UPMC Pinnacle Carlisle
&
Carlisle Regional Outpatient Surgery Center

361 Alexander Spring Road
Carlisle, PA 17015

Medical Staff
Bylaws
Rules & Regulations

Revised 07/24/2018

BYLAWS
RULES AND REGULATIONS
OF
UPMC PINNACLE CARLISLE
&
CARLISLE REGIONAL OUTPATIENT
SURGERY CENTER

Revisions/Amendments Approved by MEC	**5/7/12**
Revisions/Amendments Approved by Medical Staff	**5/09/12**
Revisions/Amendments Approved by Board of Trustees	**5/22/12**
Reviewed by MEC	**8/5/13**
Revisions/Amendments Approved by MEC	**5/6/14**
Revisions/Amendments Approved by Medical Staff	**6/11/14**
Revisions/Amendments Approved by Board of Trustees	**6/23/14**
Revisions/Amendments Approved by MEC	**8/11/14**
Revisions/Amendments Approved by Medical Staff	**9/10/14**
Revisions/Amendments Approved by Board of Trustees	**9/23/14**
Revisions/Amendments Approved by MEC	**6/27/16**
Revisions/Amendments Approved by Medical Staff	**7/20/16**
Revisions/Amendments Approved by Board of Trustees	**7/26/16**
Revisions/Amendments Approved by MEC	**11/8/16**
Revisions/Amendments Approved by Medical Staff	**11/16/16**
Revisions/Amendments Approved by Board of Trustees	**11/22/16**
Revisions/Amendments Approved by MEC	**11/6/2017**
Revisions/Amendments Approved by Medical Staff	**11/15/2017**
Revisions/Amendments Approved by Board of Trustees	**11/21/2017**
Revisions/Amendments Approved by MEC	**6/4/2018**
Revisions/Amendments Approved by Medical Staff	**6/29/2018**
Revisions/Amendments Approved by Board of Trustees	**7/24/2018**

UPMC PINNACLE CARLISLE MEDICAL STAFF BYLAWS
TABLE OF CONTENTS

ARTICLE I **NAME AND DEFINITIONS**

ARTICLE II **PURPOSES AND RESPONSIBILITIES**

2.1 Purposes
2.2 Responsibilities of the Medical Staff
2.3 Exclusion of Patient's Third Party Beneficiary Rights

ARTICLE III **MEMBERSHIP**

3.1 Nature of Medical Staff Membership
3.2 Qualifications for Membership
3.3 Nondiscrimination
3.4 Conditions and Duration of Appointment
3.5 Medical Staff Membership and Clinical Privileges
3.6 Responsibilities of Each Medical Staff Member
3.7 Medical Staff Member Rights
3.8 Staff Dues / Assessments
3.9 Indemnification

ARTICLE IV **CATEGORIES OF THE MEDICAL STAFF**

4.1 Categories
4.2 Active Staff
4.3 Associate Staff
4.4 Community Care Staff
4.5 Consulting Staff
4.6 Emeritus Staff

ARTICLE V **ALLIED HEALTH PERSONNEL**

5.1 Definitions
5.2 Categories for Allied Health Personnel
5.3 Clinical Privileges
5.4 Rights and Responsibilities
5.5 Clinical Evaluation and Assignment to Department
5.6 General Conditions and Principles
5.7 Allied Health Personnel Committee
5.8 Corrective Action & Hearing Procedure for Allied Health Professionals

ARTICLE VI PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 General Procedure
6.2 Application for Initial Appointment
6.3 Processing the Application
6.4 Medical Staff Reappointment
6.5 Requests for Modification or Membership Status or Privileges
6.6 Leave of Absence
6.7 Resignation from Medical Staff

ARTICLE VII DETERMINATION OF CLINICAL PRIVILEGES

7.1 Exercise of Privileges
7.2 Delineation of Privileges in General
7.3 Temporary Privileges
7.4 Emergency Privileges
7.5 Disaster Privileges
7.6 History & Physicals
7.7 Telemedicine Privileges

ARTICLE VIII CORRECTIVE ACTION

8.1 Procedure
8.2 Summary Suspension
8.3 Automatic Suspension

ARTICLE IX HEARING AND APPELLATE REVIEW PROCEDURE

9.1 Right to Hearing and Appellate Review
9.2 Request for Hearing
9.3 Notice of Hearing
9.4 Composition of Hearing and Appellate Review
9.5 Conduct of Hearing
9.6 Appeal to the Board of Trustees
9.7 Final Decision by the Board of Trustees
9.8 Rights to Additional Hearings/Appellate Review
9.9 Rights of Hospital Employed Practitioners

ARTICLE X MEDICAL STAFF ORGANIZATION

10.1 Officers
10.2 Committees
10.3 Clinical Departments
10.4 Dues and Educational Assessments

ARTICLE XI **OFFICERS**
11.1 Officers of the Medical Staff
11.2 Duties of Officers
11.3 Chain of Command

ARTICLE XII **COMMITTEES AND FUNCTIONS**

12.1 Designations
12.2 Medical Executive Committee
12.3 Constitution and Bylaws Committee
12.4 Credentials Committee
12.5 Infections Committee
12.6 Medical Education Committee
12.7 Medical Records Committee
12.8 Medical Staff Health Committee
12.9 Medical Staff Planning Committee
12.10 Medical Staff Quality & Peer Review Committee
12.11 Pharmacy and Therapeutics Committee
12.12 Radioisotope and Radiation Safety Committee
12.13 Utilization Management Committee

ARTICLE XIII **MEDICAL STAFF CLINICAL DEPARTMENTS**

13.1 Departments
13.2 Organization of Departments
13.3 Assignment to Departments
13.4 Functions of Departments
13.5 Department Chairmen

ARTICLE XIV **MEETINGS**

14.1 General Staff Meeting
14.2 Department Meetings
14.3 Committee Meetings`
14.4 Quorum
14.5 Minutes
14.6 Procedure/Rules of Order
14.7 Attendance at Meetings

ARTICLE XV **IMMUNITY FROM LIABILITY**
ARTICLE XVI **ADOPTION OF RULES AND REGULATIONS**
ARTICLE XVII **AMENDMENTS**
ARTICLE XVIII **ADOPTION**
ARTICLE XIX **SURGERY CENTER**

MEDICAL STAFF
RULES & REGULATIONS

R-1.0 Admissions

R-2.0 Patient Care
- General Provisions
- Dental Patients
- Podiatry Patients
- Informed Consent
- Interruption of Pregnancy
- Transfusions
- Coroner Notification
- Consultations
- Emergency Care
- Psychiatric Patients

R-3.0 Pharmacy
- Automatic Stop Orders

R-4.0 Medical Records
- H&P Requirements, Op Reports, Progress Notes
- Access to Records
- Standing Orders
- Verbal Orders
- Symbols and Abbreviations
- Autopsies

R-5.0 Utilization Review

R-6.0 Quality Assurance

R-7.0 EMTALA – Medical Screening Exams

R-8.0 Anesthesia Services

ARTICLE I.
NAME AND DEFINITIONS

The name of this organization shall be the "UPMC Pinnacle Carlisle Medical Staff" which also includes the Carlisle Regional Surgery Center.

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

1. **"Board",** "Board of Trustees", or "governing body" means the Board of Trustees of the UPMC Pinnacle Carlisle and Carlisle Regional Surgery Center, and, when appropriate due to existing circumstances, the President of the Hospital.

2. **"Hospital",** or "UPMC PINNACLE CARLISLE", means the UPMC Pinnacle Carlisle, 361 Alexander Spring Drive, Carlisle, PA 17015.

3. **"Administration",** "hospital administration", or "hospital management" means the President of UPMC PINNACLE CARLISLE and/or the staff employed by the President and/or the Board to carry out the general management and administration of the Hospital.

4. **"Medical Executive Committee"** or "MEC" means the Medical Executive Committee of the Medical Staff.

5. **"UPMC Pinnacle Carlisle Medical Staff",** "Medical Staff" and "Staff" means the organization of practitioners who have been granted membership and clinical privileges at UPMC PINNACLE CARLISLE.

6. **"Prerogative"** means the substantive and procedural rights arising from the granting of privileges to a member of the Medical Staff subject to the conditions imposed in the Hospital and Medical Staff Bylaws, Rules and Regulations and Policies.

7. **"President of the Hospital"** means the individual appointed by the Board of Trustees to be the chief executive officer of the Hospital.

8. **"President of the Medical Staff"** means the individual elected by the Medical Staff to serve as the chief officer of the Medical Staff.

9. **"Physician"** means an individual with an unrestricted license to practice medicine or osteopathy as authorized by either the Pennsylvania Board of Medical Education and Licensure or the Pennsylvania Board of Osteopathic Examiners.

10. **"Dentist"** means an individual who is fully licensed by the Pennsylvania Examining Board of Dental Council to practice dentistry in all is phases.

11. **"Podiatrist"** means an individual who is fully licensed by the Pennsylvania State Board of Podiatry Examiners to practice podiatric medicine.

12. **"Practitioner"** means a physician, dentist, or podiatrist as defined in this Article.

13. **"Allied Health Personnel"** means an individual, other than a licensed physician, dentist, or podiatrist who is duly licensed or otherwise qualified by training, experience and certification to provide patient care under the supervision of a member of the Medical Staff and whose patient care activities require that the authority to perform specific patient care services be processed through the usual Medical Staff procedures as set forth in these Bylaws.

14. **"Hospital Medical Service Area"** means the geographic area, as defined by the Board in consultation with the Medical Staff.

15. **"Carlisle Medical Service Area"** means the geographic area which includes the central and western portions of Cumberland County, northern Adams County and adjacent townships in Perry County.

16. **"Gender"** – Whenever the term he/him/his appears, it shall be interpreted to refer to the practitioner regardless of gender.

17. **"Clinical Privileges"** or "privileges" means 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 and Surgery Center, such approved clinical privileges to be within defined limits based on the individual's license and/or certification, education, training, experience, demonstrated competence and judgment".

18. **"Admission"** shall be defined as inpatient admissions to the hospital, admissions to the outpatient procedure unit and operating room, admissions to the observation unit, and inpatient transfers to the individual physician's service.

ARTICLE II.
PURPOSES AND RESPONSIBILITIES

2.1 Purposes

The purpose of the Medical Staff shall be to:

a) Provide the organizational framework for initiating and maintaining a form of self-government which will include both the professional and legal structure necessary for the Medical Staff to effectively:

- conduct its business and operations;
- discharge its responsibilities;
- maintain relations with the Hospital's Board and administration; and
- establish working relationships with Medical Staff members and allied health personnel granted clinical privileges;

b) Serve as the formal organizational structure for developing mechanisms for monitoring the professional performance and ethical conduct of its members and any allied health personnel granted clinical privileges and for reporting such activities to the Board; and

c) Provide the structure and procedures necessary for the Medical Staff to effectively participate in the Hospital's policy-making and planning processes related to patient care.

2.2 Responsibilities of the Medical Staff

The responsibilities of the Medical Staff, which responsibilities may not be delegated, shall be to:

a) Monitor and evaluate the quality of patient care in the Hospital and related facilities and to take action and make recommendations to the Board so that patients admitted to or treated in any of the facilities, departments or services of the Hospital may receive quality medical care consistent with the circumstances and the available resources, manpower and facilities;

b) Make recommendations to the Board concerning the appointment of a practitioner or the reappointment of a member to the Medical Staff and delineate the nature and extent of clinical privileges to be granted to each;

c) Recommend the classifications for allied health personnel and the nature and extent of clinical privileges to be granted;

d) Strive for an acceptable level of professional performance of all practitioners and allied health personnel authorized to practice in the Hospital through:

- The appropriate delineation of the clinical privileges that each practitioner or allied health personnel may exercise in the Hospital; and
- An ongoing review and evaluation of the performance of each practitioner or limited health personnel.

e) Provide an appropriate educational setting and offer continuing medical education programs for members of the Medical Staff and Hospital personnel to maintain scientific standards and to enhance advancement in professional knowledge and skill, the content of such programs to be determined in part by educational needs identified through Medical Staff peer review procedures; and

f) Participate as determined appropriate by the Medical Staff in the identification of community health needs and in any subsequent development and operation of health care programs intended to meet such identified needs.

2.3 Exclusion of Patients' Third Party Beneficiary Rights

It is not the intention of any provision of these Bylaws, the Medical Staff, its members, the Hospital, its governing body or its administrative staff to grant to any patient any right of recovery as a third-party beneficiary.

ARTICLE III.
MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the UPMC Pinnacle Carlisle Medical Staff is a privilege that shall be extended only to professionally competent physicians (M.D. and D.O.), dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the UPMC Pinnacle Carlisle Medical Staff.

3.2 Qualifications for Membership

3.2-1 Specific qualifications for membership are delineated in Article VI of these Bylaws.

3.2-2 General qualifications include evidence of the following:

a.) current licensure

b.) adequate education, training, experience and evidence of current competence and sound clinical judgment to warrant all privileges requested;

c.) the ability to safely and competently meet the obligations of the Medical Staff category requested;

d.) demonstration to the satisfaction of the Medical Staff and Board that patients applicant may treat can reasonably expect quality medical care;

e.) willingness to properly discharge the responsibilities established by the Medical Staff and Hospital;

f.) ability to provide, to the satisfaction of the Medical Executive Committee (MEC), continuous patient care coverage and to respond adequately to patient care emergencies as well as specify an arrangement for alternative coverage when the member will not be available;

g.) the applicant is requesting privileges in a specialty which is not subjected to an exclusive contract granted by the Board;

h.) compliance with professional liability insurance requirements as set out in these Bylaws or in Medical Staff policies;

i.) an ability and willingness to work cooperatively with other clinicians and Hospital staff in a professional manner and in compliance with established Medical Staff and Hospital policies; and

j.) compliance with any other criteria for eligibility that may be recommended by the MEC and approved by the Board.

3.3 Nondiscrimination

UPMC Pinnacle Carlisle will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care, or on any other basis prohibited by applicable law, to the extent the Applicant is otherwise qualified.

3.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and Reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

3.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and Clinical Privileges will be processed only when the potential Applicant meets the current minimum qualifying criteria approved by the Board. Requested Clinical Privileges will be considered only when the request demonstrates compliance with any threshold criteria recommended by the MEC and approved by the Board. In the event there is a request for a clinical privilege for which there are no approved criteria, the Board, with input from the MEC and hospital administration, will first determine if it will allow the privilege to be practiced at UPMC Pinnacle Carlisle and, if so, direct the MEC to promptly develop privileging criteria by considering required licensure, relevant training or experience, current competence, and ability to perform the privilege requested. Once specific criteria for the Clinical Privilege have been recommended by the MEC and approved by the Board, the request for the Clinical Privilege will be evaluated as described in Article VI of these Bylaws.

3.6 Responsibilities of Each Medical Staff Member

3.6-1 Each staff member must provide appropriate, timely, and continuous care of his/her patients.

3.6-2 Each staff member must participate, as assigned, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions as may be required.

3.6-3 Each Active Staff member, unless specifically exempted by these Bylaws or the MEC and Board, must participate in the on call coverage of the emergency department and other coverage programs as recommended by the MEC and approved by the Board.

3.6-4 This obligation will cease upon the attainment of 60 years of age and specific written request by the practitioner.

3.6-5 Each staff member must submit to an appropriate health evaluation as requested by an officer of the Medical Staff and/or Department Chair when deemed necessary to protect the well-being of patients or staff, when requested by the MEC or Credentials Committee as part of an investigation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any hospital or Medical Staff policies addressing physician health or impairment.

3.6-6 Each staff member shall promptly notify the President of the Medical Staff of any physical or mental disability which impairs his/her ability to meet the obligations imposed by these Bylaws.

3.6-7 Each staff member must abide by the Bylaws, rules and regulations, and other policies, procedures, and plans of the Hospital and the Medical Staff, including but not limited to the Medical Staff and hospital policies on professional conduct and behavior.

3.6-8 Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board.

3.6-9 Each physician who is a member of the hospital's medical staff agrees, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the Hospital, any ownership or investment interest in the Hospital that is held by the physician or by an immediate family member (as defined by §411.351*) of the physician. Disclosure must be required at the time the referral is made.

* *Immediate family member or member of a physician's immediate family* means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

3.7 Medical Staff Member Rights

3.7-1 Each member of the medical staff in the active category has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event such Practitioner is unable to resolve a matter of concern after working with his Department Chair or other appropriate medical staff leader(s), that Practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

3.7-2 Each member of the medical staff in the active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Article IV, Section, 7 of these Bylaws, regarding removal and resignation from office.

3.7-3 Each member of the medical staff in the active category may call a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty percent (20%) of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

3.7-4 Each member of the medical staff in the active category may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by twenty (20%) of the active category. When the MEC has received such petition, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

3.7-5 Each member of the medical staff in the active category may call for a Department meeting by presenting a petition signed by twenty percent (20%) of the members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

3.7-6 The above sections 7.1 - 7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical Privileges, or any other matter relating to individual membership or privileges. Section 8.7 and Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provide recourse in these matters.

3.8 Staff Dues / Assessments

3.8-1 Annual Medical Staff dues and education assessments, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The Medical Executive Committee may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

3.9 Indemnification

3.9-1 Members of the medical staff of UPMC Pinnacle Carlisle are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff.

3.9-2 Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

ARTICLE IV.
CATEGORIES OF THE MEDICAL STAFF

4.1 Categories

The categories of the Medical Staff shall be: Active, Associate, Community Care, Consulting and Emeritus. The MEC shall recommend to the Board during the appointment and reappointment process the appropriate category of the Medical Staff for each member.

4.2 Active Staff

4.2-1 Qualifications

Members of the Active Staff are physicians, dentists and podiatrists who are regularly involved in the care of patients in the hospital, and the first year of which shall be on provisional status except as otherwise provided herein, and who otherwise meet the qualifications prescribed in these Bylaws. Members of the Active Staff who have admitting privileges or perform on any "on call" basis, must live and practice within a reasonable distance from the hospital in order to provide continuous care to and supervision of their patients.

In the event that an appointee to the active category does not meet the qualifications for reappointment to the active category, and if the appointee is otherwise abiding by all Bylaws, Rules, Regulations, and policies of the staff, the appointee may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

4.2-2 Prerogatives

The prerogatives of an Active Staff member shall be:

(a) Exercise such clinical Privileges as are granted by the Board

(b) Vote on all matters presented by the Medical Staff and by the appropriate Department and committee(s) to which the appointee is assigned.

(c) Hold office and sit on or be the chairperson of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

4.2-3 Responsibilities

The responsibilities of an Active Staff member shall be:

a) Contribute to the organizational and administrative affairs of the Medical Staff.

b) Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of other staff functions as may be required.

c) Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures

d) Pay yearly educational assessments as established by the MEC

e) Pay yearly Medical Staff Dues as established by the MEC

f) Maintain a primary office location within the Carlisle Medical Service Area

g) Reside within a reasonable distance from the hospital for on-call purposes.

4.3 Associate Staff

4.3-1 Qualifications

The Associate category is reserved for all Medical Staff members who do not meet the eligibility requirements for the Active category or choose not to pursue Active status. Criteria for this category are:

a) Meet the basic qualifications set forth in Article III, Section 2.2
b) Have no more than 20 patient encounters in a calendar year
c) Have practices which are primarily office based and located within the Carlisle Medical Service area.

4.3-2 Prerogatives

The prerogatives of an Associate Staff member shall be:

a) Exercise such clinical privileges as are granted by the Board;

b) Attend Medical Staff meetings and Department meetings of which he or she is an appointee and any staff or hospital education programs.

c) May not vote on matters before the entire Medical Staff or be an Officer of the Medical Staff; and

d) May serve on Medical Staff Committees other than the Medical Executive Committee and may serve as chair and vote on matters that come before such committees.

4.3-3 Responsibilities

Each member of the Associate Staff shall:

a) Contribute to the organizational and administrative affairs of the Medical Staff.

b) Actively participate as required or required in activities and functions of the Medical Staff including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities and in the discharge of other staff functions as may be required.

c) Pay yearly educational assessments as established by the MEC;

d) Pay yearly dues as established by the MEC;

e) Fulfill or comply with any applicable Hospital or Medical Staff policies and procedures

4.4 Community Care Staff

4.4-1 Qualifications

The Community Care Staff shall consist of practitioners each of whom:

a) Wish to be affiliated with the Hospital;

b) Refer patients to members of the Active and Associate Staff but who do not admit or treat patients in the Hospital.

c) May not admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the Hospital and shall not have delineated clinical privileges.

4.4-2 Prerogatives

The prerogatives of a Community Care Staff member shall be:

a) Visit their patients in the hospital;

b) Review medical records and enter progress notes into the medical record which are confined to information concerning patient history and information which is contained in the office records of the practitioner;

c) Attend Medical Staff department meetings, CME functions and social events;

d) Not be eligible for clinical privileges and may not manage patients in the hospital;

e) May vote at Medical Staff, committee or departmental meetings

f) May hold Departmental office.

4.4-3 Responsibilities

Each member of the Community Care Staff shall:

a) Fulfill or comply with any applicable Hospital or Medical Staff policies and procedures;

b) Pay yearly educational assessments as established by the MEC;

c) Pay yearly dues as established by the MEC.

4.5 Consulting Staff

4.5-1 Procedure

Consulting Staff privileges may be extended in accordance with the following procedure:

a) Initial application to the Consulting Staff will be reviewed by the Credentials Committee to determine if the physician's specialty is acceptable as a consultative service. Consultative Service is outlined as a specialty that may contribute unique areas of medical expertise but does not require routine day to day primary and specialty management.

b) If the decision is made that the specialty is not appropriate for the Consulting Staff category, the applicant will be advised that they will be considered for Active Staff membership.

4.5-2 Qualifications

Consulting Staff shall:

a) Meet the requirements for membership to the Medical Staff as outlined in Article III, Section 2.2 of these Bylaws.

4.5-3 Prerogatives

Members of the Consulting Staff may:

a) Exercise such clinical privileges as are granted by the Board

b) Not admit patients to the hospital;

c) Not be eligible to vote or hold office but are encouraged to attend meetings of the Medical Staff.

4.5-4 Responsibilities

The responsibilities of a Consulting Staff member shall be:

a) To answer requests for consultation;

b) Exempted from the requirement to take call;

c) Pay yearly educational assessments as established by the MEC;

d) Pay yearly dues as established by the MEC.

4.6 Emeritus Staff

4.6-1 Qualifications

The Emeritus Staff is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Reappointment to this category is not necessary, as appointees are not eligible for clinical privileges.

Appointees to the Emeritus Staff shall consist of:

a) Practitioners who have retired from active hospital practice;
b) Practitioners who are of outstanding reputation;
c) Practitioners who have provided distinguished service to the hospital.

4.6-2 Prerogatives

Members of the Emeritus Staff may:

a) Attend Medical Staff and departmental meetings;

b) Attend continuing medical education activities and social events;

c) Be appointed to committees;

d) Not hold office or be eligible to vote.

4.6-3 Responsibilities

Members of the Emeritus Staff:

a) Do not have clinical privileges;

b) Are exempt from the requirement to take call;

c) Are exempt from paying Medical Staff dues and educational assessments.

ARTICLE V.
ALLIED HEALTH PERSONNEL

5.1 Definitions

5.1-1 Independent Allied Health Personnel

For the purposes of these Bylaws, an independent allied health personnel is an individual other than a licensed practitioner who: (1) is duly licensed by the appropriate professional licensing board of the Pennsylvania Department of State; (2) is authorized by Pennsylvania law to provide specific patient care services without direct physician supervision; and (3) qualifies for an independent allied health personnel category recommended by the Medical Staff and established by action of the Board.

5.1-2 Dependent Allied Health Personnel

For the purpose of these Bylaws, dependent allied health personnel are individuals, other than licensed practitioners and independent allied health personnel, who: (1) are duly qualified by training, experience and certification and/or licensure to provide specific patient care services under the direct supervision of a physician member of the Medical Staff; (2) are either employed by a member of the Medical Staff or by the Hospital; and (3) qualify for a dependent allied health personnel category recommended by the Medical Staff and established by action of the Board.

5.2 Categories for Allied Health Personnel

When it is recommended by the Medical Staff and approved by the Hospital's Board that the services of any recognized allied health personnel are proper and necessary to the Hospital's function and patient treatment and that the Hospital has the necessary facilities and supportive services available the Board may establish a category for the particular discipline of allied health personnel in question.

5.3 Clinical Privileges

Individuals who qualify as allied health personnel, in any category established by the Board, may be granted specific clinical privileges in accordance with credentialing procedures recommended by the MEC and approved by the Board. Such clinical privileges shall be recommended by the MEC and approved by the Board, such approval to be consistent with applicable State licensing statutes and regulations and recognized education, training, certification, and/or licensure, experience, demonstrated competence and judgment. Clinical privileges granted to allied health personnel shall be specifically delineated and need not include all modes of treatment or surgery that may be within the definition of the practice of any particular allied health personnel as set forth in Pennsylvania statutes.

5.4 Rights and Responsibilities

The rights and responsibilities of allied health personnel shall be recommended by the MEC and approved by the Board as necessary to govern the activities of allied health personnel for which the board has specified a category.

5.5 Clinical Evaluation and Assignment to Department

Each allied health personnel shall be assigned to the department recommended by the MEC that is most appropriate to the clinical privileges granted. The clinical performance of each allied health personnel shall be monitored and evaluated according to departmental performance monitoring and activities.

5.6 General Conditions and Principles

5.6-1 Credentials

The credentials of all allied health personnel shall be kept current in accordance with credentials policies.

5.6-2 Identification

All allied health personnel shall wear identifying badges indicating their titles as designated and required by the Pennsylvania Department of Health.

5.6-3 Medical Staff Bylaws, Rules and Regulations

Allied health personnel shall agree in writing to comply with those aspects of the Medical Staff Bylaws and rules, regulations, and policies, departmental rules and regulations, and Hospital policies that logically pertain to them.

5.6-4 Liability Insurance

The allied health personnel must show evidence of adequate professional liability coverage as required by the Board.

5.6-5 Membership Status

Allied health personnel are not eligible for membership on the Medical Staff and, therefore, are not entitled to the rights and privileges of Medical Staff membership, unless specifically provided for in these Bylaws.

5.6-6 Dues and Assessments

Allied health professionals may be assessed dues by the Hospital to help defray the costs involved in processing applications, monitoring performance, and general administration of the Medical Staff including the offering of educational programs.

5.6-7 Regulatory Compliance

Both allied health professionals, and where applicable, their employers are responsible for complying with appropriate statues and regulations of the Commonwealth.

5.6-8 Termination

a) Independent Allied Health Personnel

The President of the Medical Staff or the President of the Hospital may suspend the clinical privileges of an independent allied health professional whenever such action must be taken immediately to protect a patient's health and welfare and/or the safety of hospital employees and the public or to assure the continued effective operation of the hospital. Such suspension may be for a period of up to thirty (30) days, during which time the suspension will be reviewed by the MEC which will recommend disposition of the case for final action by the Board, which may include, without limitation, termination of the Independent Allied Health Professional's Clinical Privileges. The Independent Allied Health Professional shall have procedural rights as defined in Section 5.8.

b) Dependent Allied Health Professionals

Clinical functions of dependent allied health professionals employed by a member of the Medical Staff may be terminated immediately for any of the following reasons:

(1) termination of Medical Staff appointment of the employer or the termination or expiration of the employer's registration with the appropriate Pennsylvania professional licensing board;
(2) curtailment of the employer's clinical privileges to the extent that the services of the individual are no longer necessary or permissible to assist the employer;
(3) termination of employment of the dependent allied health professional;
(4) loss by the dependent allied health professional of professional liability insurance coverage, licensure, certification, or other regulatory status in the Commonwealth of Pennsylvania;

(5) recommendation of the MEC with the approval of the Board; or

(6) action of any two (2) of the following: The President of the Medical Staff (or his/her designee), the President of the Hospital, who may suspend the clinical functions of a dependent allied health professional for a period of up to thirty (30) days when there is potential harm to the health and welfare of patients, employees and/or others associated with the Hospital. Such suspension will be reviewed by the MEC which will recommend disposition of the case for final action by the Board. The Dependent Allied Health Professional shall have procedure rights as defined in Section 5.8.

Whenever a Dependent Allied Health Professional terminates his employment with a physician member of the Medical Staff, the Allied Health Professional and physician employer shall provide immediate written notice to the President of the Medical Staff.

5.7 Allied Health Personnel Committee

When it is necessary to comply with statutes and regulations of the Commonwealth, the Medical Staff shall organize a Allied Health Personnel Committee which will be responsible for recommending policies and procedures pertaining to the scope and circumstances of the practice of allied health personnel.

5.8 Corrective Action and Hearing Procedure for Allied Health Professionals

An Allied Health Professional whose application is disapproved or whose privileges are restricted, suspended, or revoked may request a hearing concerning such adverse action in accordance with the following procedure:

(1) Notice of the adverse action shall be given to the Allied Health Professional and the physician employer of a dependent Allied Health Professional by the President of the Hospital. The notice shall inform the Allied Health Professional of his entitlement to a hearing and that such hearing shall be waived unless requested by written notice delivered to the President of Hospital within seven (7) calendar days thereafter.

(2) When a hearing is timely requested, the President of the Hospital shall give the Allied Health Professional written notice informing him of the time and place of the hearing, the composition of the hearing committee appointed by President of the Medical Staff and the President of the Hospital, and the reasons or basis for the adverse action. The Allied Health Professional requesting a hearing must appear in person at the designated time and place, and failure to do so waives any further procedure or rights under this Article.

(3) The hearing shall be conducted before a committee that includes a representative member of the Board and two (2) members of the Medical Staff. The member of the Board shall preside the hearing, and the hearing committee in the performance of its duties shall exercise the authority and discretion of the Board delegated by its approval of this Section.

a) A Medical Staff representative shall present appropriate evidence and support of the adverse action, and the Allied Health Professional shall thereafter be responsible for supporting his challenge to the adverse action by an appropriate showing that the reasons or basis for the adverse action lack any factual basis of that such basis or any action based thereon is arbitrary, unreasonable, or capricious.

b) The objective of the hearing shall be to reach a fundamentally fair result. The immediate interests of patients and the Hospital, the quality of the care provided, and the efficiency of Hospital operation shall be considered as well as the interests of the Allied Health Professional.

(4) The parties may call and examine witnesses, introduce written evidence, cross-examine any witness regarding any relevant matter, and make opening statements and summations. The Allied Health Professional may be required to testify under cross-examination even though he does not choose to testify on his own behalf. The hearing need not be conducted strictly in accordance with rules of evidence or procedure applicable to courts of law. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered. A record of the hearing shall be kept. The hearing committee may recess and reconvene at reasonable times. Upon conclusion of the presentation of evidence, the hearing shall be closed and the hearing committee shall transmit its written decision based on the record to the President of the Hospital, who shall promptly inform the Allied Health Professional, physician employer (for a dependent Allied Health Professional), MEC, and the Board. The decision of the hearing committee shall be final.

ARTICLE VI.
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 General Procedure

The Medical Executive Committee, through the designated departments, committees and officers of the Medical Staff, shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of Medical Staff membership status or privileges and shall adopt and transmit recommendations thereon to the Board. The MEC shall perform the same investigation, evaluation, and recommendation functions in connection with any allied health personnel or other individual who seeks to exercise clinical privileges or provide specified services in any department or service of the hospital, whether or not such individual is eligible for Medical Staff membership.

6.2 Application for Initial Appointment

6.2-1 Application Form

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form, and signed by the applicant. When a practitioner requests an application form, he shall be given a copy of the Medical Staff Bylaws, the Bylaws of the hospital, the Medical Staff rules, regulations, policies and departmental policies.

6.2-2 Content

The application form shall include:

a) Acknowledgment and Agreement: A statement that the applicant has received (or has had access to) and read the Bylaws, rules, regulations, policies, and departmental policies and that he agrees to be bound by the terms thereof if he is granted membership and /or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted membership and/or clinical privileges.

b) Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Section 3.2-2 and of any additional qualifications specified in these Bylaws for the particular medical staff category to which the applicant requests appointment.

c) Privileges:

- A statement of the department and clinical privileges for which the applicant wishes to be considered; and
- A statement of the department and clinical privileges which he currently possesses and the identity of the institution.

d) References: The names of at least three (3) persons who have recently worked with the applicant in a supervisory capacity and directly observed his professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character, and ability to work with others as related to the specific privileges requested. Additionally, a reference will be required from the applicant's current department chairman, and, if appropriate, from the applicant's previous department chairman (or designee).

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

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

If any such actions ever occurred or are pending, the particulars thereof shall be included.

f) Professional Liability Insurance: A statement that the applicant carries professional liability insurance coverage required by Commonwealth of Pennsylvania and/or Board, whichever is greater, the identity of his insurance carrier for the previous five year period, and information on his malpractice claims history, including any settlements or verdicts, which statement shall also include a consent to the release of information by his present and past malpractice insurance carrier(s).

g) Administrative Remedies: A statement whereby the practitioner agrees that if an adverse ruling is made with respect to his appointment to the staff, staff membership, staff status, and/or clinical privileges, he shall first exhaust the administrative remedies afforded by these Bylaws.

6.2-3 Effect of Application and Consent

A separate consent form setting forth the following agreements shall form a part of the application and shall be signed by the applicant. By applying for appointment to the Medical Staff, each applicant:

a) Signifies his willingness to appear for interviews in regard to his application, and to submit to a physical and/or psychiatric examination;

b) Authorizes hospital and/or medical staff representatives to consult with members of the medical staffs of other hospitals or institutions with which the applicant has been associated and with others who may have information bearing on his competence, character, ethical qualifications and ability to work with others;

c) Consents to hospital and/or medical staff representatives inspecting all records and documents that may be important to an evaluation of his professional qualifications and competence to carry out the clinical privileges he requests, of his physical and mental health status, and of his professional ethical qualifications;

d) Releases from any liability all hospital and/or medical staff representatives for their acts performed in good faith in connection with evaluating the applicant and his credentials;

e) Releases from any liability all individuals, corporations, health care institutions and organizations, or their representatives, who provide information, including otherwise privileged or confidential information, to hospital and/or medical staff representatives in good faith concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;

f) Authorizes and consents to hospital and/or medical staff representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the hospital may have concerning him, and releases hospital and/or medical staff representatives from liability for so doing, provided that such furnishing of information is done in good faith.

For the purposes of this Section (6.2) the term "hospital representative" includes the Board, its members and committees; the president of the

hospital or his designee; the medical staff and all medical staff members, departments and committees, and any authorized representative for collecting or evaluating the applicant's credentials and acting upon his application.

6.3 Processing the Application

6.3-1 Applicant's Burden

The applicant shall have the burden of producing adequate information as determined necessary by the hospital and the MEC for a proper evaluation of his experience, background, training, demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.3-1. The absence of such information shall constitute an incomplete application which need not be processed until such time as the applicant fulfills the responsibility to provide the information or cause it to be provided, unless the absence of same is waived or both the hospital and the MEC for cause shown.

If the physician fails to complete his application within 60 days of notification that his application is incomplete, the application will be deemed to have been withdrawn.

6.3-2 President Action

The applicant shall deliver a completed application to the president of the hospital who shall submit the application and any supporting materials to the Medical Staff Services Coordinator.

6.3-3 Initial Action

Upon receipt in the Medical Staff Office, the application shall be referred to the Credentials Committee of the Medical Staff for the action described herein.

6.3-4 Credentials Committee Action

a) Within thirty (30) days after receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the MEC. This period may be extended by a reasonable period of additional days if required by the Credentials Committee to complete its investigation.

b) Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, ethical standing and ability to work with other and

shall determine, through information contained in references given by the practitioner and form other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the practitioner has established and meets all the necessary qualifications for the category of staff membership and the privileges requested by him. The Credentials Committee or a member thereof may further conduct at least one personal interview with applicant either on site, or via telephone if the applicant has already been on site. The committee may require a physical and/or psychiatric evaluation.

c) The department chairman for every department in which the practitioner seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for delineating the practitioner's clinical privileges, taking into account the qualifications of the applicant and the facilities and resources of the hospital, and these recommendations shall be made a part of the report.

d) The Credentials Committee report shall transmit to the MEC the completed application and a recommendation that the practitioner be either appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration. If the recommendation is for rejection, the Credentials Committee shall set forth the specific reasons for such rejection.

6.3-5 Medical Executive Committee Action

At its next regular meeting after receipt of the completed application, report, and recommendations of the Credentials Committee, the MEC shall determine whether to recommend to the Board that the practitioner be appointed to the Medical Staff, that he be rejected for Medical Staff membership or that his application be deferred for further consideration. Only such information as was before the Credentials Committee shall be considered in making recommendation for appointment or rejection.

All recommendations to appoint must specifically recommend the clinical privileges to be granted (which may be qualified by probationary conditions relating to such clinical privileges), the medical staff category to which the appointment is to be made and the medical staff department assigned. A recommendation to reject must state specifically the reasons therefor.

6.3-6 Effect of Medical Executive Committee Action

a) **Deferral** – When the recommendation of the MEC is to defer the application for further consideration, it must be followed within 30 days with either a recommendation for appointment with specified clinical privileges or for rejection for staff membership.

b) **Favorable** - When the recommendation of the MEC is favorable to the applicant, the president of the hospital shall be promptly notified and shall promptly forward it, together with all supporting documentation, to the Board.

c) **Adverse** – When the recommendation of the MEC is adverse to the applicant, either in respect to appointment or clinical privileges, the president of the president of the hospital shall promptly so notify the applicant by certified mail, return receipt requested. Such notice shall include the specific reasons serving as the basis for such adverse recommendation.

No such adverse recommendation shall be forwarded to the Board until after the applicant has exercised, or has been deemed to have waived, his right to a hearing as provided in Article IX of these Bylaws.

6.3-7 Board of Trustees' Action

a) At its next regular meting at least fifteen days after receipt of a favorable recommendation, the Board shall act in the matter, however, the Board shall have the right at all times to defer its action until its next regular meeting. If the Board's action is favorable, the applicant shall be promptly notified by letter by the president of the hospital.

b) If the Board's decision is adverse to the applicant in respect to either appointment or clinical privileges, the president of the hospital shall promptly notify him of such adverse decision by certified mail, return receipt requested, such notice setting forth the reasons therefor, and such adverse decision shall be held in abeyance until the applicant has exercised , or has deemed to have waived, his rights under Article IX of these Bylaws and until there has been compliance with subparagraph (d) of this Section 6.3-7. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none previously existed.

c) At its next regular meeting, after all the applicant's rights under Article IX have been exhausted or waived, the Board shall act in the matter, unless the matter is deferred as in this subsection. The

Board's decision shall be conclusive, except that the Board may defer final determination by referring the matter to the MEC for further consideration. Any such referral to the MEC shall state the reason therefor, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive than an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting at least fifteen days after receipt of such subsequent recommendation and new evidence in the matter, if any, the Board shall make a decision either to appoint the applicant to the Medical Staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

d) Whenever the Board's decision shall be contrary to the recommendation of the MEC, the Board shall submit the matter to an ad hoc joint committee consisting of equal number of members of the Board and the MEC appointed by the chairman and president, respectively. This committee shall review the matter and make a recommendation to the Board which shall consider the committee's recommendation prior to making its final decision.

e) When the Board's decision is final, it shall send notice of such decision through the president of the hospital to the Secretary of the Medical Staff and by certified mail, return receipt requested, to the applicant.

6.4 Medical Staff Reappointment

6.4-1 Term of Appointment

Each Medical Staff member shall be reappointed for a two-year term unless a lesser term is recommended by the MEC and approved by the Board for a specific member. During the alternate year of a two-year appointment, each Medical Staff member shall inform the hospital of any changes in professional status, and provide current copies of his medical license, professional liability insurance and DEA certificate.

6.4-2 Reappointment Application

The MEC shall determine the contents of the Medical Staff reappointment application subject to the approval of the Board.

6.4-3 Reappointment Process

Applications for reappointment and the recommendations of the MEC shall be presented to the President of the Hospital at least one (1) month prior to the appropriate meeting of the Board. The same reporting timetable applies for the submission of the alternate year status certification form.

The Credentials Committee shall, at least 105 days prior to the expiration date of the present medical staff appointment of each medical staff member, provide such staff member with a privilege renewal form for use in considering this reappointment. Each staff member who desires reappointment shall, at least 90 days prior to such expiration date, send his privilege renewal from to the Medical Staff Coordinator.

Failure, without reasonable cause, to so return the form shall be deemed a voluntary resignation from the medical staff and shall result in automatic resignation of membership and privileges at the expiration of the practitioner's current term. This resignation is not reportable to the National Practitioner Data Bank as it is an administrative action.

6.4-4 Department Action

The chairman of the department wherein the practitioner has privileges shall review the privilege renewal form and the staff member's credentials file and shall transmit to the Credentials Committee a report and recommendation that appointment be renewed; renewed with modified staff category, department affiliation and/or clinical privileges designated; or terminated. The chairman may also recommend that the Credentials Committee defer action. Each such report shall satisfy the requirements of Section 6.4-5(b). Any minority views shall also be specified in writing and transmitted with the majority report. The reason for the reduction or termination of privileges shall be specified in writing.

6.4-5 Credentials Committee Action:

The Credentials Committee shall:

a) In consultation with the appropriate department, review all pertinent information including JCAHO and Commonwealth of Pennsylvania requirements for each practitioner for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the ensuing period;

b) Base each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment upon the facilities and resources of the hospital and such member's professional competence and clinical judgment in the treatment of patients, his ethics and conduct, his attendance at Medical Staff meetings and participation in staff affairs, his compliance with the hospital bylaws, the medical staff bylaws, rules, regulations and policies, his compliance with current continuing education requirements of the appropriate professional associations, his cooperation with hospital personnel, his use of the hospital's facilities for his patients, his relationship with other practitioners, and his general attitude toward patients, the hospital and the public;

c) Transmit such recommendations in writing to the MEC. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-6 Medical Executive Committee Action

The MEC action shall be the same as described in Section 6.3-5.

6.4-7 Board Action

Board action shall be the same as described in Section 6.3-7.

6.5 Requests for Modification of Membership Status or Privileges

A Medical Staff member may request, either in connection with reappointment or at any other time, modification of his staff category, department assignment, or clinical privileges by submitting a written application to the Credentials Committee. Such application shall be processed in the same manner as provided in Section 6.4 for reappointment.

6.6 Leave of Absence

6.6-1 Leave Status

A Medical Staff member may, for good cause, obtain a voluntary leave of absence by giving written notice to the Credentials Committee and to the chairman of the department in which he has his principal affiliation for review, recommendation and transmittal to the MEC. The notice must state the approximate period of time of the leave, which may not exceed one year, except for military service. During the period of the leave, the staff member's clinical privileges, prerogatives and responsibilities are suspended. The MEC makes a report and recommendation on the leave to the Board for its final action.

6.2-2 Termination of Leave

The Medical Staff member must, at least 45 days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the Medical Staff Office. The staff member must submit a written summary of relevant activities during the leave and provide evidence of current licensure, DEA and state controlled substances registration, and professional liability insurance coverage. The procedures in Article VI of these Bylaws, as applicable, are followed in evaluating and acting on the reinstatement request.

6.7 Resignation from Medical Staff

6.7-1 Notification: Any practitioner who desires to resign from the Medical Staff must submit his/her letter of resignation within thirty (30) days prior to effective date, through the MEC, stating such request. The MEC shall forward its recommendation to the Board of Trustees.

6.7-2 Obligations: No application for resignation shall be considered until all obligations to the Hospital and/or Medical Staff have been satisfactorily completed by the applicant, including completion of all medical records or arrangements, satisfactory to the Hospital and/or Medical Staff for such conclusion.

6.7-3 Non Compliance: Any practitioner not complying with 6.7-2 shall be considered as having resigned from the Medical Staff with prejudice and this shall be appropriately recorded in the credentials file, included in future reference requests, and reported to regulatory agencies as appropriate.

6.7-4 Reinstatement: Any practitioner who has resigned from the Medical Staff and desires to be reinstated, must reapply and submit a fully completed application, including an application fee.

ARTICLE VII.
DETERMINATION OF CLINICAL PRIVILEGES

7.1 Exercise of Privileges

A practitioner or other professional providing direct clinical services at the hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except as otherwise provided in Section 7.3 and 7.4, be entitled to exercise only those clinical privileges or services specifically granted to him by the Board. Said privileges and services must be within the scope of the license, certificate or other legal credential authorizing him to practice in this Commonwealth and consistent with any restrictions thereon. Clinical privileges shall be consistent with the facilities and resources of the hospital.

7.2 Delineation of Privileges in General

7.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a staff member pursuant to Section 6.5 for granting of additional privileges must be supported by documentation of additional training and/or experience supportive of the request and shall be consistent with the facilities and resources of the hospital.

7.2-2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment, keeping in mind the facilities and resources of the hospital. The basis for determination of privileges at the hospital to be made in connection with periodic reappointment, or otherwise, shall include, in addition to the foregoing, observed clinical performance and the results of the patient care audit and other quality review, evaluation and monitoring activities required by these and the hospital bylaws. Privileges determination shall also be based on the pertinent information obtained from other sources concerning clinical performance, including other institutions and health care facilities where a practitioner exercised clinical privileges.

7.2-3 Procedure

All requests for clinical privileges shall be processed through the Credentials Committee.

7.3 Temporary Privileges

7.3-1 Circumstances

Upon the written concurrence of the chair of the department where the privileges will be exercised and the President of the Medical Staff, the President of the hospital, may grant temporary privileges in the following circumstances:

a) **Pendency of Application**: At least seven days after receipt of a complete application for staff appointment, including a request for specific temporary privileges, an appropriately licensed applicant may be granted temporary admitting and clinical privileges for a maximum period of 120 days, with subsequent renewals not to exceed the pendency of the application. In exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he is assigned and in accordance with the conditions specified in Section 7.3-2. Such grant of temporary privileges may be revoked by any person whose consent was previously secured, at any time according to procedures set forth in these Bylaws.

b) **Care of Specific Patients**: Upon the receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in Section 7.3-2 and shall be restricted to the treatment of not more than six (6) patients in any one-year by any practitioner. In the event such number is exceeded, practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

c) **Locum Tenens**: The president of the hospital may permit a physician serving as a locum tenens for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff. Such privileges may be granted for a period of 120 days, providing his credentials have first been approved by the departmental chair concerned and by the president of the medical staff. The practitioner must be licensed in the Commonwealth of Pennsylvania and agree to abide by Medical Staff Bylaws, Rules and Regulations.

d) **Transfer Teams**: Upon proof of proper licensure and/or verification of same by receiving hospital, emergency privileges may be granted to the personnel of any neonatal or other emergency transfer team from any hospital to which a patient is being transferred from the Carlisle Regional Medical Center. These privileges shall only extend for such a period as shall be required to prepare for and effect such transfer. The member of the Medical Staff transferring said patient shall remain with such team throughout the preparation of the patient for transfer and shall complete and sign the chart upon the discharge of the patient. These emergency privileges are to include organ transplant teams.

7.3-2 Conditions

Temporary privileges shall be granted only when consistent with the facilities and resources of the hospital and when the information that is available, reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement, if any, of Section 8.3-3 regarding professional liability insurance. Special requirements of supervision, consultation, and reporting may be imposed by the chair of the department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he has received, or been given access to, and read the Medical Staff Bylaws, rules, regulations, and policies and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

7.3-3 Termination

The president of the hospital may at any time, upon the recommendation of the president of the Medical Staff or the chair of the department concerned, terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) then under his care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 8.2-1 of these Bylaws, and the same shall be immediately effective. The appropriate departmental chairman, or in his absence, the president of the Medical Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

7.3-4 Rights of Practitioner Having Temporary Privileges

A practitioner shall not be entitled to the procedural rights afforded by Article IX because of his request for temporary privileges is refused or because all or any portion of his temporary privileges are terminated or suspended.

7.4 Emergency Privileges

For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result 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 danger. In the case of an emergency, any practitioner, to the degree permitted by his existing and valid license and regardless of department, staff status or clinical privileges, except that he shall not have had his privileges suspended and such privileges are in such posture at the time, shall be permitted and shall be assisted by hospital personnel in doing everything possible to save the life of a patient or to save a patient from serious harm.

7.5 Disaster Privileges

The Chief Executive Officer of the hospital, Medical Staff President, Medical Staff Vice President or the Administrative Person on call may grant emergency privileges in a disaster for which the emergency management plan has been activated, and the Hospital is unable to meet immediate patient needs. Such emergency privileges shall be granted in compliance with the Hospital's then current disaster credentialing policy.

7.6 History & Physical Examination Privileges

A history and physical examination may be performed and documented by any practitioner holding the clinical privilege to do so which includes MDs/DOs, oral surgeons, podiatrists (limited to a recording of their examination and treatment given), dentists (limited to a recording of their examination and treatment given), Certified Nurse Midwives (CNMs), Nurse Practitioners (NPs), and Physician Assistants (PAs).

A complete history and physical examination shall be documented within 24 hours after admission or prior to surgery whichever comes first. The H&P may be completed in advance, though no more than 30 days before the admission or surgical procedure. If the H&P has been performed within 30 days before admission or surgical procedure, a durable, legible copy of this report may be used in the medical record, provided an interval admission note is recorded in the medical record at the time of admission or prior to the procedure. This process may also be followed for readmissions within 30 days for a related condition.

a) **History & Physical** – This rule and regulation establishes standards for the history and physical examination consistent with legal regulations and accreditation standards. Included are documentation standards for the initial diagnostic evaluation of hospital admissions (inpatient and observation) and in all cases prior to surgery or a procedure requiring anesthesia services, including inpatient, outpatient, or same-day surgeries.

DEFINITIONS:

- **History and Physical Exam (H&P):** the initial assessment of the patient, which documents the current and relevant prior medical history, physical examinations, diagnosis or differential diagnosis, and treatment plan. The assessment should be sufficiently comprehensive to provide the necessary information to plan for appropriate care of the patient.

- **Interval Admission Note:** A note on admission or prior to surgery, describing changes or additions in the patient's history or physical findings which have occurred since the H&P was completed, if the H&P was completed but no more than 30 days before admission.

- **Procedure:** An operation, treatment or test performed in the Operating room (OR) suite, outpatient surgical center, or procedural sedation areas.

- **Complex operative or invasive procedures:**
  - Procedures performed in an operating room
  - Procedures involving anesthesia or monitored anesthesia care

- **Pre-surgical Assessment:** Documented examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment.

POLICY:

1) It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination is performed on patients being admitted for inpatient care, and for operative and complex invasive procedures in an inpatient or outpatient setting.

2) A complete history and physical examination shall be documented within 24 hours after admission or prior to surgery whichever comes first.

3) A history and physical examination may be performed and documented by a qualified physician or Oral and Maxillofacial Surgeon who is a member of the professional staff and who, by virtue of education, training and demonstrated competence, is granted clinical privileges to perform specific diagnostic and therapeutic procedures and who is fully licensed to practice medicine in the State.

4) Physicians and Oral and Maxillofacial Surgeons shall have the privilege of using the short-stay form for patients admitted for minor illnesses or minor procedures where the anticipated stay is less than 48 hours. In such cases where a stay has to be prolonged by twenty-four (24 hours) because of unforeseen circumstances, the short-stay form shall be acceptable.

5) In the case of an ***emergency*** surgery the physician shall document a medical history, allergies, general physical exam and provisional diagnosis as soon as possible following the procedure.

PROCEDURE:

1) **Timing and Expiration of the History and Physical Exam**

- A complete history and physical examination shall be documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
- The H&P may be completed in advance, though no more than 30 days before the admission. If the H&P has been performed within 30 days before admission, a durable, legible copy of this report may be used in the medical record, provided an interval admission note is recorded in the medical record at the time of admission or prior to the procedure. This process may also be followed for readmissions within 30 days for a related condition.

2) **Content of History and Physical Examination**

- The H&P must contain sufficient information to support the diagnosis or differential diagnosis, justify the treatment plan and facilitate the care after discharge.
- The history and physical exam shall include the following minimal elements:
  i. Chief complaint
  ii. History of present illness
  iii. Past medical history
  iv. Family history, as applicable
  v. Social history, as applicable
  vi. Review of systems
  vii. Physical exam
  viii. Impression/Plan

3) **Documentation of the History and Physical Examination**

- The H&P may be dictated and transcribed, computer generated or handwritten
- The H&P must be legible and documented in a manner so as to be durable and permanent
- The H&P must be signed, dated, and timed by the physician who completed it.

b) **Interval Note** – If the patient is readmitted within a month's time, an interval note, delineating the patient's medical course since discharge and present physical status is acceptable. The physician or qualified licensed individual uses his/her clinical judgment, based upon his/her assessment of the patient's current condition and co-morbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the update assessment needed, as well as the information to be included in the update note in the patient's medical record prior to surgery.

c) **Pre-surgical assessment** – The surgeon uses his/her clinical judgment, based upon his/her assessment of the patient's current condition and co-morbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the pre-surgical assessment needed, as well as the information to be included in the update note in the patient's medical record prior to surgery. It is not acceptable to conduct the surgical exam after the patient has been brought into the operating or procedure room and prepped. The pre-surgical assessment must be conducted separately from the patient's procedure/anesthesia risk assessment.

d) **Discharge** – Patients shall be discharged only on written or verbal order of the attending practitioner or practitioner designated by him. Following discharge, the attending physician shall complete the medical record

7.7 Telemedicine Privileges

a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options.

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in these Bylaws. In such case, the individual must satisfy all qualifications and requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangement, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participate in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) Confirmation that the practitioner is licensed in Pennsylvania

(ii) A current list of privileges granted to the practitioner;

(iii) Information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) A signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) A signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) Any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the Credentials Committee and Medical Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges in ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in these Bylaws and credentials policies.

c) Telemedicine privileges, if granted, shall be for a period of not more than two years.

d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

ARTICLE VIII.
CORRECTIVE ACTION

8.1 Procedure

8.1-1 Requests

Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or objectives of the Medical Staff or the Board or to be disruptive, or detrimental to the operations of the hospital, corrective action against such practitioner may be requested by any officer of the Medical Staff, by the chairman of the any clinical department, by the chairman of any standing committee of the Medical Staff, by the president of the hospital or by the Board. All requests for corrective action shall be in writing, shall be made to the MEC, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.

8.1-2 Initial Action

Whenever the corrective action could result in a reduction or suspension of clinical privileges, the MEC shall forward such request to the chairman of the department wherein the practitioner has privileges. Upon receipt of such request, the chairman of the department shall immediately appoint a departmental ad hoc committee to investigate the matter, unless such department chairman requested corrective action or is the subject of the request, in which case the president of the medical staff shall appoint the departmental ad hoc investigating committee.

In no event shall the chairman of the department wherein the practitioner has privileges be a member of the departmental ad hoc investigating committee.

8.1-3 Department Action

Within thirty days after the department's receipt of the request for corrective action, the departmental ad hoc investigating committee (as appointed by the department chairman or medical staff president) shall make a report of its investigation to the MEC. Prior to the making of such report, the practitioner against whom corrective action has been requested shall receive written notice of all the specific charges against him by certified mail, return receipt requested. The notice shall also instruct the practitioner to appear before the departmental ad hoc investigating committee no sooner than ten (10) days from the date of the notice for an interview with said committee. At such interview he will be invited to discuss, explain or refute the charges against him. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearing shall apply thereto. Written minutes of such interview shall be made by the departmental ad hoc investigation committee and included with its report to the MEC.

8.1-4 Appearance Before Medical Executive Committee

Within sixty days following receipt of a request for corrective action, or following receipt of a report from a department following the department's investigation of a request for corrective action involving reduction or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the MEC. No action on such request shall be taken by the MEC prior to such appearance, unless such appearance is waived. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to hearings shall apply thereto. Written minutes of such appearance shall be made by the MEC. If the person who requested the corrective action is a member of the MEC, such person shall excuse himself from such committee pending resolution of the proceedings.

8.1-5 Medical Executive Committee Action

a) The action of the MEC on a request for corrective action may be to recommend to the Board; to reject or modify the request for corrective action; to issue a warning, a letter of admonition, or a letter of reprimand; to impose terms of probation of a requirement for consultation; to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or to recommend that the practitioner's staff membership be suspended or revoked.

b) Any recommendation by the MEC for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Article IX of these bylaws.

c) The president of the medical staff shall promptly notify the president of the hospital in writing of all requests for corrective action received by the MEC and shall continue to keep the president of the hospital fully informed of all action taken in connection therewith. After the MEC has made its recommendation in the matter, the procedure to be followed shall be as provided in Article IX of these bylaws.

8.2 Summary Suspension

8.2-1 Suspension of Privileges

The president of the medical staff or the president of the hospital shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition. Notice of such suspension shall be given to the affected practitioner as provided in Article IX of these bylaws, and included with such notice shall be a statement of the grounds upon which the suspension was imposed. Such notice shall also be given to the MEC.

8.2-2 Right to Hearing

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the MEC appoint an ad hoc hearing committee of the Medical Staff in accordance with Article IX of these bylaws.

8.2-3 Medical Executive Committee Action

The MEC, after review of the report of the ad hoc hearing committee, may recommend modification, continuance or termination of the terms of the summary suspension. If the MEC does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article IX, be entitled to request an appellate review by the Board, but the terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision thereon by the Board. A person who initiated or imposed the summary suspension may participate in discussion but may not vote.

8.2-4 Alternative Medical Coverage

Immediately upon the imposition of a summary or automatic suspension, the president of the medical staff or responsible department chairman shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner who are still in the hospital at the time of such suspension. The wishes of the patients shall be considered where feasible in the selection of such alternative practitioner.

8.3 Automatic Suspension

8.3-1 Incomplete Medical Records

Medical Records shall be completed within thirty (30) days of a patient's discharge. When a medical record is not completed within twenty (20) days of the patient's discharge, the practitioner will be notified. If the charts are not completed within an additional ten (10) days, the practitioner's clinical and admitting privileges will be suspended until all delinquent charts are completed.

On the day prior to suspension the Medical Records Department will notify the CEO of the hospital, who will, in consultation with the president of the medical staff, and/or their designee(s), notify the practitioner of the impending suspension to be effective at 8:00 AM on the following day. If a practitioner receives two or more suspensions in a 12-month time period, the following monetary fines will be imposed:

Starting with the first day of suspension, the practitioner shall be fined $100.00 per day for the first seven (7) days of the suspension; after seven (7) days, in addition to the daily fine, a $100.00 per delinquent chart fine will be levied.

During the time of the suspension, alternative medical coverage shall be arranged in accordance with Section 8.2-4 of these Bylaws. Reinstatement of clinical and admitting privileges will occur upon completion of all delinquent charts and payment of fines.

If a practitioner is either chronically delinquent in completing medical records or attempts to circumvent suspension for incomplete medical records, the matter shall be referred to the MEC for review and corrective action as indicated.

8.3-2 Medical Licensure

Action by the State Board of Medical Education and Licensure revoking or suspending a practitioner's license, or placing him on probation, shall automatically suspend his hospital privileges. The affected practitioner shall immediately notify the president of the hospital in writing of such action.

8.3-3 Professional Liability Insurance & Catastrophe Loss Fund

The failure of any practitioner to maintain Professional Liability Insurance as required by these bylaws or to pay the surcharge to the Medical Professional Liability Catastrophe Loss Fund as required by law shall automatically suspend such practitioner's hospital privileges.

8.3-4 Enforcement of Suspension

It shall be the duty of the president of the medical staff to cooperate with the president of the hospital in enforcing all automatic suspensions.

ARTICLE IX.
HEARING AND APPELLATE REVIEW PROCEDURE

9.1 Right to Hearing and Appellate Review

9.1-1 Summary Suspension/Adverse Recommendation MEC

When any practitioner receives notice of a summary suspension, or a recommendation of the MEC that if ratified by the Board will adversely affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc hearing committee of the Medical Staff. If the recommendation of the MEC following such hearing is still adverse to the affected practitioner, he shall then be entitled to appellate review. Such appellate review shall be conducted by the Board before it makes a final decision on the matter.

9.1-2 Adverse Recommendation of Board of Trustees

When any practitioner receives notice of a decision of the Board that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, and such decision is not based on prior adverse recommendation by the MEC with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by an ad hoc hearing committee appointed by the Board. If such hearing does not result in a favorable recommendation, then the practitioner shall be entitled to an appellate review by the Board before it makes a final decision on the matter.

9.1-3 Procedural Rights

All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected practitioner is accorded all rights to which he is entitled.

9.2 Request for Hearing

9.2-1 Notice

The president of the hospital shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested, advising such practitioner that a hearing or appellate review as the case may be must be requested within fifteen (15) days or the same shall be deemed to be waived in accordance with Section 9.2-2 of the Medical Staff Bylaws.

9.2-2 Waiver of Right

The failure of a practitioner to request a hearing to which he is entitled by these bylaws, within the time and in the manner herein provided, shall be deemed a waiver of his right to such hearing and to any appellate review to which he might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which he is entitled by these bylaws, within the time and manner herein provided, shall be deemed a waiver of his right to such appellate review of the matter.

9.2-3 Pending Final Decision of Board of Trustees

When the waiver of the hearing or appellate review relates to an adverse recommendation of the MEC or of an ad hoc hearing committee appointed by the Board, the adverse recommendation shall thereupon become and remain effective against the practitioner pending the Board's decision on the matter. When the waiver of the hearing or appellate review relates to an adverse decision by the Board, the adverse decision shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board provided for in Section 9.7 of this Article IX. In either of such events, the president of the hospital shall promptly notify the affected practitioner of his status by certified mail, return receipt requested.

9.3 Notice of Hearing

9.3-1 Scheduling of Hearing

Within fifteen (15) days after receipt of a request for hearing from a practitioner entitled to the same, the MEC or the Board, whichever is appropriate, shall schedule and arrange for such hearing and shall, through the president of the hospital, notify the practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days, nor more than fifty-five (55) days from the date of receipt of the request for hearing. For a practitioner who is under suspension which is then in effect, a hearing shall be held as soon as arrangements may reasonably be made, but not later than ten days from the date of receipt of such practitioner's request for hearing.

9.3-2 Notice to Practitioner

The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

9.4 Composition of Hearing & Appellate Review Committees

9.4-1 Medical Staff Ad Hoc Hearing Committee

When a hearing relates to an adverse recommendation of the MEC, such hearing shall be conducted by an ad hoc hearing committee of not less than five (5) members of the Medical Staff appointed by the president of the medical staff in consultation with the MEC, with one of the members so appointed being designated as chairman. Members of the Medical Staff shall not serve on an ad hoc hearing committee if they were either involved in initiating the corrective action or were members of a body, which formally considered the request for corrective action. In no event shall the chairman of the department wherein the practitioner has privileges be a member of the ad hoc hearing committee.

9.4-2 Board of Trustees Ad Hoc Hearing Committee

When the Board makes an adverse decision that is contrary to the recommendation of the MEC, the Board shall appoint an ad hoc hearing committee to conduct such hearing and shall designate one of the members of this committee as chairman. At least one representative from the Active Medical Staff shall be included on this committee. In no event shall the chairman of the department wherein the practitioner has privileges be a member of the ad hoc hearing committee. Committee members shall not be in violation of the requirements as outlined in Section 9.4-3.

9.4-3 Individuals Prohibited From Membership on the Ad Hoc Hearing and Appellate Review Committee

The following persons shall not be members of the ad hoc hearing or appellate review committee:

- Present patients of the practitioner;
- Members of the immediate family of a person under current regimen of treatment by the practitioner;
- Members of the Board of Trustees except as provided in this Article IX, 9.1-2, 9.3-1, 9.4-2, 9.6, and 9.7 of these bylaws;
- Partners of the practitioner; or
- Persons related by blood or marriage to the practitioner

9.5 Conduct of Hearing

9.5-1 Quorum

There shall be at least a majority of the members of the ad hoc hearing committee present when the hearing takes place, and no member may vote by proxy.

9.5-2 Record of Proceedings

An accurate record of the hearing shall be kept. The mechanism shall be established by the ad hoc hearing committee and may be accomplished by use of a court reporter, electronic recording unit, or detailed transcription.

9.5-3 Presence of Practitioner

The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the manner as provided in 9.2-2 of this Article IX and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 9.2-3 without any further proceedings before the ad hoc hearing committee.

9.5-4 Postponement

Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponement shall only be for good cause shown.

9.5-5 Practitioner's Representative(s)

The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his local professional society.

9.5-6 Presiding Officer

Either a hearing officer, if one is appointed, or the chairman of the ad hoc hearing committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

9.5-7 Conduct

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible upon objection in any civil or criminal actions. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

9.5-8 Medical Staff/Board of Trustees Representatives

The MEC, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter have the obligation of supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis, or any action based thereon, is either arbitrary, unreasonable or capricious.

9.5-9 Rights of Practitioner

The affected practitioner shall have the following rights:

- To call and examine witnesses,
- To introduce written evidence,
- To cross-examine any witness on any matter relevant to the issue of the hearing,
- To challenge any witness,
- To rebut any evidence.

If the practitioner does not testify in his own behalf, he may be called and examined as if under cross-examination.

9.5-10 Representation by Legal Counsel

The hearing provided for in these bylaws is for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, an attorney shall represent neither the affected practitioner, nor the MEC or the Board, at any phase of the hearing procedure. The ad hoc hearing committee may, in its discretion, permit the affected practitioner, the MEC or the Board to be represented in the hearing by an attorney but may also direct that the participation of said attorney shall be limited to advising his client throughout the proceedings, preparation and submission of memoranda and receipt and forwarding notices and responses thereto, however, all oral participation in the hearing would be limited to the practitioner and his witnesses. The foregoing shall not be deemed to deprive the practitioner, the MEC or the Board of the right to legal counsel in connection with preparation for the hearing or for a possible appeal; and if a hearing officer is utilized, he may be an attorney.

9.5-11 Recess/Deliberation

The ad hoc hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The ad hoc hearing committee may

thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

9.5-12 Report and Recommendation of Ad Hoc Hearing Committee

Within fifteen (15) days after final adjournment of the hearing, the ad hoc hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record, if available, and all other documentation to the MEC or to the Board, whichever appointed it. If the transcription of the record is delayed to the extent that it prevents the ad hoc hearing committee from complying with the time constraints of this section, such time periods shall be extended for the period of the delay in receiving the transcription of the record, however, if the ad hoc hearing committee determines that the decision can be made and forwarded without the transcription of the record, it may do so. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC or decision of the Board. Following the MEC decision in relation to this recommendation, the procedure to be followed is as outlined in Article VI, Section 6.3-6. All reasonable effort shall be made by the ad hoc hearing committee to secure the transcript of the record so as not to delay any step in the procedure outlined in these bylaws, however, in the event such transcript is delayed in receipt thereof, the appropriate level of procedure shall be delayed for such reasonable period of time to permit receipt of the transcript. With the consent of the ad hoc hearing committee, the practitioner, the MEC or the Board may waive the receipt of the transcript of the record.

9.6 Appeal to the Board of Trustees

9.6-1 Request for Appellate Review

Within fifteen (15) days after receipt of a notice of an adverse recommendation or decision made or adhered to after a hearing as above provided in Article 9.5-12, the affected practitioner may, by written notice to the Board delivered through the president of the hospital by certified mail, return receipt requested, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supplemented by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

9.6-2 Waiver of Right

If such appellate review is not requested within fifteen days, the affected practitioner shall be deemed to have waived his right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 9.2 of this Article IX.

9.6-3 Scheduling of Appellate Review

Within ten days after receipt of such notice of request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the president of the hospital, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of same. The date of the appellate review shall not be less than twenty (20) days, nor more than forty (40) days, from the date of receipt of the notice of request for appellate review, except that, when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than ten days from the date of receipt of such request for appellate review.

9.6-4 Appellate Review Committee

The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than five members, in whichever manner shall be determined by the Board.

9.6-5 Rights of Practitioner

The affected practitioner shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him.

The practitioner may submit a written statement in his own behalf in which those factual and procedural matters with which he disagrees, and his reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board through the president of the hospital by certified mail, return receipt requested, at least ten days prior to the scheduled date for the appellate review.

A similar statement may be submitted by the MEC or by the chairman of the ad hoc hearing committee appointed by the Board, and, if submitted, the president of the hospital shall provide a copy thereof to the practitioner at least five (5) days prior to the date of such appellate review by certified mail, return receipt requested. If the practitioner requesting review is under a suspension which is then in effect, these time limitations for submitting written statements shall be reduced by the Board or appellate review committee so as not to delay the proceedings.

9.6-6 Conduct of Appellate Review

The Board or its appointed committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted

pursuant to Section 9.6-5, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified, supported by the record and not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body. The MEC or Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.

9.6-7 Presentation of New or Additional Matters

New or additional matters not raised during the original hearing or in the ad hoc hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review level under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

9.6-8 Action of Board of Trustees

If the appellate review is conducted by the Board, it may affirm, modify or reverse its prior decision, or in its discretion, refer the matter back tot he MEC for further review and recommendation within thirty (30) days. Such referral may include a request that the MEC arrange for a further hearing to resolve specified disputed issues.

9.6-9 Action of Appellate Review Committee

If the appellate review is conducted by a committee of the Board, such committee shall, within fifteen (15) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify or reverse its prior decision, or refer the matter back to the MEC for further review and recommendation within thirty (30) days. Such referral may include a request that the MEC arrange for a further hearing to resolve disputed issues. Within fifteen (15) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board as above provided.

9.6-10 Conclusion of Appellate Review

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in 9.6 have been completed or waived. Where permitted by the hospital bylaws, all action required by the Board may be taken by a committee of the Board duly authorized to act.

9.7 Final Decision by the Board of Trustees

9.7-1 Notice of Decision

Within thirty (30) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the MEC and, through the president of the hospital, to the affected practitioner, by certified mail, return receipt requested.

9.7-2 Decision in Accordance with MEC Decision

If the decision of the Board is in accordance with the MEC's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

9.7-3 Decision Contrary to MEC's Decision

If the decision of the Board is contrary to the MEC's last such recommendation, the Board shall refer the matter to a joint committee composed of members of the Board and Medical Staff appointed by the chairman and president of the medical staff respectively, for further review and the submission of a recommendation within thirty (30) days of such reference. A final decision shall not be made until a joint committee recommendation has been received.

9.7-4 Final Decision

At its next meeting at least fifteen (15) days after receipt of a joint committee recommendation, the Board shall make its final decision with like effect and notice shall be given as first above provided in this Section 9.7-1.

9.8 Right to Additional Hearings/Appellate Review

Notwithstanding any other provision of these bylaws, no practitioner shall be entitled as a matter of right to more than one hearing and one appellate review on any matter which shall have been the subject of an action by the MEC or the Board, or by a duly authorized committee of the Board, or any joint committee or action thereof. No provision of these bylaws shall be construed to grant any right to additional hearings or appellate review and in the event of an ambiguity in regard to same, such ambiguity shall be construed in favor of the grant of only one hearing and one appellate review.

9.9 Rights of Hospital Employed Practitioners

Any physician or dentist whose employment by the hospital requires membership on the Medical Staff, as described elsewhere in these bylaws, shall not have his Medical Staff membership and privileges terminated without the same due process provisions as must be provided for any other member of the Medical Staff. The foregoing provision shall not be construed to require that such due process provisions be applied to the termination or modification of such physician's or dentist's employment relationship with the hospital, which relationship shall be governed solely by the terms of such employment agreement.

ARTICLE X.
MEDICAL STAFF ORGANIZATION

The Medical Staff shall be organized according to these Bylaws and related rules, regulations and policies. The Medical Staff membership shall serve as the governing body of the Medical Staff with duties and responsibilities delegated to officers, committees and departments as specified in these Bylaws and related rules, regulations and policies. The operation of the Medical Staff shall be funded by dues, educational assessments and funds received from other appropriate sources.

The Medical Staff shall be organized as follows:

10.1 Officers

The officers of the Medical Staff shall be elected and perform such functions as are described in Article XI.

10.2 Committees

Committees of the Medical Staff shall be organized and function according to the provisions of Article XII.

10.3 Clinical Departments

Clinical departments shall be organized and function according to the provisions of Article XIII.

10.4 Dues and Educational Assessments

Reasonable Medical Staff dues and educational assessment shall be established annually by vote of the Medical Staff. Medical Staff dues and educational assessments collected shall be placed in accounts or depositories designated by the Medical Staff and shall be used as determined appropriate by the Medical Staff to support Medical Staff operations and the accomplishment of its purposes, duties and responsibilities, as described in these Bylaws, and planned Medical Staff educational activities.

ARTICLE XI.
OFFICERS

11.1 Officers of the Medical Staff

11.1-1 Identification

The officers of the Medical Staff shall be:

(a) President
(b) Vice President
(c) Secretary/Treasurer

11.1-2 Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

11.1-3 Election and Terms of Office

Officers shall be elected at the Annual Meeting of the Medical Staff. The President and Vice President shall be elected to a two (2) year term and shall be eligible to serve two consecutive (2) year terms except in situations where the Vice President serves an unexpired term as President, such service not to be counted as part of a term in the office of President. The Secretary/Treasurer shall be elected for a term of three (3) years and may serve two (2) consecutive terms.

11.1-4 Removal of Elected Officers

Except as otherwise provided, Medical Staff officers may be removed by a 75% vote of all members of the Medical Staff eligible to vote for Medical Staff officers. Conditions for removal include an officer accused of gross, or willful neglect of the duties of his office, or any failure in conduct or other qualifications which might also impair or result in suspension or revocation of privileges or membership on the Medical Staff.

11.1-5 Vacancies in Elected Office

If there is a vacancy in the office of President, the Vice President shall serve out the remaining term. A vacancy in the office of Vice President, Secretary/Treasurer, or Executive Committee shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible but not to exceed two Medical Staff business meetings.

11.2 Duties of Officers

11.2-1 President

The President shall serve as the chief medical officer of the hospital. As the principal elected official of the Medical Staff, the President shall:

(a) Aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the Medical Staff;
(b) Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the hospital president, and other officials of the staff;
(c) Be responsible for the enforcement of medical staff bylaws, rules, regulations and policies, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
(d) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
(e) Serve as chairman of the Medical Staff Executive Committee, and as an ex-officio member of all other staff committees; and
(f) Make annual Medical Staff committee appointments, designate committee chairmen, and diagnostic and treatment services chairmen.

11.2-2 Vice President

In the absence (temporary or permanent) of the President, he shall assume all the duties as may be assigned to him by the President.

11.2-3 Secretary-Treasurer

(a) Give proper notice of all staff meetings on order of the appropriate authority;
(b) Keep accurate and complete minutes of all Medical Executive Committee and general staff meetings;
(c) Supervise the collection and accounting for any funds that may be collected in the form of staff dues and assessments; and
(d) Attend to all correspondence and perform such other duties as ordinarily pertain to his office.

11.3 Chain of Command

The chain of command for Medical Staff officers shall be: president, vice president, most senior member of the Medical Executive Committee (as determined by the longest consecutive term of office). In the event of equal seniority, the secretary-treasurer will take precedence.

ARTICLE XII.
COMMITTEES AND FUNCTIONS

12.1 Designation

12.1-1

The Medical Staff shall be organized under a committee structure, headed by a Medical Executive Committee (MEC). There will be a number of standing committees and special committees of the Medical Staff to perform the Medical Staff functions. Those committees deemed necessary will be formed by direction of the Medical Staff, by the Medical Executive Committee, or by the President of the Medical Staff.

12.1-2

As an additional function of the Medical Staff, there will be expected participation of Medical Staff members on hospital committees. The attendance requirement shall be equal to the Medical Staff committee obligation.

12.1-3 Mandatory Committees

The following committees of the Medical Staff are mandatory:

a) Medical Executive Committee (12.2)
b) Constitution and Bylaws Committee (12.3)
c) Credentials Committee (12.4)
d) Infections Committee (12.5)
e) Medical Education & Library Committee (12.6)
f) Medical Records Committee (12.7)
g) Medical Staff Health Committee (12.8)
h) Medical Staff Planning Committee (12.9)
i) Medical Staff Quality & Peer Review Committee (12.10)
j) Pharmacy & Therapeutics Committee (12.11)
k) Radioisotope & Radiation Safety Committee (12.12)
l) Utilization Management Committee (12.13)

12.1-4 Other Committees

There are other standing committees of the Medical Staff whose purpose, composition, duties, and meeting requirements are defined in the Medical Staff Policy and Procedure Manual. It is the responsibility of the Medical Executive Committee to maintain and review annually these committee guidelines. Any revisions to the Medical Staff Policy and Procedure Manual must be approved by the MEC and the Board.

12.1-5 Special Committees

Special committees shall be appointed from time to time as may be required to properly carry out the duties of the Medical Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Medical Executive Committee. They shall not have power of action unless such is specifically granted.

12.1-6 Committee Assignments

Unless otherwise stated, all committee assignment and designation of committee chairmen shall be made annually by the President of the Medical Staff.

12.1-7 Meetings

Unless otherwise specified, all committees shall meet at the call of the chairman, but often enough to adequately work on committee business and to meet regulatory and accrediting agency requirements.

12.1-8 Reports

The reports of each committee shall be in written form and submitted to the MEC and forwarded to the Medical Staff when deemed appropriate unless other reporting arrangement are specifically stated in these Bylaws.

12.1-9 Voting

Voting members of the committees shall consist of its Medical Staff members. Participation by individuals other than Medical Staff members on committees shall be consultative advisory services.

12.1-10 Administrative Staff

The president of the hospital may, with the concurrence of the Medical Staff President, assign administrative personnel to committees where their administrative responsibilities are relevant to a committee's functions.

MANDATORY COMMITTEES

12.2 Medical Executive Committee

12.2-1 Purpose

The purpose of the Medical Executive Committee (MEC) shall be to coordinate and oversee all the activities and policies of the Medical Staff.

12.2-2 Composition

The MEC shall consist of the President (who shall act as chairman), the Vice President, the Secretary-Treasurer as defined in Section 11.1-3, the Immediate Past President of the Medical Staff (two-year term), two (2) members elected at-large and all chairmen of the departments identified in Section 13.1. Each member-at-large shall serve for two (2) years, the term of office so arranged that only one new member shall be elected each year; members at-large may serve a maximum of two consecutive two-year terms. Upon completion of two consecutive terms, no member elected at-large may be re-elected t this committee until at least one (1) year has elapsed after his second term. The Medical Director of the Hospitalist Program shall be a voting member of the MEC. The CEO of the hospital or his designee shall attend each meeting of this committee without vote.

Vacancies: Vacancies on the MEC shall be filled in accordance with Article XI, Section 11.1-5.

Removal: MEC members may be removed by a 75% vote of all members of the Medical Staff eligible to vote. Conditions for removal include a member accused of gross, or willful neglect of their duties as an MEC member, or any failure in conduct or other qualifications which might also impair or result in suspension or revocation of privileges or membership on the Medical Staff.

12.2-3 Duties/Function

The Medical Executive Committee shall:

a) Receive and act upon the reports and recommendations from Medical Staff committees, departments, services, and assigned activity groups;

b) Recommend as required to the Medical Staff and/or Hospital Board all actions relating to Medical Staff appointment, reappointments, staff category, department assignments, clinical privileges and corrective action;

c) Fulfill the Medical Staff's accountability to the Board and make recommendations to the Medical Staff and Board for the overall quality of patient care in the hospital;

d) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating, pursuing and conducting corrective action;

e) Make recommendations on medico-administrative matters;

f) Inform the Medical Staff of the accreditation program and the accreditation status of the hospital and coordinate the Medical Staff' involvement in the accreditation process;

g) Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

h) Represent and act on behalf of the staff, subject to such limitations as may be imposed by these bylaws and the ratification of such action by the Medical Staff at its next regular meeting thereof;

i) Assure that nominations are received from the Medical Staff for all Medical Staff elections

j) The President and Vice President of the Medical Executive Committee shall meet with the Board of Trustees at their general session and communicate to the Board the actions and recommendations of the Medical Staff. In the event of the inability of any member to attend, the Medical Staff president may appoint an alternate from the MEC members.

12.2-4 Meetings

The MEC shall meet at least monthly prior to the business meeting of the Medical Staff and maintain a permanent record of its proceedings and actions. The MEC shall also meet on the call of the president when necessary.

12.3 Constitution and Bylaws Committee

12.3-1 Purpose

The purpose of the Constitution and Bylaws Committee shall be to maintain an appropriate set of Bylaws, Rules & Regulations and policies for the Medical Staff.

12.3-2 Composition

The Constitution and Bylaws Committee shall consist of at least four (4) members of the Medical Staff.

12.3-3 Duties/Function

The Constitution and Bylaws Committee shall:

a) Conduct a review of the Medical Staff Bylaws, Rules and Regulations, at least every two years;

b) Make recommendations to the MEC for revision of the Bylaws, Rules and Regulations, as necessary.

12.3-4 Meetings

The Constitution and Bylaws Committee shall meet at the call of the chairman, but at least annually.

12.4 Credentials Committee

12.4-1 Purpose

The purpose of the Credentials Committee shall be to assure that all credentialed individuals meet standards that are appropriate for their level of hospital activity in accordance with these bylaws, rules, regulations and policies.

12.4-2 Composition

The Credentials Committee shall consist of at least six (6) members of the Medical Staff representative of the major clinical departments.

12.4-3 Duties/Function

The Credentials Committee shall:

a) Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges as described in Articles VI and VII, and in connection therewith obtain and consider the recommendations of the appropriate departments;

b) Review and evaluate the qualifications of each allied health professional applying to perform specified services as described in Article V, and in connection therewith obtain and consider the recommendations of the appropriate departments;

c) Investigate, review and report on issues, including the clinical or ethical conduct of any practitioner, assigned or referred by the President of the Medical Staff or the MEC; and

d) Submit reports monthly to the MEC on the status of pending applications, including the specific reasons for any delay in processing an application or request as per Article VI, Sections 6.3-4 and 6.4-5.

12.4-4 Meetings

The Credentials Committee shall meet at the call of the chairman and report to the MEC and Board of Trustees.

12.5 Infections Committee

12.5-1 Purpose

The purpose of the Infections Committee shall be to monitor the hospital's infection control program and recommend effective measures for the control and prevention of infections.

12.5-2 Composition

The Infections Committee shall be composed of at least four (4) members of the Medical Staff.

12.5-3 Duties/Function

The Infections Committee shall:

a) Recommend the type of infection control surveillance and reporting programs to be used;

b) Recommend standard criteria for reporting all types of infections;

c) Have the authority, through its chairman or physician members, to institute any appropriate control measure or studies when there is reasonably felt to be a danger to any patient or personnel.

12.5-4 Meetings

The Infections Committee shall meet at least quarterly.

12.6 Medical Education and Library Committee

12.6-1 Purpose

The purpose of the Medical Education and Library Committee shall be to organize the continuing education programs of the Medical Staff and supervise the hospital's professional library services.

12.6-2 Composition

The Medical Education and Library Committee shall include at least five (5) members of the Medical Staff.

12.6-3 Duties/Function

The Medical Education and Library Committee shall:

a) Develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings;
b) Evaluate the effectiveness of the educational programs developed and implemented.
c) Analyze the Medical Staff's needs for professional library services;
d) Maintain a record of educational activities; and
e) Supervise the functioning of the Medical Education Director.

12.6-4 Meetings

The Medical Education and Library Committee shall meet at the call of the chairman and report to the MEC.

12.7 Medical Records Committee

12.7-1 Purpose

The purpose of the Medical Records Committee shall be to supervise and evaluate the format, quality and use of the medical record.

12.7-2 Composition

The Medical Records Committee shall be composed of at least five (5) members representative of the departments of the Medical Staff.

12.7-3 Duties/Function

The Medical Records Committee shall be responsible for:

a) Establishing the protocol for evaluating medical record to determine that the records:

- Properly describe the diagnosis, condition and progress of the patient, the tests and therapy provided, the results thereof, the identification of responsibility for all such actions taken, and the condition of the patient at discharge;
- Are clinically pertinent and sufficiently complete at all times so that they may facilitate continuity of care and communications among all those providing patient care services int eh hospital;
- Meet the standards of patient care usefulness and historical validity;
- Are adequate in form and content to permit patient care audit and other quality assurance activities to be performed;
- Assure that safe transfer of physician responsibility will take place if necessary; and
- Are adequate as medico-legal documents.

b) Review Medical Staff and Hospital policies, rules and regulations relating to medical records completion, forms formats, filing, indexing, the use of microfilming, if appropriate, storage and availability, and recommend policy and procedures for access to records;

c) Report to the MEC the names of any Medical Staff members who are persistently or frequently delinquent in the completion of their records;

d) Provide liaison with the Hospital's Medical Records Department;

e) Perform the necessary peer review functions related to medical records including the statistical analysis of the medical records and the financial relationship to the services ordered and/or provided; and

f) Recommend policy and procedures relative to the type and content of all reports derived from medical records and the use, distribution, storage and access to such peer review reports.

12.7-4 Meetings

The committee shall meet at least quarterly month and report its activities and recommendations to the MEC.

12.8 Medical Staff Health Committee

12.8-1 Purpose

The purpose of the Medical Staff Health Committee shall be to ensure a positive medical assistance program to the potentially impaired or impaired practitioner in order to:

- Ensure quality of care for all patients, and
- Maintain a safe environment for patients, employees, and Medical Staff appointees.

12.8-2 Composition

The committee shall be composed of five (5) Medical Staff members with the chairman appointed by the President of the Medical Staff. Members are appointed annually with no limit on the number of terms.

12.8-3 Duties/Function

The committee shall be responsible for the operation of the Medical Staff Health Program according to the protocol approved by the Medical Staff.

12.8-4 Meetings

Meetings of the committee and intervention teams shall be held as often as necessary to discharge the committee's responsibilities. Records and reports of committee activities shall be held in confidence.

12.9 Medical Staff Planning Committee

12.9-1 Purpose

The purpose of the Medical Staff Planning Committee shall be to study the role, philosophy, purpose and function of the Carlisle Regional Medical Center and the Carlisle Regional Medical Center Medical Staff in the delivery of health care.

12.9-2 Composition

The Medical Staff Planning Committee shall be composed of at least five (5) members of the Active Medical Staff. The Medical Staff President and Hospital CEO shall serve as ex-officio members.

12.9-3 Duties/Function

The Medical Staff Planning Committee shall:

a) Conduct a continuous study of the medical service community's health care needs utilizing all available data sources and make recommendations to the Medical Staff for satisfying such needs;
b) Review proposals advocating that the hospital embark upon new concepts of providing health care or that advocate significant modifications of existing health care services.

12.9-4 Meetings

The Medical Staff Planning Committee shall meet at the call of the chairman and report to the MEC.

12.10 Medical Staff Quality & Peer Review Committee

12.10-1 Purpose

The purpose of the Medical Staff Quality & Peer Review Committee is to promote quality practitioner and institutional performance through valid and reliable measurable systems based on objective and clinically sound indicators.

12.10-2 Composition

The committee shall be composed of at least five (5) members of the Medical Staff representative of the services provided by the hospital.

12.10-3 Duties/Function

The Medical Staff Quality & Peer Review Committee shall function in accordance with the currently approved Medical Staff Quality & Peer Review Policy:

(a) Participate in the continuous monitoring of critical patient care practices to identify patterns and trends which emerge through ongoing review that indicate the need for in-depth process or individual practitioner review.

(b) Review and analyze the results of monitoring activities which are based on the appropriateness to each medical specialty and include but are not limited to:

- Operative and other invasive procedure review
- Blood usage

- Infections
- Drug usage evaluation
- Utilization review
- Medical record review for completeness and timeliness
- Morbidity and mortality review
- Risk management referrals
- Sentinel events
- Customer satisfaction

(c) Submit reports to the Medical Executive Committee, which reflect the results of all evaluations performed, recommendations, and actions taken.

12.10-4 Meetings

The committee shall meet as needed but no less than annually.

12.11 Pharmacy and Therapeutics Committee

12.11-1 Purpose

The purpose of the Pharmacy and Therapeutics Committee shall be to develop and oversee pharmacy and therapeutic policies which relate to intra-hospital selection distribution and handling and the safe administration of drugs.

12.11-2 Composition

The Pharmacy and Therapeutics Committee shall be composed of at least five (5) members of the Medical Staff.

12.11-3 Duties/Function

The Pharmacy and Therapeutics Committee shall:

a) Monitor the appropriateness of drug utilization throughout the hospital;
b) Review all untoward drug reactions;
c) Maintain and update the hospital formulary;
d) Evaluate and approve all protocols concerned with the use of investigational or experimental drugs; and
e) Review antibiotic usage in the Hospital.

12.11-4 Meetings

The Pharmacy and Therapeutics Committee will meet at least quarterly and report to the MEC.

12.12 Radioisotope and Radiation Safety Committee

12.12-1 Purpose

The purpose of the Radioisotope and Radiation Safety Committee shall be to oversee the function of the Nuclear Medicine Department and radiation usage in the hospital.

12.12-2 Composition

The Radioisotope and Radiation Safety Committee will be composed of at least four (4) members of the Medical Staff representing specialties or departments as required by accrediting agencies.

12.12-3 Duties/Function

The Radioisotope and Radiation Safety Committee shall:

a) Review all proposals for diagnostic and therapeutic uses of unsealed radionuclides;
b) Recommend to the Medical Staff those practitioner having suitable training and experience to perform nuclear medicine procedures;
c) Develop regulations for the use, transport, storage, and disposal of radioactive materials used in nuclear medicine procedures;
d) Recommend remedial action when there is failure to observe protection recommendations, rules and regulations;
e) Establish rules to guide nursing and other individuals who are in contact with patients receiving therapeutic amounts of unsealed radionuclides; rules relating to the discharge of such patients; and rules to protect personnel involved when such patients undergo surgical procedures or autopsy;
f) Establish a liaison with the consultant physicist;
g) Review and approve all new proposed procedures for the Nuclear Medicine Department; and
h) Be familiar with all pertinent NRC regulations and review the findings of NRC inspections.

12.12-4 Meetings

The Radioisotope and Radiation Safety Committee shall meet at least quarterly and report to the MEC.

12.13 Utilization Management Committee

12.13-1 Purpose

The purpose of the Utilization Management Committee shall be to identify and analyze factors that contribute to unnecessary or inappropriate use of inpatient or outpatient facilities and services and make recommendations designed to use all facilities on an appropriate basis.

12.13-2 Composition

The Utilization Management Committee shall be composed of at least five (5) members of the Medical Staff.

12.13-3 Duties/Function

The Utilization Management Committee shall:

a) Develop a utilization review plan that meets the requirements of private, governmental, licensing, and review agencies and the approval of the Medical Staff;

b) Review the utilization of services and facilities of the hospital;

c) Have the authority to review the chart of any patient admitted to the hospital and to discuss it with the physician or physicians concerned;

d) Have no disciplinary authority; and

e) Report its findings and recommendations to the MEC.

12.13-4 Meetings

The Utilization Management Committee will at least quarterly or more frequently if deemed necessary by the chairman.

ARTICLE XIII.
MEDICAL STAFF CLINICAL DEPARTMENTS

13.1 Departments

There shall be the following departments of the Medical Staff:

- Anesthesia
- Cardiovascular Services
- Emergency Medicine
- Family Practice
- Medicine
- Obstetrics-Gynecology
- Pathology
- Pediatrics
- Radiology
- Surgery

13.2 Organization of Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a chair who is selected and has the authority, duties, and responsibilities as specified in Section 13.5.

13.3 Assignment to Departments

Medical Staff members shall be assigned to each department by virtue of the privileges requested and recommended by the Credentials Committee action on the information contained in the member's application. The exercise of clinical privileges within any department shall be subject to the Rules and Regulations of that department and the authority of the department chair.

13.4 Functions of Departments

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department.

To carry out this responsibility, each department shall:

a) Set up and review such rules, regulations or policies as are deemed necessary by the department. Such rules, regulations, or policies shall be approved by the MEC and shall be passed on by the Medical Staff. Such rules, regulations, and policies of the department shall be enacted with the approval of the Board;

b) Review all clinical work performed under its jurisdiction whether or not any practitioner whose work is subject to such review is a member of that department;

c) Establish guidelines for the granting of clinical privileges and performance within the department and submit the recommendations required under Articles VI and VII regarding the specific privileges each staff member or applicant may exercise;

d) Conduct or participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in the standards of the clinical specialty and review, evaluate and monitor activities;

e) Monitor, on a continuing and concurrent basis, adherence to:

- Staff and hospital policies and procedures;
- Requirements for alternate coverage and consultations;
- Sound principles of clinical practice;
- Fire and other regulations designed to promote patient safety;

f) Coordinate the patient care provided by the department's members with nursing and ancillary patient care services and with administrative support services; and

g) Meet at least four times per calendar year and submit written reports to the MEC.

13.5 Department Chair

13.5-1 Qualifications

Each department chair shall be a member of the Active Staff and must be certified by his specialty board or its equivalent. If there are no physicians so certified in the department, an acting chair shall be chosen from the members of the department.

13.5-2 Selection and Appointment

Department chairs, excepting those departments where a majority of the members hold salaried or contractual positions, shall be elected annually by each department at the last meeting of the calendar year unless otherwise specified in their department rules and regulations, and shall be approved by the President of the Medical Staff. For those departments where a majority of the members hold salaried or contractual positions with the hospital, the President of the hospital shall name the chair.

13.5-3 Term of Office

Term of office for each department chair shall be one year and they may succeed themselves.

13.5-4 Duties

(1) Each chair shall:

a) Be accountable to the MEC and to the President of the Medical Staff for all activities within the department, and particularly for the quality of patient care rendered by members of his department and for the effective conduct of the patient care surveillance and other quality review, evaluation and monitoring functions of his department; serve as a voting member of the MEC; if unable to attend, the assistant department chairman or designee shall attend without vote;

b) Develop and implement departmental programs in cooperation with the President of the Medical Staff, consistent with the provisions of Section 13.4, including establishing the type and scope of services required to meet the needs of the patients and the hospital;

c) Transmit to the appropriate authorities as required by Articles VI through VIII, his department's recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners in his department;

d) Enforce the hospital and Medical Staff Bylaws, rules, policies and regulations within his department, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or to be sought when necessary.

e) Implement within his department actions taken by the MEC and by the Board;

f) Assure that the service is adequately covered at all times; and

g) Perform such duties commensurate with his office as may from time to time be reasonably requested of him by the president of the Medical Staff or the Board.

(2) The Chair of the Surgery Department will be specifically responsible for the supervision of surgical services in the O.R. suite.

ARTICLE XIV.
MEETINGS

14.1 General Staff Meetings

14.1-1 The Annual Meeting

The Annual Meeting of the Medical Staff shall be the last meeting before the end of the calendar year. At his meeting the retiring officers and committees shall make such reports as may be desirable. Officers for the ensuing year shall be elected for those positions open for election.

14.1-2 Medical Staff Business Meetings

Medical Staff Business Meetings shall be held at least four times per calendar year. At these meetings various committees shall make their reports, various medical staff problems shall be discussed, and the actual business of the Medical Staff acted upon. After each meeting the Secretary of the Medical Staff shall transmit to the President of the Hospital such requests and recommendations as the Medical Staff may wish to make to the Administration, or through the President of the Hospital, to the Board of Trustees.

14.1-3 Special Meetings

Special meetings may be called at any time by the President of the Medical Staff or shall be called at the request of any 25 members of the Active Staff. The meeting shall be held at a time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

14.1-4 Order of Business and Agenda

a) Medical Staff Business Meetings:

- Call to order and announcements
- Approval of minutes of the last meeting of the Medical Staff
- Review of minutes of last MEC meeting(s)
- Reports of standing and special committees
- Unfinished Business
- New Business
- Communications
- Adjournment

b) Special Meetings:

- Reading of the notice calling the meeting
- Discussion of the business for which the meeting was called
- Adjournment

14.2 Department Meetings

14.2-1 All Medical Staff departments shall meet at least annually.

14.2-2 Discussion at these meetings shall be in accordance with the function of the departments as outlined in Section 13.4.

14.2-3 Voting on any matters at these meetings is open to all members obliged to attend.

14.3 Committee Meetings

Committee meetings shall be held as outlined in Article XII of these Bylaws.

14.4 Quorum

14.5-1 Medical Staff Business Meetings & Special Meetings
Those present or those eligible Medical Staff members voting on an issue but not less than ten (10).

14.5-2 Department and Committee Meetings
Those present or those eligible Medical Staff members voting on an issue but not less than two (2) members, shall constitute a quorum at any meeting of such department or committee. Quorum for the Surgery Department will be not less than five (5) members.

14.5-3 Medical Executive Committee and Credentials Committee
A quorum will exist when fifty percent (50%) of the members are present.

14.5 Minutes

Minutes of all meetings shall be prepared by the chairman or secretary of the meeting and shall include a record of attendance and the vote taken on each matter.

Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the MEC, and made available to the Medical Staff.
A permanent file of the minutes of each meeting shall be maintained.

14.6 Procedure/Rules of Order

Meetings shall be conducted according to the "Sturgis Standard Code of Parliamentary Procedure" unless stated otherwise in the Bylaws.

14.7 Attendance at Meetings

Although there is no minimal meeting attendance requirement, members of the Medical Staff are encouraged to attend and participate in their assigned department and committee meetings as well as the Medical Staff business meeting.

ARTICLE XV.
IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges of this hospital; the filing of such application and/or exercise of such privileges shall be deemed an adoption of same by practitioner:

15.1 Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extend permitted by law.

15.2 Such privileges and protection shall extend to members of the hospital's medical staff, medical staff committees, its Board and its representatives and members thereof, its other practitioners, its president and his representatives, and to third parties, who supply information to any of the foregoing as authorized to receive, release, or act upon the same. For the purpose of this Article XV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Medical Staff or any of its committees.

15.3 There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

15.4 Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

- Applications for appointment or clinical privileges;
- Periodic reappraisals for reappointment or clinical privileges;
- Corrective action, including summary suspensions;
- Hearings and appellate reviews;
- Medical care evaluations;
- Utilization reviews; and
- Other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.

15.5 The acts, communications, reports, recommendations, and disclosures referred to in this Article XV may related to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

15.6 In furtherance of the foregoing, each practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of this Article XV in favor of the individuals and organizations specified in paragraphs 15.2, subject to such requirements, including those of good faith and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this Commonwealth.

15.7 The consents, authorizations, releases, rights, privileges, and immunities provided by Article VI, Section 6.2-3, of these Bylaws for the protection of this hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XV.

ARTICLE XVI.
RULES AND REGULATIONS

16.1 STAFF RULES & REGULATIONS & POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. Such rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

16.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

16.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 16.1(c) of this Article shall be implemented.

16.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon

notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

ARTICLE XVII.
AMENDMENTS

Amendments to these Bylaws may originate with either the Medical Staff or the Board but shall only be effective with the consent of both parties as per the following process.

These Bylaws may be amended after notice is given at any regular meeting of the Medical Staff. Such notice shall be laid on the table until the next regular meeting and shall require a two-thirds majority of the voting Medical Staff present for adoption. Voting may occur via printed ballot or in a manner determined by the MEC. Amendments so adopted shall be effective when approved by the Board and be equally binding on the Medical Staff and the Board.

These Bylaws shall be reviewed for necessary revision every two years.

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. Neither the Medical Staff nor the Board may unilaterally amend these Bylaws.

ARTICLE XVIII.
ADOPTION

These Bylaws are adopted and made effective **August 26, 2009** and amended **November 21, 2017**, 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, its members and its administrative staff shall comply with the requirements of these Bylaws.

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

ARTICLE XIX
UPMC PINNACLE CARLISLE
OUTPATIENT SURGERY CENTER
31 Sprint Drive
Carlisle, Pennsylvania, 17013

BYLAWS AMENDMENTS
OF
THE MEDICAL STAFF

The following are the responsibility of the Medical Staff of UPMC Pinnacle Carlisle Outpatient Surgery Center as outlined in Chapter 551 of the Pennsylvania Code.

I. Purpose

There shall be an organized Medical Staff which is accountable to the Medical Staff which is accountable to the governing body and which has responsibility for the quality of medical care provided to patients and for the ethical conduct and professional practice of its members and other practitioners who have been granted clinical privilege at the UPMC Pinnacle Carlisle Outpatient Surgery Center.

II. Medical Staff Membership

Each member of the Medical Staff shall be qualified for membership and the exercise of clinical privileges granted to him specific to the Outpatient Surgery Center. Members of the Medical Staff and others granted clinical privileges shall currently hold licenses to practice in the Commonwealth of Pennsylvania.

III. Requirements for Membership and Privileges

The following shall be the requirements for membership and privileges:

(a) To receive a favorable recommendation for appointment, or reappointment, members of the Medical Staff shall always act in manner consistent with the highest ethical standards and levels of professional competence.

(b) Privileges granted shall reflect the results of peer review or utilization review programs, or both, specific to ambulatory surgery.

(c) Privileges granted shall be commensurate with the individual practitioner's qualifications, experience and present capabilities.

(d) Granting of clinical privileges shall follow established policies and procedures in the Bylaws or similar rules and regulations/policies and procedures. The procedures shall provide the following:

(1) A written record of the application, which includes the scope of privileges sought and granted. The delineation of clinical privileges shall address the administration of anesthesia.

(2) A review, summarized on record with appropriate documentation, of the qualifications of the applicant.

(e) Reappraisal and reappointment shall be required of every member of the Medical Staff at regular intervals no longer than every 2 years.

(f) The governing body shall request and consider reports from the National Practitioner Data Bank on each practitioner who requests privileges.

Approved by MEC & Medical Staff: 7/18/06
Approved by Board of Trustees: 7/18/06

UPMC PINNACLE CARLISLE
RULES & REGULATIONS

The following are the Rules and Regulations of the Medical Staff of the UPMC Pinnacle Carlisle:

R-1.0 ADMISSIONS

R-1.1

Except in emergency, no patient shall be admitted to the hospital until:

a) A provisional diagnosis has been stated and,

b) The consent of the chief executive officer, or person designated by him secured.

In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

R-1.2

Practitioners admitting patients shall be held responsible for:

a) Designating the primary physician who shall have the responsibility for such orders as are necessary for the patient's total care;

b) Giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever (i.e., behavioral problems, communicable disease, etc.);

c) Assuring that appropriate facilities exist for the care of their patients, including those patients with disease, etc.;

d) Accepting patients applying for admission who have no attending physician and no choice of physician who have been referred to the Emergency Department for appropriate evaluation.

R-1.3

a) All admissions to a practitioner's service must be approved by him.

b) A referring practitioner should notify the practitioner to whom he is referring a patient prior to sending that patient to the hospital.

c) In an emergency, or if the practitioner to whom the patient is to be admitted is not available or has not cleared the admission with the admission office, the patient will be referred to the Emergency Department physician for determination of the necessity of the admission.

R-2.0 PATIENT CARE

R-2.1
Except in an emergency, no member of the Medical Staff shall attend any patient not under his care except on invitation of the practitioner in charge.

R-2.2
If any member of the Medical Staff is unable to see his patient daily, he shall be required to designate a member of the Medical Staff as his representative to make such visits.

R-2.3
Nursing Service, through the Director of Nursing, may request a clinical review by an appropriate Medical Staff department chairman whenever deemed necessary.

R-2.4

a) Dental Patients

Patients admitted for dental services may be admitted to the service of the attending dentist. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. A physician member of the medical staff shall be responsible for the care of any medical problem which may be present or suspected or which may arise during the hospitalization of a dental patient; this includes a complete history and physical (short-form is appropriate), pre and postoperative medical orders, and completion of the medical parts of the chart. The attending dentist will be responsible for recording his examination and treatment given. Oral surgeons on the medical staff may perform Histories and Physicals on their patients.

b) Podiatry Patients
Patients admitted for podiatric services may be admitted to the service of the attending podiatrist who has operating room surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the chief of surgery. A physician member of the medical staff shall be responsible for the care of any medical problem which may be present or suspected or which may arise during the hospitalization of a podiatric patient; this includes a complete history and physical (short-form is appropriate) pre and postoperative medical orders, and completion of the medical parts of the chart. The attending podiatrist will be responsible for recording their examination and treatment given.

R-2.5 Informed Consent

Except when not possible because of an emergency, informed consent shall be obtained from the patient, if of age and responsible, or from a legal guardian, for any procedure or treatment for which it is appropriate. The informed consent shall be recorded in the patient's medical record.

R-2.6 Interruptions of Pregnancy

All interruptions of pregnancy must conform with current law.

R-2.7 Transfusions

It shall be a rule of the Medical Staff that indications for all transfusions shall be noted on the patient's hospital chart.

R-2.8 Coroner Notification

It shall be the duty of the attending physician to notify the coroner of all deaths legally coming under the coroner's jurisdiction.

R- 2.9 Consultations

a) The attending physician or designee may request a consult from any member of the Active, Associate, or Consulting Staff when they feel it is indicated. This consult will be ordered and will be answered by the consultant or designee in an appropriate time frame as indicated by the patient's medical condition. Consultations must be answered and a note written or dictated within ***48 hours*** of request unless otherwise specified. If the consultation needs to be answered more expeditiously, it is the responsibility of the requesting practitioner to personally contact the consultant.

b) The Medical Executive Committee may, from time to time, specify conditions under which consultations may be mandatory.

R-2.10 Emergency Care

The duties and responsibilities of all practitioners and personnel serving patients within the Emergency Department shall be defined in the Emergency Department Policy and Procedure Manual.

R-2.11 Psychiatric Patients

A doctor of medicine or osteopathy will manage and coordinate the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine or optometry, a chiropractor, or a clinical psychologist.

R-3.0 PHARMACY

Automatic stop orders will be as follows:

- Narcotics – 7 days;
- Toradol – 4-days;
- Antibiotics – 7 days.

In accordance with Medicare requirements, all other medications will have an automatic stop order of 28 days. The attending physician will be informed by Nursing Service prior to the medication being discontinued.

R-4.0 MEDICAL RECORDS

R-4.1

a) The attending practitioner shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, a provisional diagnosis, a complete History and Physical (which consists of chief complaint, history of present illness, past medical history, family history, social history, review of systems and physical examination), special reports such as consultations, clinical laboratory, x-ray, and others; medical or surgical treatment; pathological findings, progress notes; final diagnosis, condition on discharge; follow-up and autopsy report when available.

b) An operative report describing techniques and findings shall be written or dictated immediately following surgery and signed by the surgeon.

c) Progress notes shall be recorded at the time of patient evaluation, sufficient to permit continuity of care and transferability. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated by the attending physician at least daily on all patients except on the day of admission. The admission note shall serve as a progress note for the day of admission, unless the patient's condition warrants further progress notes on that date. Documentation of progress notes on the Inpatient Rehab Unit will follow CMS guidelines.

d) All entries in the medical record must be dated, timed and authenticated by the responsible practitioner.

R-4.2

All records are the property of the hospital.

a) They shall not be removed from the hospital except by court order, subpoena, or statute.
b) In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner.
c) A practitioner making a request to either view the record or obtain copies of the record shall either furnish a written patient authorization to the record librarian or shall certify that he is actively engaged in treating the patient.
d) Department chairmen and members of the Medical Staff committees, in line with their assigned duties, shall be permitted to examine records of patients of other practitioners.
e) Chart review for medical research will be permitted by any member of the Medical Staff upon submission of a written request to the Medical Executive Committee and /or President of the Medical Staff and their subsequent approval.

R-4.3 Standing Orders

Standing orders shall be formulated and changed only by conference between the Medical Staff and Nursing Staff. These orders shall be signed and dated by the attending practitioner when utilized.

R-4.4 Verbal Orders

All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out except when dictated over the telephone and signed by the person to whom dictated with the name of the practitioner per his or her own name. Such orders shall be signed by the attending practitioner, or the practitioner responsible during the attending physician's absence, within seven (7) days. An order shall be considered to be valid if dictated to: a Physician's Assistant taking verbal orders from his or her supervising physician, a registered nurse, a licensed practical nurse, physical therapist, respiratory therapist, or pharmacist as pertaining to their particular specialty, a polysomnographic tech for orders for Bipap, Cpap, O2 only and radiologic technicians related to medical imaging studies, provided these studies are for diagnostic purposes.

R-4.5 Symbols and Abbreviations

Only those symbols and abbreviations which have been approved by the Medical Staff shall be used in the medical record.

R-4.6 Autopsies

When an autopsy is performed, provisional anatomic diagnosis shall be recorded in the medical record, and the complete protocol shall be made part of the record .

R-5.0 UTILIZATION REVIEW

The chairman of the Utilization Review Committee may request a letter of clarification from the practitioner in charge of the patient for the purpose of utilization review. Such a letter shall be furnished within 72 hours following practitioner notification by the chairman of the Utilization Review Committee. Failure to comply with this rule will carry the penalty of loss of admitting privileges until the letter is submitted.

R-6.0 QUALITY ASSURANCE

It shall be the responsibility of the attending practitioner to promptly submit all physician-specific quality concerns from peer review organization to the appropriate medical staff departmental chairman. The practitioner's written response to such letter shall also be submitted.

R-7.0 EMTALA – Medical Screening Exams

Medical Screening examinations performed under EMTALA will be performed by a Qualified Medical Practitioner (QMP). A Qualified Medical Practitioner is defined as any physician on the Medical Staff of UPMC Pinnacle Carlisle, or a certified nurse midwife, or a nurse practitioner, or physician's assistant acting under the direct or indirect supervision of the appropriate department physician. The OB RN may perform a "labor check" or "membrane check" and notify the physician/certified nurse midwife of the results of the "check" (limited to physical examination).

R-8.0 ANESTHESIA SERVICES

a) **Director:** The Anesthesia Service shall be directed by a physician member of the Medical Staff with qualifications as follows:

- Licensed qualified physician who has successfully completed an anesthesiology program approved by the American Board of Anesthesiology,
- Board Certified by the American Board of Anesthesiology
- Member of the Active Staff
- Elected by the physician members of the department

b) **Responsibilities** of the director include:

- Planning, directing, and supervising all activities of the service,
- Evaluating the quality and appropriateness of the anesthesia services (to include the administration of moderate sedation by non-anesthesia providers) provided to patients as part of the hospital's Quality & Peer Review program.
- Recommending of privileges for all individuals with primary anesthesia responsibility,
- Development of regulations concerning anesthetic safety and retrospective evaluation of all anesthesia care,
- Decision as to which anesthetic agents will be used in the hospital,
- Availability of equipment necessary for administering anesthesia and for related resuscitative efforts,
- The establishment of a program of continuing education for all individuals,
- Participation in the development of policies relative to the functioning of anesthetists in various departments or services of the hospital.

Rules & Regs
Revised: 11-22-16