MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF UPMC MEMORIAL

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in these Bylaws are set forth in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Administrative Leadership, by a Medical Staff member, or by a Medical Staff committee, including a Peer Review Committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain Privileged Peer Review Information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under these Bylaws is unavailable or unable to perform that function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of these Bylaws, substantial compliance is required. Technical or minor deviations from the procedures set forth within these Bylaws do not invalidate any review or action taken.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary depending upon staff category and/or clinical privilege status.

(2) Dues shall be payable upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff, the Treasurer, and the Manager of the Medical Staff Office, as designated by the Board.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix A** to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his or her two-year Appointment term shall not be eligible to request Active Staff status at the time of his or her reappointment.

** The member will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Community, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in their specific delineation of clinical privileges, the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;

(c) hold office, serve as Department Chairs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(c) providing care for unassigned patients;

(d) participating in the evaluation of new members of the Medical Staff;

(e) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) accepting inpatient consultations, when requested;

(g) countersigning patient records completed by an AHP's when serving as a Supervising/Collaborating Physician, in accordance with Hospital policy and applicable state law;

(h) paying application fees, dues, and assessments; and

(i) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least six, but fewer than 24, patient contacts per two-year Appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each Reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than six patient contacts during his or her two-year appointment term will be transferred to another staff category that accurately reflects his or her relationship to the Medical Staff and the Hospital (options – Consulting, Community, or Coverage).

** Any member who has 24 or more patient contacts during his or her two-year appointment term may be transferred to Active Staff status, at the discretion of the Credentials Committee.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) shall exercise such clinical privileges as are granted to them;

(b) may attend and participate in Medical Staff and department meetings (without vote);

(c) may not hold office or serve as Department Chairs or committee chairs (unless waived by the MEC);

(d) may be invited to serve on committees (with vote);

(e) countersigning patient records completed by an AHP when serving as a Supervising/Collaborating Physician, in accordance with Hospital policy;

(f) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician,

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(g) shall cooperate in the professional practice evaluation and performance improvement processes; and

(h) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment);

(b) provide services at the Hospital only at the request of other members of the Medical Staff or as otherwise permitted by the MEC; and

(c) at each Reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for Appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat patients in conjunction with other members of the Medical Staff;

(b) may admit patients when permitted by the individual's delineation of privileges;

(c) may not hold office or serve as Department Chairs or committee chairs (unless waived by the MEC);

(d) may attend meetings of the Medical Staff and applicable department meetings (without vote);

(e) may be invited to serve on committees (with vote);

(f) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients;

(g) countersigning patient records completed by an AHP when serving as a Supervising/Collaborating Physician, in accordance with Hospital policy;

(h) shall cooperate in the professional practice evaluation and performance improvement processes; and

(i) shall pay application fees, dues, and assessments.

2.D. COMMUNITY STAFF

2.D.1. Qualifications:

The Community Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Credentials Policy with the exception of those pertaining to response times, emergency call coverage, coverage arrangements, and eligibility criteria for clinical privileges; and

(b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Staff as outlined in Section 2.D.2.

The primary purpose of the Community Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to

access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

2.D.2. Prerogatives and Responsibilities:

Community Staff members:

(a) may attend meetings of the Medical Staff (without vote) and applicable departments (with vote);

(b) may hold office or serve as Department Chairs or committee chairs;

(c) may be invited to serve on committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) may refer patients to the Hospital's infusion center and write appropriate orders and also make referrals to the Hospital's diagnostic facilities and order such tests;

(l) may actively participate in the professional practice evaluation and performance improvement processes; and

(m) must pay application fees, dues, and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire Appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each Reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for Appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy any defined response time requirements in place at the Hospital, except for those times when they are providing coverage; and

(d) agree that their Medical Staff Appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member who is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as Department Chairs or committee chairs;

(e) countersigning patient records completed by an AHP when serving as a Supervising/Collaborating Physician, in accordance with Hospital policy;

(f) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote); and

(g) shall pay applicable fees, dues, and assessments.

2.F. REGIONAL STAFF

2.F.1. Qualifications:

The Regional Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are Active Staff at (at least) one other UPMC Facility within the Hospital's region; and who

(b) has been determined to require clinical privileges at the Hospital for the sole purpose of providing regional coverage assistance to Medical Staff members who are members of their practice, department, or coverage group.

Guidelines:

If a question arises about whether an individual's relationship to the Hospital fits within the specified purpose of this category (either at the time of initial appointment or reappointment), the Credentials Committee has the discretion to assess the individual's relationship with the Hospital and to determine the Medical Staff category that is most appropriate. Other categories such as Active, Consulting or Coverage may be more appropriate depending on the amount of clinical practice at the Hospital, or the individual's leadership or committee responsibilities to the Hospital. In such circumstances, this category would not be appropriate and other categories should be utilized.

2.F.2. Prerogatives and Responsibilities:

Regional Staff members:

(a) when providing coverage assistance and consistent with the clinical privileges granted, shall be entitled to admit and/or treat patients who are the responsibility of clinical service that is being covered (i.e., patients of the practice, department or coverage group, or unassigned patients who present through the Emergency Department) when the member is on call;

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, specialty coverage for the Emergency Department, consultations, and teaching assignments when covering for members of their group practice, department or coverage group;

(c) are not required to satisfy any defined response time requirements in place at the Hospital, except for those times when they are responsible for providing coverage for the Hospital;

(d) at each reappointment cycle, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from other UPMC facilities);

(e) shall be entitled to attend Medical Staff and department meetings (without vote);

(f) may not hold office or serve as department chairs or committee chairs;

(g) shall have no staff committee responsibilities, but may be invited to serve on committees (with vote);

(h) shall not pay application fees; and

(i) shall not pay annual dues.

2.**G**. ALLIED HEALTH PROFESSIONAL STAFF

2.**G**.1. Qualifications:

The Allied Health Professional Staff shall consist of practitioners who satisfy the qualifications and conditions for appointment contained in the Credentials Policy. Allied Health Professionals shall not be members of the Medical Staff but are included in this Article for convenience.

2.**G**.2. Prerogatives and Responsibilities:

Allied Health Professional Staff members:

(a) may exercise such clinical privileges as are granted to them;

(b) may not admit patients;

(c) may attend Medical Staff and department meetings (without vote);

(d) may be invited to serve on committees (with vote);

(e) may not hold office or serve as Department Chairs or committee chairs;

(f) shall cooperate in the performance improvement and ongoing and focused professional practice evaluation activities; and

(g) are required to pay application fees, dues, and assessments.

2.**H**. EMERITUS STAFF

2.**H**.1. Qualifications:

(a) The Emeritus Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years, who are in good standing, and who have been recommended for Emeritus Staff appointment by the MEC.

(b) Once an individual is appointed to the Emeritus Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.**H**.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff and department meetings (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Department Chairs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

2.**I**. CLINICAL PRIVILEGES WITHOUT APPOINTMENT

The following types of affiliations with the Hospital include a grant of clinical privileges only. Practitioners with the below types of relationships with the Hospital are not considered to be members of the Medical Staff and shall not be granted Medical Staff appointment:

(1) distant-site telemedicine practitioners;

(2) moonlighting physicians in training;

(3) non-ACGME fellowship applicants;

(4) temporary privileges (important patient care need); and

(5) locum tenens providers.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, Vice President, Treasurer, and Immediate Past President.

3.B. ELIGIBILITY CRITERIA

(1) Only those members of the Medical Staff who satisfy the following criteria initially and continuously, as determined by the Leadership Council, shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the Leadership Council and approved by the MEC. They must:

(a) be appointed in good standing to the Active Staff and have served on the Active Staff for at least two years;

(b) have no past or pending adverse recommendations concerning Medical Staff Appointment or clinical privileges;

(c) not presently be serving as a Medical Staff officer, or Board member, at any other hospital outside of UPMC and shall not so serve during their term of office;

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

(e) have experience in a leadership position or other involvement in performance improvement functions;

(f) attend continuing education relating to Medical Staff leadership, credentialing, and/or peer review functions prior to or during the term of the office, when requested;

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

(h) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. The Leadership Council and MEC shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

(2) All Medical Staff Officers, Department Chairs, committee chairs, at-large members of the MEC must maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved unless an exception is recommended by the MEC and approved by the Board.

3.C. DUTIES

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

The President of the Medical Staff shall:

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

(b) represent and communicate the views, policies, and needs, and report on the activities, of the Medical Staff to the Hospital President and the Board;

(c) call, preside at, and be responsible for the agenda of the MEC;

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

(e) serve as a member of the Board, ex officio without vote;

(f) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(g) perform all functions authorized in all applicable policies, including collegial counseling in the Credentials Policy.

3.C.2. Vice President:

The Vice President shall:

(a) assume all duties and authority of the President of the Medical Staff when the President is unavailable within a reasonable period of time;

(b) serve on the MEC and the Leadership Council, with vote; and

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

3.C.3. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC, with vote;

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

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

3.C.4. Treasurer:

The Treasurer shall:

(a) serve on the MEC;

(b) be responsible for the collection of and accounting for any funds in the Medical Staff Fund and report to the Medical Staff; and

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

3.D. NOMINATIONS

(1) The Leadership Council shall convene at least 45 days prior to the election and shall submit the names of at least one qualified nominee for the relevant Medical Staff Officer positions and for the at-large MEC members. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 21 days prior to the election.

(2) Additional nominations may also be submitted in writing by petition signed by at least five members of the Voting Staff at least 14 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Council, and be willing to serve.

(3) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Elections shall be held by written or electronic ballot returned to the Medical Staff Services in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Voting Staff and completed ballots must be received in the Medical Staff Services by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal

protections and indemnification by the Board for acting in a Medical Staff leadership role.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Voting Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected or appointed. The term of office shall commence on the first day of the staff year following election.

3.G. REMOVAL FROM OFFICE OR MEMBERSHIP ON THE MEDICAL EXECUTIVE COMMITTEE

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Voting Staff, or by the Board. Grounds for removal shall be:

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

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

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

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

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Voting Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President of the Medical Staff's unexpired term. In the event there is a vacancy in the Vice President, Treasurer, or Immediate Past

President position, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments as determined by the MEC and listed in the Organization Manual. The MEC may create new departments, eliminate departments, create, or eliminate sections within departments, or otherwise reorganize the department structure, in accordance with the amendment provisions contained in the Organization Manual.

4.B. ASSIGNMENT TO DEPARTMENTS

(1) Upon initial appointment to the Medical Staff, each Medical Staff member shall be assigned to a clinical department. Assignment to a particular department does not preclude a Medical Staff member from seeking and being granted clinical privileges typically associated with another department.

(2) A Medical Staff member may request a change in department assignment to reflect a change in his or her clinical practice.

(3) Department assignment may be transferred at the discretion of the MEC.

4.C. FUNCTIONS OF DEPARTMENTS

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

4.D. QUALIFICATIONS OF ELECTED DEPARTMENT CHAIRS AND VICE CHAIRS

Except as otherwise provided by contract, each Department Chair and Vice Chair shall satisfy the eligibility criteria in Section 3.B, except that he or she only needs to have been on the Medical Staff for a period of one year prior to serving as Department Chair or Vice Chair.

4.E. TERM OF APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Except as otherwise provided by contract, candidates for Department Chair and Vice Chair will be identified by the Leadership Council and must be willing to serve.

(2) The election for these two positions may be held at a designated department meeting. Candidates receiving a majority of votes cast by those voting members present at the meeting will be elected, subject to Board confirmation, which confirmation will signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

(3) In the alternative, and in the discretion of the department, elections may occur solely by written or electronic ballot, to be returned in the manner as indicated on the ballot at the time it is distributed. Ballots will be provided to all voting members of the department and completed ballots must be returned by the date indicated on the ballot. Those who receive a majority of the votes cast will be elected, subject to Board confirmation, which confirmation will signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(4) Any Department Chair or Vice Chair may be removed by a two-thirds vote of the department or by a two-thirds vote of the MEC after reasonable notice and opportunity to be heard. Grounds for removal shall be:

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

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

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

(d) an infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office.

Prior to the initiation of any removal action, the Medical Staff member shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The Medical Staff member shall be afforded an opportunity to speak to the department or MEC, as applicable, prior to a vote on such removal being taken.

(5) Elected Department Chairs and Vice Chairs shall serve a term of two years and may be reelected for additional terms.

4.F. DUTIES OF DEPARTMENT CHAIRS

Department Chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) all clinically-related activities of the department;

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

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

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

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

(6) the integration of the department into the primary functions of the Hospital;

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

(8) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(9) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

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

(11) continuous assessment and improvement of the quality of care and services provided;

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

(13) recommendations for space and other resources needed by the department;

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

(15) the orientation and continuing education of all persons in the department; and

(16) as authorized by the Credentials Policy and other related Medical Staff Policies, perform functions on behalf of Peer Review Committees, including (but not limited to) case reviews and assessments, monitoring clinical practice, and collegial education and counseling activities. All documentation generated when performing these functions are records of the Peer Review Committees.

4.G. DUTIES OF DEPARTMENT VICE CHAIRS

When required or appropriate, a department may have a Vice Chair who will carry out the duties requested by Department Chairs. Upon request, these duties may include:

(1) assisting with the review of applications for initial appointment, reappointment, and clinical privileges, including interviewing applicants;

(2) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(3) participation in the development of criteria for clinical privileges;

(4) reviewing and reporting on the professional performance of individuals practicing within the department; and

(5) assuming all duties and authority of the Department Chair when the Chair is unavailable within a reasonable period of time.

4.H. SERVICE LINES

(1) The Hospital may also establish multi-disciplinary service lines to facilitate the delivery of quality, safe, and effective patient care.

(2) When service lines exist, a physician or administrative leader shall be designated to serve as a Service Line Director who shall have the responsibility for the day-to-day operations of the service line. This individual will assist with day-to-day operations and overall management of the service line.

(3) Notwithstanding the creation of services lines, the primary responsibility for activities related to credentialing, privileging, and professional practice evaluation related to the Practitioners who function within the service line shall remain the responsibility of the relevant Department Chair or other appropriate Medical Staff Leader or Medical Staff committee.

(4) Service Line Directors may participate in credentialing, privileging, and professional practice evaluation activities if requested by a Medical Staff Leader or Medical Staff committee. In these circumstances, the Service Line Directors must follow the processes and procedures outlined the Medical Staff Bylaws and policies and treat all such activities and documentation in a strictly confidential and

privileged manner. Any documentation that is created by a Service Line Director in this regard will be maintained in the Practitioner's Confidential Quality/Peer Review File.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the Leadership Council. Allied Health Professionals may be appointed to serve as voting members of Medical Staff committees.

(2) Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, except that they only need to have been on the Medical Staff for a period of one year prior to serving as committee chair.

(3) Committee chairs and members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual. They shall be appointed for initial terms of one year but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Leadership Council.

(4) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the Hospital President, in consultation with the VPMA. All such representatives shall serve on the committees, without vote.

(5) Unless otherwise indicated, the President of the Medical Staff, VPMA, and the Hospital President shall be members, *ex officio*, without vote, on all committees.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC shall consist of the following voting members: Chairpersons of Anesthesia, Cardiovascular Medicine, Emergency Medicine, Family Practice, Medicine, Obstetrics & Gynecology, Orthopedic Surgery, Radiology, and Surgery; and the at-large Members.

(b) In the discretion of the Leadership Council, an Advanced Practice Professional may also be appointed to the MEC, without vote.

(c) The Hospital President, VPMA, and CNO shall serve as *ex officio*, non-voting members.

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

(e) Other Medical Staff members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

(f) The Medical Staff Services specialist shall serve as *ex officio*, without vote, to facilitate the MEC activities and to perform functions on behalf of the committee between meetings.

5.C.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

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

(1) the Medical Staff's structure;

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

(3) applicants for Medical Staff appointment and reappointment;

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

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

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

(7) hearing procedures;

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

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

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

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

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

(h) prioritizing continuing medical education activities;

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

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

5.C.3. Meetings:

The MEC shall meet at least 10 times per year, unless an exception has been granted by the Pennsylvania Department of Health, in which case the committee shall meet as often as necessary to fulfill its responsibilities. The MEC shall maintain a permanent record of its proceedings and actions.

5.D. PERFORMANCE IMPROVEMENT FUNCTIONS

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

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

(2) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medical assessment and treatment of patients;

(4) use of information about adverse privileging determinations regarding any practitioner;

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

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

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

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

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

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

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of these Bylaws;

(14) the use of developed criteria for autopsies;

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

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is

not assigned to an individual Medical Staff member, a standing committee, or a special task force shall be performed by the MEC.

5.F. SPECIAL COMMITTEES

Special committees shall be created and their Medical Staff members and chairs shall be appointed by the President of the Medical Staff. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, and more often as needed.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, or by a petition signed by not less than 10% of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least 14 days in advance of the meetings. The primary mechanism utilized for providing notice will be e-mail; however, notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least 14 days prior to the meetings. All notices shall provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours and posting may not be the sole mechanism used for providing notice of a special meeting.

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

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC, Committee for Professional Enhancement, and Leadership Council, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for amendments to these Medical Staff Bylaws, at least 10% of the voting staff shall constitute a quorum.

(b) The Presiding Officer may permit some members of a department or committee that is meeting in person to participate in the meeting via telephone or videoconference. All such individuals shall count for purposes of calculating the quorum and for voting.

(c) As an alternative to an in-person meeting, at the discretion of the Presiding Officer, meetings of a department or a Medical Staff committee may be conducted entirely by telephone or videoconference or the voting members may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, or telephone and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws (which requires a 10% quorum) and actions by the MEC, Committee for Professional Enhancement, and Leadership Council (which require a 50% quorum), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a department or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be by written ballot at the discretion of the Presiding Officer.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings, and the Presiding Officer (Medical Staff Officer, Department Chair, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

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

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of Medical Staff members and the recommendations made and the votes taken on each matter. The minutes shall be approved in accordance with Medical Staff, department, or committee custom.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and to the Hospital President for purposes of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, Privileged Peer Review Information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Privileged Peer Review Information must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, Committee for Physician Enhancement, Leadership Council, and the Credentials Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Medical Staff member is encouraged, but not required, to attend and participate in all Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 7

LEGAL PROTECTIONS FOR PRACTITIONERS
PERFORMING MEDICAL STAFF FUNCTIONS

Practitioners have significant personal legal protections from various sources when they perform functions pursuant to these Bylaws, the Credentials Policy, the Medical Staff Organization Manual, and all other policies of the Medical Staff and Hospital, as long as they maintain confidentiality and act in accordance with these Bylaws and related policies. The sources of these legal protections include:

(a) As set forth in Section 2.C.2 of the Credentials Policy, all practitioners agree, as a condition of applying for appointment, reappointment, and/or clinical privileges, to release from liability, extend immunity to, and not sue other practitioners for any actions, recommendations, communications, and/or disclosures made or taken in the course of credentialing and peer review (PPE) activities.

(b) All applicants for appointment, reappointment, and clinical privileges sign an application form by which they release from liability and agree not to sue other practitioners who participate in credentialing and peer review (PPE) activities.

(c) Protections are also available under both the Pennsylvania Peer Review Protection Act and the federal Health Care Quality Improvement Act ("HCQIA") for practitioners who participate in credentialing and peer review (PPE) activities. The Medical Staff Bylaws and related policies have been structured to take full advantage of these legal protections.

(d) The Hospital will indemnify practitioners who perform functions under these Bylaws and related policies for any claims made against the practitioner that are not completely covered by an applicable insurance policy, in accordance with the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

8.B. PROCESS FOR PRIVILEGING

Requests for clinical privileges are provided to the Department Committee which evaluates the quality and efficiency of services ordered or performed by the individual at past or current healthcare entities, reviews the individual's education, training, and experience, and prepares a report on a form provided by Medical Staff Services. The Credentials Committee then reviews the Department Committee's report and makes a recommendation to the MEC. The MEC may accept the recommendation, refer the application back to the Department Committee for further review, or state specific reasons for disagreement with the recommendation. If the recommendation of the MEC to grant clinical privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the Hospital President of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the Department Committee which evaluates the quality and efficiency of services ordered or performed by the individual at past or current healthcare entities, reviews the individual's education, training, and experience and prepares a report on a form provided by Medical Staff Services. The Credentials Committee then reviews the Department Committee's report and makes a recommendation to the MEC. The MEC may accept the recommendation, refer the application back to the Department Committee for further review, or state specific reasons for disagreement with the recommendation. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the Hospital President of the right to request a hearing.

8.D. TEMPORARY PRIVILEGING

Temporary privileges may be granted by the Hospital President, or designee, to (i) applicants for initial appointment and (ii) individuals seeking visiting privileges or locum tenens privileges when there is an important patient care, treatment, or service need. The grant of temporary privileges will not exceed 120 days for new applicants, 60 days for visiting privileges, or 180 days for locum tenens privileges.

8.E. DISASTER PRIVILEGING

When the disaster plan has been implemented, the Hospital President, VPMA, or President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

8.F. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) attend a special conference to discuss issues or concerns;

(v) notify the Hospital of changes in information pertaining to qualifications;

(vi) provide the required notice to Medical Staff Services of changes in information regarding a Practitioner's status or credentials; or

(vii) timely pay dues;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year unless an extension is granted.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.G. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical Staff Officer or relevant Department Chair, acting in conjunction with the VPMA or the Hospital President, is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the MEC or Hospital President.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.H. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Medical Staff or is disruptive to the orderly operation of the Hospital or its Medical Staff.

8.I. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by at least ten voting members of the Medical Staff or by the MEC.

(2) In the discretion of the MEC, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:

(a) Amendments Subject to Vote at a Meeting: The proposed amendments may be voted upon at any regular or special meeting if notice and the proposed amendments have been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(b) Amendments Subject to Vote via Written or Electronic Ballot: The MEC may present proposed amendments to the voting staff by written or electronic ballot, to be returned to the Medical Staff Services by the date indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the voting staff. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(3) The MEC shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

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

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

(6) Neither the Medical Staff, the MEC, nor the Board shall unilaterally amend these Bylaws.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice at the Hospital. These other Medical Staff documents will be amended in accordance with this section and include: the Medical Staff Credentials Policy, the Medical Staff Glossary, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to these other Medical Staff documents may be made by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists.

(3) Notice of all such amendments made pursuant to this section will be provided to the voting members of the Medical Staff promptly after adoption. If any voting members of the Medical Staff have any questions or concerns regarding an amendment, they may submit written comments on the amendment to the MEC and the Bylaws Committee for their consideration.

(4) In addition, amendments to these other Medical Staff documents may also be proposed by a petition signed by at least 20% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC and the Bylaws Committee as described above, which may comment on the amendments before they are forwarded to the Board for its final action.

(5) Adoption of, and changes to, the other Medical Staff documents described in this section will become effective only when approved by the Board.

(6) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No notice is required.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 20% of the voting staff. The agenda for that meeting will

be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Hospital President, who will forward the request for communication to the Chair of the Board. The Hospital President will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

9.D. UNIFIED MEDICAL STAFF PROVISIONS

If the Hospital Board elects to adopt a single unified Medical Staff that includes the Hospital, the Voting Staff may approve or opt out of the unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 9.A for amending these Medical Staff Bylaws.

9.D.1. Bylaws, Policies and Rules and Regulations of the Unified Medical Staff:

Upon approval of a unified Medical Staff structure, the unified Medical Staff will adopt Medical Staff Bylaws, policies and rules and regulations that:

(a) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

(b) address the localized needs and concerns of Medical Staff members at each of the participating hospitals.

9.D.2. Opt-Out Procedures:

If a unified Medical Staff structure is approved, the Voting Staff of the unified Medical Staff may later vote to opt out of the unified Medical Staff. Any such vote will be

conducted in accordance with the process outlined in the unified Medical Staff Bylaws at the time of the vote.

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Medical Staff: __May 20, 2022; March 7, 2023___

Board of Directors: _May 27, 2022; March 24, 2023_____

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Community	Coverage	Emeritus	AHP	Privileges w/out Appointment
Basic Requirements								
Number of patient contacts/2-year	≥ 24	≥ 6 - 24	NA	N	NA	N	N	NA
Rights								
Admit	Y	Y	N*	N	Y	N	N	N
Exercise clinical privileges	Y	Y	Y	N	Y	N	Y	Y
May attend meetings	Y	Y	Y	Y	Y	Y	Y	N
Voting privileges	Y	P	P	P	P	P	P	N
Hold office	Y	N	N	N	N	N	N	N
Responsibilities								
Serve on committees	Y	Y	Y	Y	Y	Y	Y	N
Emergency call coverage	Y	N**	N	N	Y	N	N	N
Meeting expectations	Y	N	N	N	N	N	N	N
Dues	Y	Y	Y	Y	Y	N	Y	N
Comply w/guidelines	Y	Y	Y	Y	Y	N	Y	Y

Y	=	Yes
N	=	No
NA	=	Not Applicable
P	=	Partial (with respect to voting, only when appointed to a committee)
*	=	When permitted by the individual's granted delineation of privileges
**	=	Unless the MEC makes a determination that there are an insufficient number of Active Staff members to provide coverage, considering recommendation by relevant Department Chair

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) An H&P examination must be performed and documented in the patient's medical record, no more than 30 days prior to, or within 24 hours after, admission or registration, but in all cases prior to surgery or an invasive procedure requiring anesthesia services, by an individual who has been granted privileges by the Hospital to perform histories and physicals. Practitioners who have been granted clinical privileges at the Hospital may use telemedicine in place of an in-person assessment when performing an H&P examination. Any H&P examination performed via telemedicine must be completed (i) in conjunction with procedures that facilitate the appropriate evaluation of any physical findings that are needed to complete an adequate assessment (e.g., real-time visual and auditory communication), **OR** (ii) with the assistance of a licensed health care professional who can evaluate any physical findings that are needed to complete an adequate assessment.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- details of present illness;
- review of systems and physical examination, to include pertinent findings in those organ systems relevant to the presenting illness;
- relevant medical history, appropriate to the age of the patient;
- medications and allergies;
- assessment or problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) If the Hospital delivers infants, the current obstetrical record will include a prenatal record.

(b) Individuals Who May Perform H&Ps

The following types of practitioners may perform histories and physicals at the Hospital pursuant to appropriately granted Medical Staff appointment and clinical privileges:

(1) physicians;

(2) podiatrists (in accordance with the Credentials Policy);

(3) dentists (in accordance with the Credentials Policy);

(4) residents, fellows, interns, or medical students who have been granted practitioner-specific privileges, or given permission by the Hospital, to perform history and physical examinations can do so but the H&P must be countersigned by the physician, podiatrist, or dentist within 30 days;

(5) individuals who are not licensed independent practitioners may contribute information to be used as part of a patient's H&P examination, under the supervision of, or through appropriate delegation by, a specific qualified Doctor of Medicine or osteopathy, podiatrist or dentist who is accountable for the patient's H&P examination; and

(6) Physician Assistant ("PA"), Certified Nurse Midwife ("CNM") or certified registered nurse practitioner ("CRNP")*.

* A history and physical performed by a CRNP only needs to be countersigned if a countersignature is required by the written collaboration agreement between the CRNP and his or her Supervising Physician.

An H&P performed by a PA must be countersigned by his or her Supervising Physician within ten days, unless the State Board of Medicine has approved changes to the written supervision agreement between the PA and his or her Supervising Physician, in which case the countersignature requirements in the amended written agreement shall apply.

(c) H&Ps Performed Prior to Admission

(1) Any H&P performed more than 30 days prior to an admission or registration – either through an in-person assessment or via telemedicine – is invalid and may not be entered into the medical record as a current H&P.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. In these circumstances, an update documenting any changes in the patient's condition must be completed within 24 hours of the time of inpatient admission or registration but prior to surgery or an invasive procedure requiring anesthesia services, by an individual who has been granted clinical privileges to complete H&Ps. For an H&P examination that was performed via telemedicine, the update must include a physical examination of the patient on the day of the surgery or invasive procedure to be performed.

(3) The update of the H&P examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) Some procedures do not require a full H&P prior to a procedure. In those cases, a focused H&P may be used. A focused H&P will involve current medications, allergies, a brief review of the systems, mental status, heart exam, lung exam, vital signs if not documented elsewhere.

The following procedures are examples of procedures that may use a focused H&P. These are not all inclusive: Cardiac Catheterization, Colonoscopy, Endoscopic Retrograde Cholangiopancreatography, TIPS procedure (Transjugular Intrahepatic Portal-Systemic Shunt), Upper Endoscopy.

(d) Cancellations, Delays, and Emergency Situations

(1) When the H&P examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suite, endoscopy, colonoscopy, bronchoscopy, cardiac catheterization, radiological procedures with sedation, and procedures performed in the Emergency department), the operation or procedure will be canceled or delayed until an appropriate H&P examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete H&P the attending physician will record a H&P immediately after the emergent procedure or when the patient is stabilized.

(e) Situations where an H&P Is Unnecessary

An H&P is not required for the following non-inpatient hospital services: routine clinic visits, minimally invasive or noninvasive procedures routinely performed under local or no anesthesia (such as blood transfusions, chemotherapy, Thoracentesis, Joint Injection, Paracentesis, Skin Biopsy, Muscle Biopsy, Bone Marrow Biopsy, Ileoscopic Biopsy, Mobility Studies, Flexible Sigmoidoscopy), research patients where the patient assessment is addressed under the research protocol, and image-guided interventional procedures.