be performed, and that physician shall be responsible for the medical care of the patient throughout the period of hospitalization. Dentists shall be responsible for the dental care of the patient, including the dental history and the dental physical examination, as well as other appropriate elements of the patient's record. The dentist may write orders within the scope of the dentists’ license and consistent with these Bylaws and the Medical Staff Rules and Regulations.

B) Those oral surgeons who have been appropriately trained by physicians in their post-graduate specialty programs and maintain current competence, may be credentialed to perform and record the required history and physical examinations for their patients. Such oral surgeons may also assess the fitness of such a patient for surgery provided that the history, physical examination or other evaluative procedure does not reveal the possibility of a medical abnormality that might adversely affect the patient's health. In each case where a substantial medical disorder is suspected, the oral surgeon is required to consult with a physician who is a Member of the Medical Staff. A physician so consulted shall evaluate the patient's medical status, assess the fitness for oral surgery, and to the extent appropriate, be responsible for concurrent medical care. The Rules and Regulations of the Medical Staff may establish further stipulations appropriate to the provisions of this paragraph.

**Part 3 – Podiatry Privileges**

A) The scope and extent of surgical procedures that a podiatrist who is a Member of the Medical Staff may perform in this Hospital shall be delineated and recommended to the Board in the same manner as clinical privileges for physicians and dentists. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a Member of the Medical Staff before podiatric surgery shall be performed. The podiatrist may write orders within the scope of the podiatrist’s license and consistent with these Bylaws and the Medical Staff Rules and Regulations.
Section 4 – Procedure for Initial Appointment

Part 1 – Processing of Application

A) The completed application for appointment to the Medical Staff shall be submitted by the applicant to the Chief Executive Officer. After collecting references and other materials deemed pertinent, the Chief Executive Officer shall transmit the application and all supporting materials to the office of the Medical Staff Secretary who shall secure this material in the designated locked file cabinet and notify the Chairperson of the Credentials Committee of the receipt of the material.

B) Upon receipt of the completed application for appointment to the Medical Staff the Credentials Committee shall:

1) Inform the chairperson of each department in which the applicant seeks clinical privileges of the pending application for the review of the application in the office of the Medical Staff Secretary and making recommendations to the Credentials Committee;

2) Announce the name at the next meeting of each department so that each Member of the Medical Staff may have an opportunity to submit to the committee, in writing, information bearing on the applicant's qualifications for appointment. In addition, any Member of the Medical Staff shall have the opportunity to appear in person before the Credentials Committee to discuss in private and in confidence any concerns about the applicant.

C) The Medical Staff Office shall, in timely fashion, seek to collect and verify by primary source the references, licensure, and evidence of other qualifications and competency submitted. The National Practitioner Data Bank will also be queried. The Medical Staff Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information.

D) The chairperson of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the Credentials Committee's report. As part of the process of making this recommendation, the department chairperson, and where pertinent, the subdivision Chief, may meet with the applicant to discuss any aspect of the application, qualifications and the requested clinical privileges.

E) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant, status of physical and mental health, and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, including an appraisal from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the Medical Staff and the clinical privileges requested.

F) As part of this process, the Credentials Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for consideration in a manner consistent and in accordance with applicable law with respect to confidentiality. For Medical Staff Members who are 70 years of age and older at the time of initial application, and annually thereafter, completion of a Medical Staff Health Evaluation Form by another physician is required.
G) As part of the process of making its recommendation, the Credentials Committee shall have the right to require the applicant to meet with the Committee to discuss any aspect of this application, qualifications and the requested clinical privileges. The applicant has no right to an interview before the Credentials Committee.

**Part 2 – Credentials Committee Reports**

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

A) Not later than ninety (90) days from receipt of the completed application from the Chief Executive Officer, the Credentials Committee shall make a written report and recommendation on the applicant to the Medical Executive Committee.

B) If the recommendation of the Credentials Committee is delayed longer than ninety (90) days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer, and a copy to the Medical Executive Committee explaining the delay. In such case, the Credentials Committee shall act within thirty (30) days with a report recommending appointment or rejection of the applicant to the Medical Staff.

C) The Credentials Committee shall transmit to the Medical Executive Committee the complete application and its recommendation that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that it be rejected. The chairperson or designee of the Credentials Committee shall be available to the Medical Executive Committee and to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

**Part 3 – Action on the Application**

A) **Favorable recommendation** - When the recommendation of the Medical Executive Committee is favorable to the applicant, the Medical Executive Committee shall promptly forward its recommendation to the next monthly meeting of the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. The Board shall vote to accept or reject the recommendations of the Medical Executive Committee.

B) **Defer action** - When the recommendation of the Medical Executive Committee is to defer the application for further consideration it must be followed up within thirty (30) days by a subsequent recommendation to the Board through the President of the Medical Staff for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application and denial of appointment.

C) **Adverse recommendation** - When the recommendation of the Medical Executive Committee is adverse to the applicant or when the Board rejects the applicant, the applicant shall be entitled to such hearing pursuant to the Hearing and Appeal Procedures set forth in Article XIII.
Section 5 – Procedure for Temporary Clinical Privileges

Part 1 – Temporary Privileges for Applicants

A) The Chief Executive Officer may grant Temporary Privileges to a physician, dentist or podiatrist holding an unrestricted license to practice in Pennsylvania in the following circumstances:

1) To fulfill an important patient care, treatment and service need; or

2) When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board.

B) Temporary Privileges may be awarded to an appropriately licensed physician, dentist or podiatrist who has applied for appointment to the Staff only if the chief Executive Officer has received the following:

1) Proof of unrestricted licensure as a physician, dentist, or podiatrist issued by the Commonwealth of Pennsylvania;

2) A completed application for Appointment to the Staff, all supporting documents, including references, verification of an active practice location located close enough to the Hospital to provide continuous care to their patients; and

3) Approval of the Temporary Privileges by the responsible Clinical Department Chairperson or designee, the Medical Staff President or designee and the Chief Executive Officer or designee.

C) Temporary Privileges granted under this Section will be for a two-month period and may be renewed for only one additional two-month period by the Chief Executive Officer or designee if that person has received approval for such renewal by the responsible Clinical Department Chairperson.

D) If Temporary Privileges are granted pursuant to this Section, the Chief Executive Officer will give the applicant written notice of such action and the period for which the Temporary Privileges are granted. Such notice will also inform the applicant that the exercise of such Temporary Privileges will be subject to immediate revocation without cause, and will be under the close supervision of the responsible Clinical Department Chairperson.

E) Privileges granted under this Section of the Bylaws may be terminated at any time at the direction of the Chief Executive Officer upon the recommendation of the President of the Medical Staff and/or the relevant Department Chairperson. Such termination shall not be subject to review under the Fair Hearing and Appeal Procedures.

Part 2 – Temporary Privileges for Non-Applicants

Temporary admitting and clinical privileges for care of a specific patient or patients may be granted by the Chief Executive Officer or designee with the concurrence of either the chairperson of the department concerned or, in the chairperson’s absence, the President of the Medical Staff, to a physician, dentist or podiatrist who is not an applicant for appointment, provided that the Chief Executive Officer is satisfied that the individual meets the qualifications for membership and is capable of carrying out the basic responsibilities of membership. Such privileges shall be restricted to the specific patients during a specific admission for which they are granted.
Part 3 – Special Requirements

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

Part 4 – Locum Tenens

The Chief Executive Officer may grant an individual serving as a locum tenens for a Member of the Medical Staff temporary admitting and clinical privileges to attend patients of that member or department. This shall be done in the same manner and upon the same conditions as set forth in Part 1 of this Section, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment that the individual has received and read copies of the policies of the Hospital, these Bylaws and the rules and regulations of the Medical Staff then in force and that the individual agrees to be bound by the terms thereof in all matters relating to the temporary clinical privileges.

Part 5 – Termination of Temporary Clinical Privileges

A) Termination – The Chief Executive Officer or, in his or her absence, the designee, may at any time terminate an individual’s temporary admitting privileges for failure to comply with any special conditions imposed, or for a breach of Hospital policies, these Bylaws or Medical Staff rules and regulations. Clinical privileges shall then be terminated when the individual’s inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed and such termination shall be immediately effective.

B) Reassignment of patients - The appropriate Department Chairperson or, in his/her absence, the President of the Medical Staff, shall assign to a Member of the Medical Staff responsibility for the care of such terminated individual's patients until such patients are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

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

D) Immediate termination of temporary privileges- Temporary privileges shall be terminated immediately if the Medical Executive Committee recommends unfavorably in respect to the applicant’s appointment to the Medical Staff or if the Medical Executive Committee’s recommendation shall be to modify the recommendation of the Credentials Committee so that the applicant be granted permanent privileges which differ from the temporary privileges previously granted.
Section 6 – Emergency Clinical Privileges

Part 1 – Emergency Privileges for Nonmembers

In an emergency involving a particular patient, a physician, dentist or podiatrist who is not currently a Member of the Medical Staff is permitted by the Hospital to exercise clinical privileges to act in such emergency, within the scope of the individual’s license, using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.

Part 2 – Emergency Privileges for Members

In an emergency situation, the Member shall do all in his or her power to serve the best interests of the patient, regardless of the limitations imposed by these Bylaws, the Rules and Regulations and the Hospital’s policies, but within the scope of the Member’s license.

Part 3 – Termination of Emergency Privileges

When the emergency situation no longer exists, such physician, dentist or podiatrist must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or the individual does not request such privileges, the patient shall be assigned to an appropriate person who is currently a Member of the Medical Staff by the appropriate department chairperson or the President of the Medical Staff, giving consideration wherever possible to the wishes of the patient.

Part 4 – Definition of “Emergency”

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

Part 5 – Disaster Preparedness Credentialing

In the event of a disaster in the Sacred Heart service area or within the hospital itself, the President & Chief Executive Officer (or designee) or the Medical Staff President (or designee) has the option to grant disaster preparedness privileges on a case by case basis.

In order to grant disaster preparedness privileges, the following criteria must be met:

1) Physician, dentist or podiatrist must have a current picture hospital identification from the hospital (in Pennsylvania) in which he or she practices.

2) Physician, dentist or podiatrist must produce a current license to practice in Pennsylvania and valid picture identification issued by a state, federal or regulatory agency.

OR

3) Presentation by current hospital or Medical Staff Member(s) with personal knowledge regarding physician, dentist or podiatrist’s identity (individual must be licensed in Pennsylvania).
Disaster Preparedness privileges can also be granted to the following:

1) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

2) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state or municipal entity.

Individuals granted disaster preparedness privileges will be given appropriate identification with a unique identification number which must be recorded on all orders and notes written by the individual. This process will be done in accordance with the Medical Staff Disaster/Incident Command System Plan.

Verification – Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer physician, dentist or podiatrist presents to the organization. At that time, the organization makes a decision (based on information obtained regarding the professional practice of the volunteer) related to the continuation of the disaster privileges initially granted. All individuals granted disaster privileges will be reviewed by the Credentials Committee at its next meeting.

Follow-up – a record will be maintained of all patients cared for by individuals granted disaster preparedness privileges. Appropriate department quality review will be conducted on all cases.

The patient care, treatment and services provided by volunteer physicians, dentists and podiatrists will be monitored and overseen by the Department Chairperson in which services are provided.

Disaster privileges shall automatically terminate once the disaster no longer exists or when the volunteer’s services are no longer needed. Disaster privileges may be revoked at any time. The termination of disaster privileges shall be final. There is no right to a hearing or an appeal upon the denial, reduction or termination of disaster privileges.

Section 7 – Telemedicine Privileges

The Board of Directors will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department and the Medical Executive Committee. Medical Staff appointment and/or privileges may be addressed through one of the following processes:

A) Medical Staff appointment and privileges may be granted to the physicians in the same manner as for any other applicant in accordance with Article X of these Bylaws; or

B) Privileges may be granted by Sacred Heart Hospital, the originating site, by using the credentialing and privileging decision from the distant site which has been contracted to provide such services for Sacred Heart Hospital. The physician must be a credentialed member at the distant site, which must be a Joint Commission accredited facility. In addition, the Medical Staff Office will query the following regarding the physician: the National Practitioner Data Bank, Pennsylvania state license, and the Office of the Inspector General. Physicians approved for privileges under this process are not approved for Medical Staff Membership and are not eligible to vote, hold office or required to pay dues.

Individuals granted telemedicine privileges will be subject to Sacred Heart Hospital’s performance improvement and professional and peer review activities.
Section 8 – Confidentiality of Peer Review Credentialing Documents and Material

Part 1 – Introduction

The intent of this policy statement and related procedural guidelines is to: (a) protect both the interests of the Hospital and the rights of individual Members of the Medical Staff; (b) create an environment that will enhance candor in the credentialing and corrective action process; and (c) to minimize the inadvertent abuse of the confidentiality of the credentials file. Individual members involved in peer review are acting on behalf of the Credentials Committee.

Part 2 – Contents of Credentials Files

The content and organization of the credentials files as stipulated in this Part 2 may be altered from time to time by policy adopted by the Medical Executive Committee and approved by the Board.

In the case of physicians, dentists and podiatrists who are either employed by or work under a contractual arrangement (exclusive of these Bylaws) with the Hospital, all documents and material related to the employment or contractual arrangement shall be maintained by the Hospital in a file separate from the credentials file.

In order to secure the privacy of all peer review credentialing documents and material, the Hospital's Board of Directors, and its Administration, and the Medical Staff hereby agree to faithfully and responsibly adhere to the stipulations of this Section.

For the purpose of this Section and these Bylaws, the phrase "peer review credentialing documents and material" means all written or otherwise recorded information related to:

1) Processing applications for Medical Staff membership and the granting of clinical privileges;

2) Reappointment of Medical Staff Members;

3) Corrective action taken against a Member of the Medical Staff; and

4) Any and all other material and information maintained in the Credentials file which may lead to an adverse action against a Member of the Medical Staff.

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

The following documents and/or information shall be maintained in the credentials file of each Medical Staff Member and shall be separated within the file according to the categories indicated:

A) Subfile A – Contains confidential material that may not be reviewed by the individual member in question:

1) Letters of reference and any supporting documentation included with the original application;
2) Report of initial appointment interview or recommendation by department chairperson; and


B) **Subfile B** – Contains material that may be reviewed by the individual member in the presence of an officer of the Medical Staff or the officer’s designated agent:

1) Record of payment of Medical Staff dues;

2) Record of deficiencies cited in completion of medical records (letters of suspension);

3) Copy of original application for membership (excluding all supporting documentation, such as letters of reference);

4) Documentation of current medical licensure and Drug Enforcement Agency (DEA) licensure;

5) Verification of specialty Board certification, if applicable;

6) Reappointment applications, exclusive of recommendations and evaluations;

7) Record of continuing medical education activities; and

8) Record of any disciplinary action taken by the State board of Medical Education and Licensure and the Federal Drug Enforcement Agency (DEA).

---

**Part 3 – Access Procedures for Peer Review Credentialing Documents and Materials**

Any matter constituting peer review credentialing documents and material received by either the Board, or any of its individual members, the Administration, or the Medical Staff, or any of its individual Members, shall be personally delivered in its entirety to the Medical Staff Secretary as soon as reasonably possible. The Medical Staff Secretary shall immediately store the documents and/or material in a locked, file cabinet located in the Medical Staff Office. If any adverse material is placed in a Member's file, the Member shall be notified and shall have the opportunity to enter a written response to the adverse material in the file.

Peer review credentialing documents and material, in their original form, may not be removed from the Medical Staff Office.

The Chairperson of the Board or another Board member designated by the Chairperson, the Chief Executive Officer, the President of the Medical Staff, the Chairperson of the Credentials Committee, the Vice-President for Medical Affairs or the chairperson of any department may examine the peer review credentialing documents and materials of any individual, subject to the applicable laws with respect to confidentiality, within the confines of the office of the Medical Staff secretary. Such persons may make handwritten notes but may not remove any such materials from the office.

A permanent record sheet shall be maintained in the office of the Medical Staff Secretary. For each instance of receipt or examination of an individual's credentials, as permitted here-in-above, the person delivering or examining the file shall enter the following on the record sheet: signature, the time of the day, the date and the purpose for review of the file.
Either the President of the Medical Staff or the Chief Executive Officer, upon notification of the other, may direct the Medical Staff Secretary to copy all or portions of specified credentials files.

A record sheet shall be maintained in each credentials file and shall contain the following information:

1) Confirmation of notification of the President of Medical Staff or the Chief Executive Officer;
2) List of material copied;
3) Date material is copied;
4) Name of person authorized to copy material;
5) Purpose for which the copied material will be used; and
6) Date the material is returned and destroyed.

Any Member of the Medical Staff may review the record sheet maintained to document the examination or copying of the respective Member's credentials file.

Should any court, having jurisdiction subpoena any individual's credentialing materials, the material will not be released until copies of all items in that file have been made under direction of the President of the Medical Staff.

Section 8 – Medico-Administrative Officer

For the purpose of these Bylaws, a "medico-administrative officer" is a Medical Staff Member employed by the Hospital in a position which involves administrative duties related to clinical activities. The removal of the Member from his or her medico-administrative officer position shall be governed solely by the terms of the contract between the Member and the Hospital.

All Members, including medico-administrative officers, who have contractual or employment relationships with the Hospital must be Members of the Medical Staff. Termination from a group with an exclusive contract leads to automatic loss of hospital privileges for the individual with the exception of Members of the Honorary or Affiliate staff.

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

ARTICLE XI – MEDICAL STAFF CODE OF CONDUCT GUIDELINES

All practitioners appointed to the Medical Staff and Allied Health Professional Staff agree, as a condition of their appointment, to abide by the Medical Staff Bylaws, Rules and Regulations, policies and all other lawful standards, policies and rules of the Hospital. All appointees are further required to work cooperatively with other Medical Staff and Allied Health Professional Staff appointees and Hospital employees and to participate in the discharge of Medical Staff responsibilities. To that end, the Hospital requires all individuals associated with the Hospital, including employees of the Hospital, Medical Staff appointees, Allied Health Professional appointees and independent contractors with clinical privileges who provide services at the
Hospital, to conduct themselves in a professional and cooperative manner in the Hospital. No policy should be construed as precluding the Hospital from taking formal disciplinary action on the basis of a single incident at any time.

ARTICLE XII – ACTIONS AFFECTING MEDICAL STAFF MEMBERS

Section 1 – Procedure for Reappointment

Part 1 – Completion of Reappointment Form

A) Any Member of the Medical Staff who, at the designated time of processing the member’s reappointment to the Medical Staff, wishes to be considered for a change in the Member’s Medical Staff category or a change in clinical privileges, or who does not desire reappointment, shall so indicate in writing submitted to the Credentials Committee. All Members of the Medical Staff who do not indicate otherwise shall be considered for reappointment to the same category of the staff with the same clinical privileges they then hold. Reappointment to the Medical Staff shall be for a period of not more than two (2) years.

B) Each Member who wishes to be reappointed shall be responsible for reviewing the Member’s initial application form and stating on the reappointment form any material changes in the information given there, particularly with regard to any question of professional competence or disciplinary action taken or pending, any change in the status of professional liability insurance coverage, any change in status concerning the initiation or settlement or any malpractice litigation, as stated in Article X, conviction of a felony, any change in federal license to prescribe and administer controlled substances and any change in the Member’s state license to practice medicine, osteopathy, dentistry or podiatry and shall, upon request, submit proof of such current state license, DEA license, or professional liability insurance coverage or any voluntary or involuntary relinquishment of medical staff privileges in any other institution. Information regarding change in state and federal licenses shall include voluntary relinquishment. Each reappointment form shall include each Member’s acknowledgment in writing of the obligation to immediately inform the Credentials Committee of any change in the status of any of the factors mentioned in this paragraph during the term of appointment.

Part 2 – Factors to Be Considered

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

A) Professional ethics, demonstrated competence and clinical judgment in the treatment of patients and relevant recent training;

B) Participation at Medical Staff, Department and Committee meetings;

C) Compliance with these Bylaws, the Medical Staff Rules and Regulations and Applicable Hospital Rules;

D) Behavior and reasonable cooperation with fellow practitioners and Hospital personnel;

E) Use of the Hospital’s facilities for the Member’s patients;
F) Physical or mental capacity to effectively treat patients;

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

H) Results of peer review activities as defined by the Medical Staff Professional Practice Plan;

I) Any information contained in the National Practitioner Data Bank regarding the Member; and

J) personal conduct and attitude: namely, demonstrating continuing interest in and loyalty to this Hospital by admitting patients, by rendering professional services to its patients, by accepting and fulfilling the duties of nominated, elected or appointed Medical Staff positions, and by conducting professional activities, relationships and representations in a manner that will reflect positively upon the Hospital, the Medical Staff and the Member.

**Part 3 – Department Procedures**

A) At appropriate times the Credentials Committee shall transmit to the Chairperson of each department a current list of those Members being evaluated for reappointment in that department.

B) The Chairperson of the department shall transmit to the Credentials Committee the list of those department members recommended for reappointment in the same Medical Staff category with the same clinical privileges they then hold. In addition, the chairperson shall submit individual recommendations, and the reasons therefore, for any changes recommended in staff category, in clinical privileges, or for non-reappointment.

C) Recommendations for changes by the department chairperson shall be based upon, but not necessarily limited to, any or all of the factors listed in Section 1, Part 2 of this Article.

**Part 4 – Credentials Committee Procedures**

A) The Credentials Committee, after receiving recommendations from the chairpersons of each department, shall review all pertinent information available including all information submitted from other committees of the Medical Staff and from the Hospital for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for granting of clinical privileges for the ensuing two years.

B) The Credentials Committee may require that a person currently seeking reappointment undergo an impartial physical or mental examination either as part of the reapplication process or at any time to aid in determining whether clinical privileges should be granted or continued and make results available for the committee’s consideration, subject to the laws with respect to confidentiality. Failure of the Member to undergo such an examination within reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges.

C) The Credentials Committee shall prepare a list of Medical Staff members recommended for reappointment.
D) If, during the processing of a staff Member’s reappointment, it becomes apparent to the Credentials Committee or its chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges or reduce clinical privileges, the chairperson of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation and ask whether the Member desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided by these Bylaws with respect to hearings shall apply.

E) The Credentials Committee shall transmit its report and recommendations to the Medical Executive Committee. When the recommendation for reappointment is favorable those names shall be transmitted by the President of the Medical Staff to the Board for its consideration.

F) Where non-reappointment, non-promotion of an eligible current staff Member, or a limitation in clinical privileges is recommended, the reason or reasons shall be stated, documented and included in the report. This report shall not be transmitted to the Board until the affected staff Member has exercised or has been deemed to have waived the right to a hearing as provided in Article XIII. The chairperson of the Credentials Committee or its designee shall be available to the Medical Executive Committee and to the Board or its appropriate committee to answer any questions that may arise with respect to the recommendation.

Part 5 – Procedure Thereafter

Any decision by the Medical Executive Committee or the Board to recommend an adverse action as set forth in Article XIII, Section 2, Part 1, A(1), shall entitle the affected individual to the procedural rights provided in Article XIII.

Section 2 – Procedure for Requesting Increase in Clinical Privileges

Part 1 – Application for Increased Clinical Privileges

Whenever, during the term of the Member’s appointment to the Medical Staff, a Member desires to increase clinical privileges, the Member shall apply in writing to the Credentials Committee, by completing an application form. The application shall state in detail the specific additional clinical privileges desired and the applicant’s relevant recent training and experience which justifies increased privileges. This application will be transmitted by the Credentials Committee to the appropriate department chairperson.

Part 2 – Factors to Be Considered

Recommendations for an increase in clinical privileges made to the Board shall be based upon, but not necessarily limited to, any or all of the factors contained in Section 1, Part 2 of this Article.

The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such period of time as are thought necessary.
Section 3 – Corrective Action

Part 1 – Grounds for Action and Procedure

A) Whenever the activities or professional conduct of any Medical Staff Member are considered to be lower than the standards of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such Medical Staff Member may be requested by the Chief Executive Officer; the President of the Medical Staff; the Vice-President for Medical Affairs; the Medical Executive Committee; the Chair of any Department or Standing Committee of the Medical Staff; any officer of the Medical Staff; any Member of the Medical Staff through the appropriate Department Chair; or the Board of Directors. All requests for corrective action shall be in writing, shall be supported by reference to the specific activities or conduct which constitute the grounds for the request, and shall be directed to the Credentials Committee. The Chairperson of the Credentials Committee shall promptly notify the President of the Medical Staff and the Chief Executive Officer of all such requests and keep them and the Credentials Committee fully informed of its actions in connection therewith.

B) The Credentials Committee shall take action upon the request for corrective action. Such action may include, without limitation:

1) To reject the request for corrective action; or

2) To impose appropriate corrective action as follows:

   a) To issue a warning letter, a letter of admonition, or a letter of reprimand. Action of this type will not entitle the Medical Staff Member to any rights under the Fair Hearing and Appellate Review Process.

   b) To impose terms of probation, not including a reduction, limitation, modification or suspension of clinical privileges. Corrective action of this type will not entitle the Medical Staff Member to any rights under the Fair Hearing Plan.

   c) To recommend to the Medical Executive Committee reduction, limitation, modification (which may include a requirement for consultation), suspension or revocation of clinical privileges and/or a suspension or revocation of the Medical Staff Member’s staff appointment.

C) Whenever a request for corrective action could result in action under Article XII, Section 3, Part 1, B(2)(c), the following shall occur upon receipt of the request for corrective action:

1) The Credentials Committee, if it is satisfied with the depth and accuracy of the request for corrective action, may act upon the request without further investigation; or

2) The Credentials Committee may conduct a further investigation concerning the grounds for the corrective action request. The Credentials Committee may conduct such investigation itself or may assign this task to a Standing Committee of the Medical Staff or an Ad Hoc Committee appointed by the Credentials Committee, or may retain the services of outside consultants for professional review and evaluation when the Credentials Committee determines it is appropriate under the circumstances. The committee so appointed shall conduct a fact-finding investigation to determine the facts and circumstances surrounding each activity or conduct of the Medical Staff Member that
is the basis for the request for corrective action. This committee shall make a written report of its findings to the Credentials Committee setting forth a summary of the facts and circumstances surrounding each activity or conduct of the Medical Staff Member that is the basis for the request for corrective action and the conclusions of the committee as to the extent to which the facts and circumstances support or fail to support the request for corrective action. Prior to the preparation of such report, the Medical Staff Member against whom corrective action has been requested shall have the opportunity for an interview with the Committee. This interview will not constitute a hearing, will be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings will apply thereto. A summary record of such interview shall be made by the Committee and included with its report to the Credentials Committee.

3) At its next meeting after receipt of the report of the Standing or Ad Hoc Committee, the Credentials Committee shall take action upon the requested corrective action and report of the Committee. The discussion of the report shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Bylaws with respect to hearings shall apply hereto. A summary record of such discussion shall be made by the Credentials Committee.

4) Any recommendation by the Credentials Committee for a reduction, limitation, modification (which may include a requirement for consultation), suspension or revocation of clinical privileges, or for suspension or revocation of a staff appointment which is upheld by the Medical Executive Committee shall entitle the affected Medical Staff Member to the procedural rights provided in Article XIII of these Bylaws; provided, however, that the recommendation of the Credentials Committee shall remain in effect pending a final decision under Article XIII of these Bylaws. If the recommendation of the Credentials Committee is a warning, a letter of admonition, a letter of reprimand, or a term of probation, the affected Medical Staff Member shall not be entitled to a hearing or any of the procedural rights provided in Article XIII of these Bylaws.

5) In the event that the affected Medical Staff Member is a member of any Standing Committee appointed to investigate the matter, he or she shall be excluded from all participation in the investigation. In the event the affected Medical Staff Member is a member of the Credentials Committee, he or she shall be excluded from all deliberations relating to his or her case by the Credentials Committee.

D) The corrective action procedures outlined in this Section shall not preclude any other action as outlined in these Bylaws and are not required prerequisite to action under Parts 2, 3 or 4 of this Article.

E) These same procedures (including specifically the establishment of an investigative committee and the use of outside consultants) may be utilized by the Medical Staff to evaluate and review the performance of a Medical Staff Member. The goal of any such evaluation and review shall be the enhancement of quality assurance and improvement of the clinical performance by the Medical Staff Member.
Part 2 – Precautionary Suspensions

A) Whenever immediate action must be taken in the best interest of patient care or whenever the failure to take immediate action may result in imminent danger to the health of any individual, the President of the Medical Staff, the Vice-President for Medical Affairs, the Chair of any Department, the Chief Medical Officer, the Chief Executive Officer, or the Medical Executive Committee shall each have the authority to impose a precautionary suspension on all or any portion of the clinical privileges of a Medical Staff Member, and such precautionary suspension shall become effective immediately upon imposition. It is specifically understood that a precautionary suspension is an interim cautious and precautionary step in the ultimate professional review action that will be taken with respect to the suspended Medical Staff Member and is not a complete professional review action in and of itself.

B) When a suspension has been imposed by any individual or entity other than the Medical Executive Committee, the Medical Executive Committee shall review the suspension within fifteen (15) days. Upon completion of the review of the suspension, the Medical Executive Committee shall continue, modify or terminate the precautionary suspension. This review shall be preliminary in nature and none of the procedural rules provided in Article XIII of these Bylaws shall apply thereto.

C) When the Medical Executive Committee imposes a precautionary suspension, the affected Medical Staff Member shall be entitled to the procedural rights provided in and subject to the limitations outlined in Article XIII of these Bylaws; provided, however, the terms of the precautionary suspension shall remain in effect pending a final decision under Article XIII of the Bylaws and Fair Hearing Plan.

D) Immediately upon the imposition of a suspension, the President of the Medical Staff or responsible Chair of the Department shall have authority to provide for alternative medical coverage for the patients of the suspended Medical Staff Member still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Medical Staff Member.

Part 3 – Automatic Suspension and Relinquishment Process

A) Automatic suspension of a Medical Staff Member and/or relinquishment of privileges and Medical Staff membership shall occur under the following circumstances:

1) The suspension, loss, restriction or revocation of a Medical Staff Member’s license to practice issued by the Commonwealth of Pennsylvania;

   a) Revocation - Whenever a Medical Staff Member’s license, certificate or other legal credential so authorizing him or her to practice in the Commonwealth of Pennsylvania is revoked by the appropriate State Board of Licensure, his or her staff membership and clinical privileges shall immediately and automatically be revoked.

   b) Restriction - Whenever a Medical Staff Member’s license, certificate or other legal credential authorizing him or her to practice in this Commonwealth is restricted by the appropriate State Board of Licensure, those clinical privileges or specified services that he or she has been granted that are within the scope of said limitation or restriction shall be immediately and automatically revoked.
c) **Suspension** - Whenever a Medical Staff Member’s license, certificate or other legal credential is suspended by the appropriate State Board of Licensure, his or her staff membership, clinical privileges or specified services shall be automatically suspended, effective upon and at least for the term of the suspension imposed by the State Board of Licensure.

2) Revocation or suspension of a Medical Staff Member’s DEA certificate;

a) In the case of an impaired Medical Staff Member, already known to be participating in a rehabilitation program, the requirement for automatic suspension and relinquishment may be waived at the sole discretion of the Medical Executive Committee through the President of the Medical Staff. In all other instances, as soon as practicable after the suspension or revocation of privileges occurs, the Medical Executive Committee shall convene to review and consider the facts under which such action was taken. The Medical Executive Committee may recommend such further corrective action as appropriate to the facts disclosed in its investigation.

3) Failure to maintain adequate malpractice insurance as required by the laws of the Commonwealth of Pennsylvania.

4) Exclusion from any Federal health care program;

a) Provided, however, that such staff membership and clinical privileges may be reinstated upon action of the Medical Executive Committee and the Governing Body at their sole discretion in the event that they conclude that the Medical Staff Member has made the showing described in Article V. For purposes of this subsection, an excluded Medical Staff Member shall refer only to a Medical Staff Member who has been excluded from any Federal health care program as part of a formal sanction. An excluded Medical Staff Member shall not include a “nonparticipating” Medical Staff Member or a Medical Staff Member who has “opted out” of any Federal health care program (i.e. a Medical Staff Member who voluntarily elects not to participate in any Federal health care program or a Medical Staff Member who wishes to terminate his/her participating agreement with Federal health care but fails to take such action during the participating enrollment period).

5) Revocation, restriction or suspension of clinical privileges or medical staff membership at another Hospital;

a) Provided, however, that such staff membership and clinical privileges may be reinstated upon action of the Medical Executive Committee and the Governing Body at their sole discretion in the event that they conclude that the Medical Staff Member has made the showing described in Article V.

B) Except for suspensions which are subject to cure, upon the occurrence of any of the events listed above, a Medical Staff Member shall be considered to have relinquished his or her clinical privileges and Medical Staff membership. The suspension, restriction or relinquishment of staff membership and clinical privileges pursuant to (1) - (5) above shall not be subject to review under the Fair Hearing Plan. Consideration for reinstatement of Medical Staff membership shall occur only after the Medical Staff Member has, in the case of exclusion (except as otherwise provided in (4) and (5) above), been reinstated to the Federal health care programs from which he or she has been excluded, has reapplied
to the Medical Staff, the incident which led to the suspension or revocation has been investigated, and
the application reviewed by the appropriate credentialing individuals and committees pursuant to these
Bylaws.

Section 4 – Procedure for Leave of Absence

A) For a leave of absence of less than 90 days, the Chairperson of the Member’s clinical department must
give written approval prior to the Member’s return. The Chairperson may renew this period for an
additional 90 days;

B) For a leave of absence of six months to one year, the Member must go through the reappointment
process prior to being able to return the Medical Staff;

C) A leave of absence shall not exceed one year. After one year, such absence will be considered a
voluntary resignation from the Medical Staff and will require going through the initial application
process;

D) The Department Chairperson, Credentials Committee, or Medical Executive Committee may require a
physical and/or mental examination prior to the return of any Member on a leave of absence, by a
physician acceptable to the Medical Executive Committee; and

E) For any Member returning from a leave of absence, the Department Chairperson, Credentials
Committee, or Medical Executive Committee may require a period of mandatory consultation, special
monitoring, or any other special program of retrospective, concurrent, or prospective review of
professional activities.

Section 5 – Requirements for Medical History and Physical Examination

The medical history and physical examination are completed and documented by a physician, an oral and
maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
The requirements related to medical history and physical examination are outlined in the Medical Staff Rules
and Regulations (Medical Records).

ARTICLE XIII – FAIR HEARING AND APPEAL PROCEDURES

Section 1 – General Terms

Part 1 – Title and Definitions

The Fair Hearing and Appellate Review Procedures shall be referred to herein as the “Fair Hearing Plan” or
“Plan.”

A) “Appellate Review Body” means the group designated under this Plan to hear a request for appellate
review properly filed and pursued by a Medical Staff Member.

B) “Hearing Committee” means the committee appointed under this Plan to hear a request for an
evidentiary hearing properly filed and pursued by a Medical Staff Member.

C) “Medical Staff Bylaws” mean the Bylaws of the Medical Staff of Sacred Heart Hospital.
D) “Parties” means the Medical Staff Member who requested the hearing or appellate review and the body or bodies whose adverse recommendation or action prompted the right to a hearing or appellate review under this Plan.

E) “Appeals Committee” means the Appeals Committee of the Board as determined and appointed by the Chair of the Board of Directors.

F) “Special Notice” means written notification sent by two (2) of the following four (4) methods: hand delivery, fax, First Class U.S. Mail or electronic mail.

**Part 2 – Interpretation**

A) The Headings in this Plan are intended only for reference purposes and shall not be construed as defining, limiting or describing the scope or intent of the Plan.

B) As used in the Plan and required by context, each number (singular or plural) shall include all numbers.

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

**Section 2 - Hearing Process**

**Part 1 – Initiation of Hearing**

A) Triggering Events

1) Recommendations or Actions

Except as otherwise set forth in the Bylaws, the following recommendations or actions, if deemed adverse, entitle the Medical Staff Member to a hearing upon timely and proper request:

a) Denial of initial staff appointment;

b) Denial of reappointment;

c) Suspension of staff membership and/or clinical privileges;

d) Revocation of staff membership and/or clinical privileges;

e) Denial of requested appointment to or advancement in staff category;

f) Reduction in staff category;

g) Suspension or limitation of the right to admit patients or of any other membership prerogative directly related to the Medical Staff Member’s provision of patient care;

h) Denial of requested department (or service) or other clinical unit affiliation;

i) Denial or restriction of requested clinical privileges;

j) Reduction in clinical privileges;

k) Individual application of, or individual changes in, mandatory consultation requirement.
2) When Deemed Adverse

A recommendation or action is adverse only when it has been:

   a) Recommended by the MEC; or

   b) Taken by the Board under circumstances where no prior right to request a hearing existed.

3) When Deemed Not Adverse

A recommendation or action is not adverse when it has been:

   a) The result of a voluntary relinquishment or relinquishment of privileges and/or Medical Staff membership by a Medical Staff Member, pursuant to the Bylaws; or

   b) Based upon a Medical Staff Member’s failure to meet objective standards for qualification at the time of initial appointment or reappointment; or

   c) Taken as a result of the Board or Hospital’s decision to close a service or department; or

   d) Taken as a result of the Board or Hospital’s decision to award or terminate an exclusive service agreement; or

   e) Taken in such a manner that, even if the action remains adverse to the Medical Staff Member, it would not otherwise result in the submission of a report to the National Practitioner Data Bank.

B) Notification of Adverse Recommendation or Action

The CEO shall promptly provide the Medical Staff Member with special notice of an adverse recommendation or action. It shall inform the Medical Staff Member:

1) That an adverse recommendation or action has been proposed to be taken against the Medical Staff Member;

2) A summary of the reasons for the proposed recommendation or action;

3) That the Medical Staff Member has the right to request a hearing on the proposed recommendation or action;

4) That the Medical Staff Member has thirty (30) days after receiving the special notice within which to submit a request for a hearing and that the request must satisfy the conditions set forth in Article XIII, Section 2, Part 2(A); and

5) A summary of the Medical Staff Member’s rights and duties pursuant to Article XIII, Section 2, Part 3.

A copy of the Medical Staff Bylaws, including the Fair Hearing Plan, shall be included with the special notice.
Part 2 – Request for Hearing

A) Request for Hearing - A Medical Staff Member has thirty (30) days after receiving notification under Article XIII, Section 2, Part 1(B) to file a written request for a hearing. The request must be delivered to the CEO by special notice (see definition). If the Medical Staff Member intends to be represented by an attorney at the hearing, the request for a hearing must state that intent and the name of the Medical Staff Member’s attorney.

B) Failure to Request Hearing - A Medical Staff Member who fails to request a hearing within the time and in the manner specified in Article XIII, Section 2, Part 2(A) waives any hearing or appellate review to which he or she might otherwise have been entitled.

Part 3 – Parties Rights and Duties

A) Rights of Parties - During a hearing, each party may:

1) Call, examine, and cross-examine witnesses;

2) Present evidence determined to be relevant by the Hearing Officer (as hereinafter defined) and/or Hearing Committee, subject to Article XIII, Section 2, Part 5(D) hereof;

3) Request that the record of the hearing be made by the use of a court reporter;

4) Request that copies of the said proceeding be available upon payment of any reasonable charges associated with the preparation thereof; and

5) Submit a written statement at the closing of the hearing.

B) Rights and Duties of Medical Staff Member

1) Subject to Article XIII, Section 2, Part 2(A), the Medical Staff Member may be accompanied and represented at the hearing by an individual of his or her choice, including an attorney. The body (or bodies) whose recommendation or action prompted the right to a hearing may be represented by an attorney at the hearing if and only if the Medical Staff Member is represented by an attorney. The foregoing provision shall not be deemed to deprive the Medical Staff Member or the body (or bodies) whose recommendation or action prompted the right to a hearing of the right to legal counsel in connection with the preparation for the hearing.

2) Upon completion of the hearing, the Medical Staff Member has the right to receive the written recommendation of the Hearing Committee (as hereinafter defined).

3) At least fifteen (15) days prior to a hearing, the Medical Staff Member shall provide the body (or bodies) whose recommendation or action prompted the right to a hearing with a list of witnesses. The parties shall also exchange exhibits at that time and provide copies of the same to the Hearing Committee.

C) Failure to Appear - If the Medical Staff Member fails, without good cause, to appear at the hearing, the right to a hearing and appellate review shall be waived.
Part 4 – Notification of Hearing

A) **Notification** - The CEO shall immediately deliver timely and proper hearing requests to the President of the Medical Staff or the Chair of the Board depending upon whose recommendation or action prompted the right to a hearing. Upon receipt of a request for a hearing, the President of the Medical Staff or Chair of the Board, as appropriate, shall schedule and arrange for a hearing which shall be not later than sixty (60) days from the receipt of the request for the hearing. At least thirty (30) days prior to the hearing date, the CEO shall send the Medical Staff Member special notice of the time, place and date of the hearing and of the composition of the hearing panel; provided, however, that a hearing for a Medical Staff Member who is under suspension then in effect must be held as soon as the arrangements may be reasonably made, but not later than forty-five (45) days after the CEO received the hearing request. The special notice shall include a list of the witnesses (if any) expected to testify at the hearing on behalf of the body or bodies whose recommendation or action prompted the right to a hearing.

Part 5 – Fair Hearing Procedure

A) **Appointment of Hearing Committee**

1) By the Medical Staff - A hearing occasioned by an adverse MEC recommendation is conducted by a Hearing Committee appointed by the President of the Medical Staff composed of at least three (3) members of the Medical Staff not in direct economic competition with the Medical Staff Member involved. The President of the Medical Staff shall designate one (1) of the appointees as Chair of the Hearing Committee.

2) By the Board - A hearing occasioned by an adverse action of the Board is conducted by a Hearing Committee appointed by the Chair of the Board and composed of five (5) persons, including at least two (2) Members of the Medical Staff, not in direct economic competition with the Medical Staff Member. The Chair of the Board shall designate one (1) of the appointees as Chair of the Hearing Committee.

3) Service on Hearing Committee -

   a) A Medical Staff or Board Member is not disqualified from serving on a Hearing Committee merely because he or she participated in investigating the underlying matter at issue or because he or she has heard of the case or has knowledge of the matter. A Medical Staff or Board Member is disqualified from serving on a Hearing Committee if that Medical Staff or Board member is in direct economic competition with the Medical Staff Member.

   b) If the Medical Staff Member has any objection to the composition of the hearing panel, the same must be raised in writing and delivered to either the President of the Medical Staff or the Chair of the Board, as appropriate, no later than ten (10) days after notice of the scheduled hearing. The Medical Staff Member’s objection must state in sufficient detail the reasons and basis for the objection so made. The President of the Medical Staff or the Chair of the Board, as appropriate, in his or her sole discretion, will take action upon the objection. Action upon the objection may include the following: overruling the objection and proceeding with the hearing on the scheduled date; sustaining the objection, replacing one or more of the Hearing Committee members and proceeding with the hearing on the scheduled date; or sustaining the
objection, replacing one or more of the Hearing Committee members, and rescheduling the hearing for a date not later than thirty (30) days from the date originally scheduled for the hearing.

B) **Hearing Officer**

1) **Use of Hearing Officer** - The use of a Hearing Officer to assist the Hearing Committee at the hearing is optional and is to be determined by the President of the Medical Staff or the Chair of the Board, as appropriate. A Hearing Officer may or may not be an attorney at law. A Hearing Officer shall not be in direct economic competition with the Medical Staff Member involved.

2) **Role of Hearing Officer** - The Hearing Officer maintains decorum and assures that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall determine the order of procedure during the hearing and shall make all rulings on procedure and the admissibility of evidence. The Hearing Officer may conduct pre-hearing conferences with the parties and is specifically empowered to impose reasonable limitations, including time limitations, upon the parties and the presentation of their cases.

C) **Personal Presence**

1) **Failure to Appear** - The personal presence of the Medical Staff Member is required. A Medical Staff Member who fails, without good cause, to appear and proceed at the hearing waives his or her rights in the same manner as provided in Article XIII, Section 2, Part 2(B).

2) **Testimony** - If the Medical Staff Member does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

D) **Procedure and Evidence** - The hearing need not be conducted strictly in accordance with the rules of law relating to the examination of witnesses or presentation of evidence. During a hearing, each party may present evidence considered to be relevant by the Hearing Officer and/or Committee, regardless of its admissibility in a court of law. Furthermore, any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Hearing Officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.

E) **Official Notice** - In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noted by the courts of the state where the hearing is held. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute any officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the Hearing Committee. The Hearing Committee is also entitled to consider all other information that can be considered under the Medical Staff Bylaws in connection with credentials matters.
F) **Burden of Proof** - The body (or bodies) whose adverse action or recommendation prompted the right to a hearing has the burden of proof by a preponderance of the evidence.

G) **Hearing Record** - A court reporter shall be utilized to prepare a record of the hearing.

H) **Postponement** - Request for postponement of a hearing may be granted by the Hearing Committee only upon a showing of good cause and only if the request is made as soon as reasonably practicable.

I) **Presence of Hearing Committee Members** - The Hearing Committee must be present for the entirety of the hearing and during deliberations on the decision.

J) **Recesses and Adjournment** - The Hearing Committee may recess and reconvene the hearing without additional notice for the convenience of the participants or for any other purpose. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee, shall at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be adjourned.

K) **Hearing Committee Report** - Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations and forwards the report along with the record and other documentation to the body (or bodies) whose adverse action prompted the right to a hearing to the Medical Staff Member involved and to the CEO. The Hearing Committee Report shall include a statement of the basis for the recommendations or action.

L) **Reconsideration** - Upon written request of either party, the Hearing Committee shall have the right, in its sole and absolute discretion, to re-open a hearing prior to the issuance of a Hearing Committee Report or to reconsider the decision set forth in the Hearing Committee Report, if new and additional information is available. The Hearing Committee shall not re-open a hearing or reconsider a decision based upon new and additional information unless the party seeking to introduce the information can demonstrate that the information was not available or discoverable in time for presentation to the Hearing Committee at the original hearing.

**Part 6 – Effect of Hearing Committee Report**

A) **Action on Hearing Committee Report** - Within thirty-five (35) days after receiving the Hearing Committee Report, the body (or bodies) whose adverse recommendation or action occasioned the hearing shall consider the Report, and affirm, modify or reverse the original recommendation or action. The final result shall be transmitted to the CEO.

B) **Notification and Effect of Result**

1) **Notification** - The CEO shall promptly send a copy of the result to the Medical Staff Member by special notice, to the President of the Staff, to the MEC and to the Board.

2) **Effect of Favorable Result**

   a) **By the Board** - If the Board’s result under Article XIII, Section 2, Part 6(A) is favorable to the Medical Staff Member, it becomes the final decision of the Board.
b) **By the MEC** - If the MEC result is favorable to the Medical Staff Member, the CEO shall promptly forward it, together with all supporting documentation, to the Board and the Board shall take action consistent with Article XIII, Section 2, Part 6(C) of this Plan.

3) **Effect of Adverse Result** - If the result of the MEC or the Board under Section Article XIII, Section 2, Part 6(A) continues to be adverse to the Medical Staff Member, this special notice shall inform him or her of his or her right to request an appellate review as provided in Article XIII, Section 3 of this Plan.

C) **Board Action After Favorable MEC Result**

1) **Action** - The Board shall, within thirty (30) days of receipt of a matter, render a decision.

2) **Effect of Favorable Action** - If the Board’s decision after a favorable MEC result is also favorable to the Medical Staff Member, it becomes the final decision of the Board.

3) **Effect of Adverse Action** - If the Board’s decision after a favorable MEC result is adverse to the Medical Staff Member, the decision of the Board shall not be considered final. The CEO shall submit the matter to the Joint Conference Committee for further review and consideration. The Joint Conference Committee shall, within thirty (30) days after receipt of a matter, submit its recommendation to the Board. The Board shall then render a final decision.

4) **Notification** - The CEO shall provide the Medical Staff Member and the President of the Medical Staff with the recommendation of the Joint Conference Committee and/or the action and/or final decision of the Board.

**Section 3 – Appellate Review Process**

**Part 1 – Request for Appellate Review**

A) **Request for Appellate Review** - A Medical Staff Member has thirty (30) days after receiving special notice under Article XIII, Section II, Part 6(B)(3) to file a written request for an appellate review. The request must be delivered to the CEO by special notice (see definition) and may include a request for a copy of the Hearing Committee Report and record and all other material, if not previously forwarded, that was considered by the Hearing Committee. If the Medical Staff Member wishes to be represented by an attorney at any appellate review proceeding, the request for appellate review must state that intent and the name of the Medical Staff Member’s attorney.

B) **Failure to Request Appellate Review** - A Medical Staff Member who fails to request an appellate review within the time and in the manner specified in Article XIII, Section 3, Part 1(A) waives any appellate review to which he or she might otherwise have been entitled.

**Part 2 – Notification of Time and Place for Appellate Review**

A) **Notification** - The CEO shall immediately deliver timely and proper requests for appellate review to the Chair of the Board. Upon receipt of a request for appellate review, the Chair shall schedule and arrange for an appellate review which shall not be later than sixty (60) days from the receipt of the request for appellate review. At least thirty (30) days prior to the appellate review, the CEO shall send the Medical
Staff Member special notice of the time, place, and date of the review and of the composition of the Appellate Review Body.

**Part 3 – Appellate Review Procedure**

A) **Appellate Review Body** - If a MEC recommendation occasions the appellate review, the Board or individuals designated by the Board, shall serve as the Appellate Review Body. If a Board action occasions the review, the Joint Conference Committee shall serve as the Appellate Review Body. The Appellate Review Body shall appoint a Chair of the Appellate Review Body.

B) **Nature of Proceedings** - The proceedings conducted by the Appellate Review Body are a review based upon the hearing record, the Hearing Committee Report, all subsequent results and actions, the written and/or oral statements, if any, provided below, and any other material that may be presented and accepted under the appellate review procedure.

C) **Hearing Officer** - The use of a Hearing Officer to assist the Appellate Review Body at the appellate review is optional and is to be determined by the Chair of the Board. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. A Hearing Officer shall not be in direct economic competition with the Medical Staff Member involved.

D) **Representation at Appellate Review** - If the Medical Staff Member desires to be represented by an attorney at an appellate review appearance, his or her request for the review pursuant to Article XIII, Section III, Part 1(A) must declare his or her intent to be so represented. The Appellate Review Body shall determine in its sole discretion whether to permit such representation. The body (or bodies) whose recommendation or action prompted the right to an appellate review may be represented by an attorney at the appellate review if and only if the Medical Staff Member is represented by an attorney. The foregoing provision shall not be deemed to deprive the Medical Staff Member or the body (or bodies) whose recommendation or action prompted the right to the appellate review of the right to legal counsel in connection with the preparation for the appellate review.

E) **Written Statements** - The Medical Staff Member shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees and his or her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing and appellate review process. The statement shall be submitted to the Appellate Review Body and the body (or bodies) whose adverse action prompted the appellate review through the CEO at least fourteen (14) days prior to the scheduled date of the appellate review, except if the time limit is waived by the Appellate Review Body. A similar statement shall be submitted to the Appellate Review Body through the CEO by the body (or bodies) whose adverse action prompted the appellate review at least seven (7) days prior to the scheduled date of the appellate review.

F) **Oral Statements** - The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and present oral statements. Any party or representative appearing shall be required to answer questions of any member of the Appellate Review Body.

G) **Powers** - The Appellate Review Body has all the powers granted to the Hearing Committee, and any additional powers that may be reasonably appropriate to or necessary for the discharge of its responsibilities.
H) **Presence of Members** - The entire Appellate Review Body must be present for each appellate review session and during deliberations.

I) **Recesses and Adjournment** - The Appellate Review Body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for any other purpose. At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

J) **Consideration of New or Additional Matters** - Upon written request of either party, the Appellate Review Body shall have the right, in its sole and absolute discretion, to consider new and additional information. The Appellate Review Body shall not consider any such new and additional information unless the party seeking to introduce the information can demonstrate that the information was not available or discoverable in time for presentation to the Hearing Committee at the original hearing.

### Part 4 – Appellate Review Action

A) **Action Taken** - Within thirty (30) days of adjournment, the Appellate Review Body may affirm, modify or reverse the adverse result or action, or in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within twenty (20) days and in accordance with its instructions. Within ten (10) days after receipt of such recommendation from the Hearing Committee the Appellate Review Body shall take action.

1) **Joint Conference Committee** - If the Joint Conference Committee acted as the Appellate Review Body, it shall submit its recommendation to the Board. The Board shall then render a final decision.

2) **Appeals Committee** - If the Board or individuals designated by the Board acted as the Appellate Review Body, it shall submit its recommendation to the Board. If the Board’s action is consistent with the last recommendation of the MEC, the decision shall be considered final. If the Board’s action is inconsistent with the last recommendation of the MEC, the decision of the Board shall not be considered final and the CEO shall submit the matter to the Joint Conference Committee for further review and consideration. The Joint Conference Committee shall, within thirty (30) days of receipt of the matter, submit its recommendation to the Board. The Board shall then render a final decision.

B) **Notification of Action Taken** - The CEO shall provide the Medical Staff Member, the President of the Medical Staff, the MEC, the Appellate Review Body and the Board with the recommendation and/or action taken by the Appellate Review Body, the Joint Conference Committee and the Board.

### Section 4 - Miscellaneous

A) **Number of Hearing and Reviews** - Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no Medical Staff Member is entitled as a right to request more than one (1) evidentiary hearing and one (1) appellate review with respect to the subject matter that is the basis of the adverse recommendation or action which prompted such right.
B) **Compliance with Bylaws** - The failure by the Hospital or any of its committees or components to meet the conditions described in this Plan shall not, in itself, constitute a violation of any state or federal law or a deprivation of the Medical Staff Member’s due process rights.

C) **Exhaustion of Remedies** - If an adverse recommendation is made or action taken pursuant to Article XIII, Section 2, Part 1(A)(2) of this Plan, the Medical Staff Member must first exhaust the remedies afforded by the Medical Staff Bylaws and this Plan before resorting to legal action. The fact that a Medical Staff Member has exhausted the remedies afforded by the Medical Staff Bylaws and this Plan shall not in any way suggest that any subsequent legal action is proper or appropriate.

---

**ARTICLE XIV – RULES AND REGULATIONS**

**Section 1 – Medical Staff Rules and Regulations**

The Medical Staff, with the approval of the Board, shall adopt such rules and regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. There will be a set of general rules and regulations which shall set standards of practice that are to be required of each practitioner in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Subject to the approval of the Medical Executive Committee, each department shall formulate and modify 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 or the general Medical Staff rules and regulations. Rules and regulations shall have the same force and effect as the Bylaws, but if they conflict with the Bylaws, the Bylaws shall prevail.

General rules and regulations may be amended, repealed or added by vote of the Medical Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions or repeals are sent to all Members of the Active Staff fifteen (15) days before being voted on and further provided that all written comments on the proposed changes by Members of the Medical Staff be brought to the attention of the Medical Executive Committee before the change is voted upon. Changes in the rules and regulations shall become effective only when approved by the Board.

Rules and regulations may also be amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure required to amend these Bylaws (as specified in Article XV) is followed. All such changes shall become effective when approved by the Board.

**Section 2 – Medical Staff Policies**

Medical Staff policies may be amended, repealed, or added by the Medical Executive Committee. All such changes shall become effective when approved by the Board.
Section 3 – Applicable Hospital Rules and Regulations

It is appropriate and necessary that the Hospital have rules, regulations and requirements concerning conduct, attire, documentation and fulfillment of responsibility which pertains to activities in the Hospital. Such hospital rules may be necessitated by law, accrediting agencies, insurance carriers or particular circumstances in the Hospital. Such Hospital rules that apply to all individuals who conduct all or a portion of their occupational activities within the Hospital shall also apply to Members of the Medical Staff, and for purposes of these Bylaws are specified as Applicable Hospital Rules. In the event the Bylaws conflict with the Hospital’s Rules and Regulations, the Bylaws prevail.

Proposed rules that are to apply specifically to any or all Members of the Medical Staff must be referred to the Medical Executive Committee for review and recommendation prior to action by the Board.

ARTICLE XV – AMENDMENTS

All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. Approval by the Medical Executive Committee shall not be unreasonably withheld or delayed.

They shall be voted upon at that meeting provided that notification of any proposed amendment shall have been given to each Member of the Active Staff at least fifteen (15) days prior to the meeting. To be adopted, an amendment must receive one-half (1/2) of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.

ARTICLE XVI - ADOPTION

These Bylaws are adopted and made effective June 27, 2016, superseding and replacing all previous bylaws of the Medical Staff; henceforth, all activities and actions of the Medical Staff and its Members, and of the Board and its members and its administrative staff shall comply with the requirements of these Bylaws.