

# Medical Staff Bylaws



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# Lancaster General Hospital

THE LANCASTER GENERAL HOSPITAL

MEDICAL AND DENTAL STAFF

BYLAWS

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## **PREAMBLE**

BECAUSE, the Lancaster General Hospital is a non-profit corporation which is licensed as an acute care hospital under the laws of the Commonwealth of Pennsylvania; and

BECAUSE, its purpose is to serve as a community general hospital providing patient care, education and research; and

BECAUSE, the Medical and Dental Staff is an integral part of the Hospital and has responsibilities concerning the quality of medical care in the Hospital and must accept and discharge these responsibilities, subject to the ultimate authority of the Hospital's governing body, and that the cooperative efforts of the Medical and Dental Staff, the Chief executive officer and governing body are necessary to fulfill the Hospital's obligations to patients; and

BECAUSE, the Medical Staff is uniquely qualified to advise the Board of Trustees regarding the clinical culture which the Hospital seeks to maintain in terms of quality of care standards and the manner in which the Members of the Medical Staff relate to each other, availing themselves of their rights and discharging their responsibilities to each other, their patients, other Hospital personnel, the administration of the Hospital and the Board of Trustees:

THEREFORE, the Physicians, Podiatrists and Dentists practicing in Lancaster General Hospital hereby set forth these Bylaws, and Rules and Regulations in conformity with applicable state law, the Charter and Bylaws of the Hospital and the requirements of the Joint Commission.

1. These Bylaws originated with the Medical Staff and were approved by the Board of Trustees of Lancaster General Hospital. These Bylaws are adopted in order to organize the Medical Staff, provide a framework for its self-governance, and establish the mechanisms through which the Medical Staff will discharge its responsibilities.
2. These Bylaws provide the professional structures for Medical Staff operations, organized Medical Staff relations with the Board, and Medical Staff relations with Members, other Practitioners, and applicants for Medical Staff Membership and Clinical Privileges.
3. In the event of a conflict between the Medical Staff Bylaws and the Medical Staff Rules and Regulations, or any other Medical Staff or Department policies, these Bylaws Shall prevail.
4. These Bylaws Shall not be unilaterally amended by the Board or by the Medical Staff. In any instance in which the Board Shall seek to amend the Corporate Bylaws on a matter which affects the Medical Staff, it Shall do so only after providing reasonable prior Notice to the Medical Executive Committee to permit consideration and comment by the Medical Staff through the Medical Executive Committee, which comments Shall be taken into consideration by the Board.

Any request of the Board for an amendment to these Bylaws Shall be submitted to the Medical Executive Committee to transmit to the Bylaws Committee for consideration pursuant to Article 16 of these Bylaws.

5. The Board of Trustees Shall inform the Medical Staff of Hospital activities which affect the discharge of Medical Staff responsibilities and Shall provide the Medical Staff with a meaningful opportunity to participate in the Hospital deliberations concerning matters which do, or could, affect the discharge of the Medical Staff responsibilities.
6. Pursuant to the authority of the Medical Staff delegated to it by the Board of Trustees, the Medical Executive Committee is the vehicle through which the Medical Staff communicates with the Board of Trustees and exercises its authority as set forth in these Bylaws. No action of the Medical Staff, whether in a Department, a Division, a Committee or any other administrative mechanism hereunder, nor any policy, procedure, criterion, rule, regulation or other administrative action will have any effect until it has been approved by the Medical Executive Committee and then the Board of Trustees.

## ARTICLE 1

### DEFINITIONS

For the purpose of these Bylaws, and the Rules and Regulations adopted by the Medical and Dental Staff and approved by the Board, the following terms Shall have the meanings assigned to them in this Article unless the context clearly indicates otherwise.

Administration – the Executive Leadership Team.

Attending Physician - the Physician with primary responsibility for management of the medical care rendered to the patient within the hospital. That Physician whose service was assigned at the time of the patient's admission until the patient is reassigned or transferred to another Physician.

Board - The Board of Trustees of the Lancaster General Hospital.

Chair of the Department – The individual with organizational authority and responsibility for the activities of the Department as assigned by the Board.

Chairperson – The individual responsible for the activities of the Committee as assigned by the President.

Chief – the individual with organizational responsibility for the activities of his Division as assigned by the Chair of his Department.

Clinical Department/ Department - An organized component of the Medical Staff which is delegated the responsibility for meetings, review and evaluation of the quality of medical care provided by its Members, and hospital-based continuing education of its Members.

Clinical Privileges/ Privileges - Permission to provide medical or other patient care services in Lancaster General Hospital within defined limits established by the Hospital.

Credentials Verification Organization (CVO) – The office in the University of Pennsylvania Health System which receives applications for appointment and reappointment and collects and verifies information required therein.

Day(s) – Calendar day(s).

Dentist - A person who holds a license to practice dentistry.

Distant Site Entity – A hospital, critical access hospital, or entity that provides Telemedicine services to Lancaster General Hospital.

Division – A component of a Department organized around a clinical subspecialty for the purpose of performing activities that would otherwise be performed by the Department.

Executive Committee / Medical Executive Committee/ MEC - The Medical Executive Committee of the Medical Staff unless otherwise specified.

Ex Officio - Service as a Member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

Focused Professional Practice Evaluation (FPPE) – The confirmation of current competency based on concerns from OPPE and/or when a question arises of a currently-privileged practitioner's ability to provide safe, high quality patient care.

Hospital / Lancaster General Hospital – The non-profit corporation licensed as an acute care hospital under the laws of the Commonwealth of Pennsylvania.

Hospital President - The Chief Executive Officer of the Lancaster General Hospital.

Initial Professional Practice Evaluation (IPPE) – Initial monitoring performed to confirm an individual Practitioner’s current competency, either at the time of granting initial privileges to a new practitioner or granting new privileges to a current member of the Medical staff.

Leader – The individual with organizational responsibility for the activities of a Section as assigned by the Department Chair or Division Chief.

May - There is an opportunity for the event or action to exist but it is not mandatory.

Medical Affiliates - Any professional in allied fields of medicine and dentistry who May render care to patients in the Hospital in accordance with the provisions of these Bylaws and the laws of the Commonwealth of Pennsylvania.

Medical and Dental Staff, Medical Staff, or Staff - All licensed Physicians, Podiatrists and Dentists who have been granted Clinical Privileges at Lancaster General Hospital. Whenever the word "Staff" appears in these Bylaws and Rules and Regulations, it Shall mean the Medical and Dental Staff unless the context clearly indicates it does not.

Member - A Physician, Podiatrist or Dentist who has been granted the rights and responsibilities associated with the category of the Medical Staff to which he is assigned at Lancaster General Hospital.

Membership – The status of being a Member.

Meeting - A forum held in-person, virtually or in combination, using audio, video conferencing, screen sharing, and other forms of interactive real-time communication. Unless otherwise set forth herein, the individual responsible to call the meeting has the authority to determine the format in which it will be held. No matter which format is chosen, the rules pertaining to the meeting (i.e., attendance requirements, voting, quorums, minutes) remain the same.

Notice – A written communication transmitted in person with a receipt or by a commercial overnight delivery service with a receipt, unless otherwise stated in these Bylaws.

Ongoing Professional Practice Evaluation (OPPE) –The routine monitoring and evaluation of current competency for Practitioners with granted privileges primarily through the use of aggregate data and systematic case review.

Physician - An individual who holds an M.D. or D.O. degree and who is fully licensed to practice medicine in all its phases.

Podiatrist – An individual licensed to practice podiatry.

Practitioner – Unless otherwise stated in these Bylaws, an individual seeking Membership and/or Clinical Privileges or who is otherwise subject to the review and evaluation processes set forth in these Bylaws regardless of the category of license he holds.

President – The President of the Medical Staff.

Resident - A graduate of an approved medical, osteopathic or dental school who participates in a hospital training program including patient care under the direction of licensed Physicians of the appropriate profession who have Clinical Privileges in the Hospital.

Section – A component of a Department or Division organized around a subspecialty, clinical practice setting or service line for the purpose of coordinating activities pertinent to a subset of a Department's Practitioners.

Shall - A mandatory requirement the breach of which constitutes grounds for corrective action.

Telemedicine – The provision of clinical services to patients by Practitioners from a distance via electronic communications.

Words used in these Bylaws Shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. Captions or headings are for convenience only and are not intended to limit or define the scope of any provision herein.

## **ARTICLE 2**

### **NAME**

The name of this organization Shall be the "Medical and Dental Staff of the Lancaster General Hospital".

## ARTICLE 3

### PURPOSE

The purposes of the medical staff are:

1. To encourage and facilitate appropriate professional performance by all Practitioners authorized to practice in the Hospital through the delineation of the Clinical Privileges that each Practitioner May exercise in the Hospital and through ongoing review and evaluation of each Practitioner's performance in the Hospital;
2. To provide a means whereby issues concerning the Hospital May be discussed by the Staff with the Board and the Hospital administration;
3. To initiate and maintain rules and regulations for the self-governance of the Staff and to carry out the Staff's responsibilities as delegated by the Board;
4. To provide medical education and maintain educational standards;
5. To provide the Board with advice and recommendations necessary to carry out the Staff's and Hospital's respective duties concerning patient care;
6. To perform those functions required by the Hospital, State and Federal law and applicable provisions of the organization which accredits the Hospital; and,
7. To assist the administration in achieving economic and efficient utilization of patient care resources.



## ARTICLE 4

### MEMBERSHIP ON THE MEDICAL STAFF

#### 4.1 Nature of Medical Staff Membership

Membership on the Staff is a Privilege which Shall be extended only to Physicians, Podiatrists and Dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and those of the Hospital, including compliance with Hospital policies.

#### 4.2 Qualifications for Membership

Only Physicians, Podiatrists and Dentists licensed to practice in the Commonwealth of Pennsylvania, and who are located close enough to the Hospital to provide continuous patient care as set forth in Article 5 for their category of Medical Staff Membership, and who can document their continuing ability to meet the qualifications set forth herein, sufficient to assure the Staff and the Board that any patient treated by them in the Hospital will receive appropriate medical care, Shall be qualified for Membership on the Staff. No Physician, Podiatrist or Dentist Shall be entitled to Membership on the Staff or to the exercise of any Clinical Privileges in the Hospital merely by virtue of being duly licensed to practice medicine, podiatry or dentistry in this or in any other state, or is a Member of some professional organization, or had in the past, or presently has, such Privileges at another hospital.

##### 4.2.1 Licensure and Competence

Members of the Medical Staff Shall be able to document their licensure, background, experience, training, demonstrated current competence, and physical and mental ability to perform the Privileges which they seek to exercise in the Hospital. They Shall comply with any continuing education requirements established by the Medical Staff.

##### 4.2.2 Legal Requirements

Members of the Medical Staff Shall adhere to applicable laws, rules and regulations, and regulatory standards, including those which permit payment to the Hospital for services ordered or provided by such Members.

#### 4.2.3 Medical Staff Standards

Members Shall comply with these Bylaws and Shall adhere to the Medical Staff standards established pursuant to these Bylaws, including those pertaining to quality performance, cooperation with other professionals, and communication with patients, families, and others providing care to patients in the Hospital. Members Shall be subject to Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) as set forth in Hospital and Medical Staff policies.

#### 4.2.4 Medical Professional Liability Insurance

Members of the Medical Staff Shall demonstrate their maintenance of medical professional liability insurance in amounts determined sufficient by the Board.

#### 4.2.5 Board Certification

Members who are Physicians Shall be board certified, including complying with recertification requirements, by a board of the American Board of Medical Specialties or the American Osteopathic Association Specialty Boards or Shall maintain qualifications to become board certified in the ordinary course of the applicable board's general policies and procedures.

#### 4.2.6 Contribution to the Hospital's Objectives

Evidence of the individual's ability to contribute to the attainment of the Hospital's institutional objectives regarding its mission as determined by the Board Shall be required for Membership on the Medical Staff.

#### 4.2.7 Ethics

Each Member of the Medical Staff Shall acknowledge in writing that he Shall not deceive a patient as to the identity of an operating surgeon, or any other Practitioner providing treatment or services; and he Shall not delegate the responsibility for diagnosis or care of hospitalized patients to another Practitioner unless he believes such Practitioner to be qualified to undertake this responsibility. Each Member of the Medical Staff Shall agree to care for patients at the Hospital regardless of ability to pay. Each Member of the Medical Staff Shall comply with both the Medical Staff's and Hospital's Code of Conduct and with the ethical standards of the profession, their applicable specialty boards, the American Medical Association, and the American Osteopathic Association, as applicable.

#### 4.2.8 Organized Health Care Arrangement

As a condition of appointment, each Member Shall, effective as of the date of appointment, become a participant in the Hospital's Organized Health Care Arrangement only as defined by and only to the extent functionally necessary in the Health Insurance Portability and Accountability Act Privacy Regulations. Members Shall also comply with any federal or state laws or Hospital policies related to the use and disclosure of individually identifiable health information, including but not limited to the HIPAA Privacy Regulations.

#### 4.3 Conditions and Duration of Appointment

The Board Shall make all appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws. However, in the event of unwarranted delay on the part of the Medical Staff, which Shall be defined as failure to act within ninety (90) Days of an established timeframe for action set forth in the appointment or reappointment process, the Board Shall offer the Executive Committee an opportunity to explain the circumstances leading to the delay. After such explanation or if the Executive Committee fails to provide an explanation, the Board May act without such recommendation on the basis of documented evidence of the applicant's or Staff Member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

##### 4.3.1 Initial Appointments

Initial appointments Shall be for no more than two (2) years.

##### 4.3.2 Reappointments

Reappointments to the Medical Staff Shall be for a period of not more than two (2) Medical Staff years.

##### 4.3.3 Appointment and Clinical Privileges

Appointment to the Medical Staff Shall confer on the appointee only such Clinical Privileges as have been granted by the Board in accordance with these Bylaws.

##### 4.3.4 Written Acknowledgment of Responsibilities of Medical Staff

Every Staff Member Shall acknowledge in writing the Member's continuing obligations, as set forth more fully herein, to provide continuous care and supervision of his patients in the Hospital, to participate in the educational programs of the Hospital, to abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments and consultation assignments, to attend meetings, to notify the Medical Staff of changes in his licensure, certification or registration status and of changes in his other hospital affiliations, or medical professional liability insurance coverage.

- (a) Within fifteen (15) Days of a trial court judgment or a settlement against a Practitioner in a professional liability lawsuit, a Member of the Medical Staff Shall notify the Medical Staff Office of such judgment or settlement.
- (b) A Member of the Medical Staff Shall notify the Medical Staff Office, within fifteen (15) Days of a change in membership status and/or change in Clinical Privileges at another hospital or institution including a voluntary or involuntary revocation, resignation, suspension, limitation, non-renewal or reduction of Privileges, or being placed on probation or mandatory suspension.
- (c) A Member of the Medical Staff Shall notify the Medical Staff Office within five (5) Days of the revocation, suspension or limitation of his professional license by any state licensing body, the revocation or suspension or limitation (for reasons of discipline or professional competence) of his staff appointment or Clinical Privileges at any hospital or other healthcare institution for more than thirty (30) Days.
- (d) A Member of the Medical Staff Shall notify the Medical Staff Office within five (5) Days of the commencement of a formal investigation or the filing of charges by the U.S. Department of Health and Human Services, or any other federal or state law enforcement agency or health regulatory agency.
- (e) A Member of the Medical Staff Shall notify the Medical Staff Office within five (5) Days of being charged in any criminal matter.
- (f) A Member of the Medical Staff Shall notify the Medical Staff Office within five (5) days of his becoming aware of his being unavailable to meet his clinical responsibilities without back-up coverage.
- (g) Failure to provide such notice as required in (a)–(f) May result in appropriate disciplinary action, which May include an immediate suspension from the Staff for thirty (30) Days.

#### 4.3.5 Cooperation with Medical Staff Leadership and Hospital Administration

It is expected that Medical Staff Members will cooperate with the duly established mechanisms for communication with Medical Staff leadership and Hospital administration. It is expected that the Medical Staff leadership and Members of the Medical Staff will use informal processes to resolve issues that arise among them. It is expected that Medical Staff Members will cooperate in the evaluation of situations involving themselves and/or other Members of the Medical Staff or Hospital personnel by participation in any meeting or meetings requested by the President or the Hospital President. The President or Hospital President Shall schedule such meeting(s) reasonably, taking into account the Medical Staff Member's schedule.

At the Member's request, the Chair of his Department, the Chief of his Division, or any officer of the Medical Staff Shall be invited to attend such meetings, which are informal in nature and not part of the corrective action processes. If corrective action is contemplated, the provisions of Article 8 with the applicable due process Shall apply. No attorneys Shall participate in or be present at such meeting(s), unless agreed to by all involved parties.

#### 4.3.6 Confidentiality

Medical Staff Members Shall maintain the confidentiality of patient health information and of peer review information to which they have access in accordance with Hospital and Medical Staff standards.

#### 4.3.7 Required Time for Completion of History and Physical Examination

As more fully set forth in the Rules and Regulations, a Physician, oral surgeon, podiatrist or Dependent Medical Affiliate must complete an admission History and Physical (H&P) within no more than thirty (30) Days prior to or within twenty-four (24) hours after an inpatient admission but before a surgical procedure, unless a shorter timeframe is set forth in the Rules and Regulations. For a history and physical examination that was completed within thirty (30) Days prior to an inpatient admission or surgical/high risk interventional procedure, an update documenting any changes in the patient's condition is to be completed within twenty-four (24) hours after admission or prior to surgical procedure. as more fully set forth in the Rules and Regulations. An H&P performed more than thirty (30) Days prior to admission or surgical procedure must be redone.

#### 4.3.8 Basis for Denied Medical Staff Appointment or Clinical Privileges

No person Shall be denied Medical Staff appointment or Clinical Privileges on any basis unrelated to his professional qualifications.

#### 4.3.9 Service Assignments

As a continuing requirement of Medical Staff Membership, each Member Shall be willing to accept reasonable service assignments.

- (a) Each Shall respond to emergency consultation requests by other Members of the Medical Staff in accordance with Medical Staff guidelines;
- (b) Each Shall comply with emergency call responsibilities as required by Department and Division rules and regulations, Hospital policy, and as required by federal and state law (e.g., EMTALA);
- (c) Each Shall accept clinical service appointments and responsibilities as determined by the President or the Department Chair, subject to excuse for exceptional circumstances as approved by the President and Department Chair;

- (d) Physicians, Podiatrists and Dentists May be excused (on a limited or permanent basis) or limited in their service responsibilities, including the responsibility to take emergency call, if they meet criteria established by the Executive Committee. The Executive Committee Shall review and adopt such criteria from time to time as deemed necessary.
- (e) In order to ensure timely, competent, and efficient patient care for patients presenting to the Emergency Department, Physicians, Podiatrists or Dentists with restricted Privileges are not eligible for emergency call or trauma Privileges.

#### 4.3.10 Responsibilities Regarding the Hospital

Medical Staff Members Shall:

- (a) Cooperate with and participate in the Hospital's quality assurance and performance improvement program, risk management and malpractice prevention programs, legal compliance program and carry out committee activities as May be assigned.
- (b) Participate in relevant programs of continuing education as required by the Appropriate Department Chair. Such participation Shall be documented in the Practitioner's Medical Staff credentials file.
- (c) Prepare and complete in a timely manner the medical record and other required records for all patients he admits or for whom he in any way provides care in the Hospital, as provided in these Medical Staff Bylaws and the Rules and Regulations and other applicable Hospital policies, rules and regulations.
- (d) Safeguard the confidentiality of information learned or obtained from service on Hospital and Medical Staff committees, including but not limited to peer review information and strategic information of the Hospital.

#### 4.3.11 Responsibilities Regarding the Department

Medical Staff Members Shall:

- (a) Continuously meet all performance standards promulgated by the Department.
- (b) Attend Department meetings and participate in continuing education activities according to Department guidelines.
- (c) Participate in Department and Medical Staff review and evaluation functions, and serve on Departmental committees as May be requested by the Department Chair.

#### 4.3.12 Responsibilities Regarding the Medical Staff

Medical Staff Members Shall:

- (a) Discharge the Staff, Department, committee, and Hospital functions and assignments for which he is responsible by appointment, election or otherwise.
- (b) Pay Medical Staff dues as established from time to time by the Medical Staff for their category of Membership.
- (c) Provide current contact information (mail and electronic mail addresses, and telephone, cellular phone and pager numbers) to the Medical Staff Office, and update such information whenever it changes.
- (d) Serve on Medical Staff committees and on ad hoc hearing committees and perform other peer review activities as May be requested by the Department Chair and/or President.

## ARTICLE 5

### CATEGORIES OF THE MEDICAL STAFF

#### 5.1 Categories of Medical Staff Membership

The Staff Shall be divided into Active, Courtesy, Consulting, and Telemedicine Staff.

#### 5.2 The Active Staff

The Active Staff Shall consist of Members who are located close enough to the Hospital to provide continuous patient care and who assume all the functions and responsibilities of Membership on the Active Staff including, where appropriate, emergency service care and consultation assignments.

##### 5.2.1 Location

They Shall either be able to return to the Hospital to attend a patient within no more than sixty (60) minutes of a request or such shorter time as Shall be established by the applicable Department or Division.

##### 5.2.2 Responsibilities of Active Staff

Members of the Active Staff Shall be appointed to specific Departments, Shall be eligible to vote, to hold office and to serve on Staff committees, and Shall be required to attend Staff meetings and to pay regular dues. Members of the Active Staff Shall accept reasonable service assignments including:

- (a) Acceptance of consultation and emergency call responsibilities as required by Department and/or Division Rules and Regulations, Hospital Policy and Federal and State law (e.g. EMTALA).
- (b) Acceptance of clinical service appointments and responsibilities as determined by the President of the Medical Staff or the Department Chair.
- (c) Service on the Medical Staff Executive Committee, other Medical Staff Committees, and Board Committees.

##### 5.2.3 Exclusivity

No Member of the Active Staff May be a Member of the active staff of any other Lancaster County general, acute or specialty hospital, except for joint ventures between Lancaster General Health and another entity.



#### 5.2.4 Scope of Privileges

Membership on the Active Staff Shall be limited to those individuals who have Clinical Privileges to provide substantially the full range of services which the Member provides at any location at which he or she renders professional medical services. No Practitioner May be a Member of the Active Staff while privileged for only a limited number of services or procedures when compared to the services or procedures which other Physicians, Podiatrists or Dentists in the same Department or Division are privileged to perform, unless the Practitioner limits his or her entire practice, regardless of practice site, to those limited services or procedures.

#### 5.2.5 Coverage

Notwithstanding any other provision contained in this Article, the Medical Staff reserves the right to determine, in any particular instance, whether an applicant for the Active Staff is capable, by himself or herself, through his or her group practice, or through other documented coverage arrangements, to provide continuous patient care for those patients which the applicant May treat at the Hospital. The burden of proving that the applicant is capable of providing continuous patient care Shall be on the applicant.

#### 5.2.6 Senior Staff Status

A Member of the Active Staff with Senior Staff Status Shall be at least sixty (60) years old and is relieved of the obligation to pay dues, but Shall otherwise meet all the other responsibilities of Active Medical Staff Membership. A Member of the Active Staff with Senior Staff Status, if he so requests, Shall be relieved of the obligation to take unassigned patient call in the Emergency Department in accordance with the standards established by the applicable Department or Division. Such standards Shall not permit Senior Staff Status for call for anyone under the age of sixty (60), but the Department May set the threshold age higher.

### 5.3 The Courtesy Staff

The Courtesy Staff Shall consist of those Members who meet the education, training, and experience qualifications for appointment to the Active Staff, who wish to attend patients in the Hospital, but are Members of the Active Staff at another hospital.

#### 5.3.1 Responsibilities of Courtesy Staff

Members of the Courtesy Staff Shall be appointed to specific Departments and are required to pay dues. They Shall not be eligible to vote nor hold office, but they May be appointed to committees and Shall be encouraged to attend Departmental and Divisional meetings. They May be permitted to vote in Departmental or Divisional meetings if allowed by the Department or Division.

### 5.3.2 Qualifications

All Members of the Courtesy Staff Shall be required to maintain membership on the active staff of another Lancaster County general, acute care hospital.

### 5.3.3 Location

All Members of the Courtesy Staff Shall be located close enough to the Hospital to provide continuous patient care. As used in this Section, the term “located close enough to the Hospital to provide continuous patient care” Shall have the meaning set forth in 5.2.1.

## 5.4 Alternatives to Location Requirements

Active and Courtesy Staff Members May meet the coverage criteria set forth in this Section 5.4 in lieu of meeting the location requirements at 5.2.1 and 5.3.3.

### 5.4.1. Specification of Covering Physicians

Upon initial application to the Medical Staff, and as a part of any reappointment process, Active and Courtesy Staff applicants Shall specify the name of one or more Staff Members or group practices consisting of one or more Staff Members who have agreed to provide consultation and backup coverage for the applicant’s inpatients and outpatients during the applicant’s absence from the Hospital.

- (a) A Staff Member Shall notify the Medical Staff at any time of changes in coverage arrangements, provided, however, that the Member must always have in place coverage arrangements to adequately care for patients. If the back-up Practitioner becomes unavailable, the Staff Member shall have thirty (30) days to find a replacement.
- (b) The back-up Practitioner Shall have the specific Clinical Privileges necessary to provide back-up care for the applicant's patients.
- (c) Each such applicant Shall comply with such standards as May be established for the appropriate use of back-up coverage by the relevant Department or Division.

### 5.4.2 Outpatient Services Only

Notwithstanding 5.4.1, in evaluating applications for initial Membership or reappointment, each Department and Division, with the approval of the Credentials Committee and the Medical Executive Committee, May recommend granting Membership to an applicant not meeting any of the other coverage requirements described in this Section 5.4, if the applicant is seeking limited credentials for outpatient services only, and it is determined that the likelihood of the need for inpatient services due to potential complicating factors is minimal.

### 5.4.3 Discretionary Judgment

Notwithstanding any other provision contained in this Section, the Medical Staff reserves the right to determine, in any particular instance, whether an applicant for the Active or Courtesy Staff is capable, by himself, through his or her group practice, or through other documented coverage arrangements, to provide continuous patient care for those patients which the applicant May treat at the Hospital. The burden of proving that the applicant is capable of providing continuous patient care Shall be on the applicant.

### 5.5 Consulting Staff

The Consulting Staff Shall consist of Members who, by virtue of special skills and limited availability, are appointed for the specific purpose of providing care at the request of the Attending Physician in the diagnosis and treatment of patients. Appointment to the Consulting Staff does not entitle the Member to admit patients, or to vote at Medical Staff meetings or hold an office of the Medical Staff. Members of the Consulting Staff May, but are not required to, attend meetings of the Medical Staff and their assigned Department. Members of the Consulting Staff are not required to pay dues or take call. The Consulting Staff Members Shall meet the same coverage requirements as pertain to Courtesy Staff, provided that the covering Practitioner has Clinical Privileges sufficient to manage the complications associated with the Consulting Staff Members' care of patients.

### 5.6 Telemedicine Staff

The Telemedicine Staff Shall consist of Members who provide Telemedicine services to Hospital patients pursuant to a written contract between the Hospital and a Distant Site Entity at which the Practitioner is a Member of the Active Staff.

#### 5.6.1 Qualifications

In order to be eligible for appointment to the Telemedicine Staff category, a Member Shall meet all eligibility requirements as stated in Article 4 of these Bylaws, with the exception of those related to Practitioner location.

#### 5.6.2 Responsibilities

Members of the Telemedicine Staff:

- (a) May exercise such clinical privileges as granted, but will never have primary responsibility for any patient;
- (b) May attend meetings of the Department or Division to which he/she is appointed but May not vote;
- (c) May not serve as a Medical Staff officer, Department Chair or Division Chief, or member of any committee; and May not vote in Medical Staff matters;

- (d) Except as relevant to fulfill obligations in providing Telemedicine services, are exempt from all responsibilities of emergency service care (call), consultation assignments, and clinic duties; and
- (e) Are required to pay Medical Staff dues.

5.7 Medico-Administrative Officers

Medico-Administrative Officers who render services pursuant to a contract with the Hospital Shall apply for Membership and Clinical Privileges in accordance with the processes and standards which otherwise apply in these Bylaws.

5.8 Medical Staff Alumni

Medical Staff Alumni Shall include senior physicians who have retired from the active practice of medicine. They are not Members of the Medical Staff. They do not have Clinical Privileges. They are not appointed by the Board. They May attend Medical Staff, Departmental and Division meetings. They have no right to vote, or otherwise have any rights or responsibilities in the Medical Staff Organization. They May serve on a committee or a Fair Hearing Panel at the request of the President. They are permitted to participate in meetings in recognition of their past services to the Medical Staff and to foster ongoing collegial interactions.

5.9 Change in Medical Staff Category

A Member May request a change in category of the Medical Staff by making such request to the MEC stating in writing the reason for the request. The MEC shall have the right to inquire further regarding the request which shall be granted in the sole discretion of the MEC, taking into account the needs of the Hospital and the Medical Staff for such Member's services. A denial of such request Shall not entitle the Member to any rights under the Fair Hearing Plan.

## ARTICLE 6

### PROCEDURES FOR APPOINTMENT OR REAPPOINTMENT

#### 6.1 Initial Application Process

Once an applicant has met the qualifications to receive an application as set forth in Articles 4 and 5 an application for Clinical Privileges and appointment Shall be submitted electronically on the prescribed form. No initial application will be provided for any Department which is closed or subject to an exclusive contract unless the applicant will be joining the group which holds the exclusive contract. The determination of eligibility to receive an application Shall be made by the Medical Staff Office.

##### 6.1.1 Application Information

The application form Shall be approved by the Staff and the Hospital and include as a minimum:

- (a) adequate documentation of the applicant's qualifications including, but not limited to: evidence of current licensure; relevant training, education and work experience; current competence and health status;
- (b) current evidence of required professional liability insurance;
- (c) claims history of involvement, final judgments, and settlements in any professional liability action;
- (d) previous or current challenges to or voluntary or involuntary relinquishment, suspension, revocation, or non-renewal of any licensure, certification, or registration;
- (e) voluntary or involuntary loss, suspension, revocation, limitation, or reduction of Clinical Privileges or staff membership at any other hospital or institution;
- (f) the names of at least three (3) persons who have had experience in observing and working with the applicant who are not affiliated either by family relationship or professional and financial association with the applicant and who can provide adequate references pertaining to the applicant's current professional competence, ethics, ability to work with others and character, although one reference May be from a prior professional affiliation, if applicable. If an applicant is within three (3) years of completing a residency or fellowship, one of the references Shall include the director of the training program or his delegee or successor;

- (g) demographic information to include current office address, office telephone number, home and cell phone number, and current preferred email address;
- (h) a statement that the applicant has received and read these Bylaws and Rules and Regulations and agrees to be bound by their terms; and an Ethical pledge to:
  - (i) provide for continuous care for his patients;
  - (ii) seek consultation when necessary;
  - (iii) refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical Practitioner who is not qualified to undertake this responsibility and who is not adequately supervised.

#### 6.1.2 Applicant's Burden

The applicant Shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. The applicant Shall also provide evidence of professional liability insurance in the amount considered adequate by the laws of the Commonwealth of Pennsylvania and the Board.

- (a) Neither the Board, the Hospital President, nor the Medical Staff Shall have any duty or obligation to review any application until the applicant completes it in all respects and submits all required information and supporting material in accordance with the provisions of these Bylaws.
- (b) The failure of an applicant to complete an application or timely supply requested information Shall be deemed a voluntary withdrawal of such application.
- (c) An application is complete only when verification as required in 6.1.3 has been completed.
- (d) An application deemed incomplete within one hundred twenty (120) Days after submission Shall be considered voluntarily withdrawn by the applicant. Section 6.2.9 Shall not apply to these applications.
- (e) The CVO shall notify the Medical Staff Office of any application deemed incomplete hereunder.

### 6.1.3 Verification

The Credentials Verification Organization (CVO) Shall seek to verify information in the application by contacting original sources for such information.

- (a) If verification cannot be obtained within sixty (60) Days of a request, the CVO Shall notify the applicant of his obligation to assist in obtaining verification.
- (b) An applicant Shall have thirty (30) Days to arrange for verification information to be submitted.
- (c) The CVO Shall verify licensure, medical professional liability insurance, training, experience and current competence.
- (d) In no instance will an appointment be made or Clinical Privileges awarded until information is verified.

### 6.1.4 Completed Application

An application is complete when all of the information in 6.1.1 is present and verification as set forth in 6.1.3 is finished. The CVO Shall provide to the Medical Staff Office any application it deems incomplete with all supporting documentation submitted by the applicant and verified or not by the CVO.

### 6.1.5 Effect of Application

By applying for appointment to the Medical Staff, each applicant thereby undertakes the following obligations:

- (a) agrees to appear upon request for an interview in regard to his application;
- (b) authorizes representatives of the Hospital to consult with members of medical staffs of other hospitals with which he has been associated and with others who May have information bearing on his competence, character, ethics, and other qualifications; consents to the Hospital's inspection of all records and documents needed to evaluate his qualifications;
- (c) releases from any liability all representatives of the Hospital and the Staff for their acts performed in connection with evaluating the applicant and his qualifications or credentials;
- (d) releases from any liability and consents to and directs the production of information by all individuals and organizations who possess and/or provide information to the Hospital concerning the applicant's competence, ethics, character and other qualifications for appointment or Clinical Privileges.

The terms "Hospital" and "all representatives of the Hospital and the Staff" as used in this section are intended to include the Board, the Hospital President and their authorized representatives, and all Members of the Staff who have responsibility for collecting or evaluating the applicant's credentials or acting upon his application.

## 6.2 Procedure for Initial Appointment

Applications for appointment Shall be reviewed by the Division Chief, where applicable, the Department Chair, the Credentials Committee, the Executive Committee, and the Board, taking into account the character, professional competence, qualifications and ethical standing of the applicant and Shall determine, through information contained in references given by the applicant and from other sources available, whether the applicant has established and met the criteria set forth in these Bylaws and all qualifications for the category of Staff Membership and the Clinical Privileges requested. In the reviews hereunder, if at any time the reviewing body believes that its decision would benefit from expertise not otherwise available from the Medical Staff, with the prior approval of the Executive Committee, it Shall have the right to engage the services of outside consultants.

### 6.2.1 Divisional Review

When the CVO deems the application complete, it Shall promptly provide it with all supporting materials to the Medical Staff Office. Within ten (10) Days of a request from the Medical Staff Office, the Chief Shall review the materials provided and Shall provide a written recommendation to the Department Chair. There May be one extension of five (5) Days if necessary. If the Division Chief does not complete the review in this timeframe, the Medical Staff Office Shall provide the application to the Department Chair for review and recommendation without the Chief's review.

### 6.2.2 Departmental Review

Within ten (10) Days of a request from the Medical Staff Office, the Chair of the Clinical Department in which appointment is sought Shall provide the Credentials Committee with specific written recommendations for appointment in the Department. There May be one extension of five (5) Days if necessary. If the Chair of the Department does not complete his review within the requisite timeframe, the application will be provided to the Credentials Committee by the Medical Staff Office without the recommendation.

### 6.2.3 Credentials Committee Review

At its next regularly scheduled meeting after receipt of a completed application, the Credentials Committee Shall make a written report to the Executive Committee. The Credentials Committee Shall transmit to the Executive Committee the completed application together with its report and a recommendation that the applicant be provisionally appointed to the Staff and, that



the requested Privileges be granted. If the application is deferred, rejected or approved but Clinical Privileges requested are modified or denied, the Credentials Committee Shall transmit to the President, a report of the reasons for doing so. The President Shall present the report to the Medical Executive Committee. If the application is deferred, the Credentials Committee Shall make a subsequent recommendation within thirty (30) Days.

#### 6.2.4 Executive Committee Review

At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Executive Committee Shall determine whether to recommend the applicant be provisionally appointed to the Staff or rejected for Membership, the requested Privileges be granted, modified or denied, or the application be deferred for further consideration. All recommendations to appoint Shall state the specific Clinical Privileges to be granted.

- (a) The Executive Committee Shall inform the Staff, via the Executive Committee minutes, of all recommendations made on applications for appointment or additional Privileges.
- (b) The Hospital President Shall be notified promptly in writing of the action taken by the Executive Committee.

#### 6.2.5 Executive Committee Deferral

When the recommendation of the Executive Committee is to defer the application for further consideration, it Shall within thirty (30) Days make a subsequent recommendation for provisional appointment or rejection for Membership or that the requested Privileges be granted, modified or denied.

#### 6.2.6 Favorable Executive Committee Action

When the recommendation of the Executive Committee is favorable to the applicant, the President Shall forward it together with all supporting documentation, to the Board for consideration at its next regularly scheduled meeting. A favorable recommendation Shall be final Executive Committee action.

#### 6.2.7 Adverse Executive Committee Action

When the recommendation of the Executive Committee is adverse to the applicant either in respect to appointment or Clinical Privileges, no later than ten (10) Days from the date of such recommendation, the President Shall notify the applicant. The Executive Committee Shall inform the Board, in writing, of any adverse recommendation whether or not the applicant is entitled to exercise the rights provided in the Fair Hearing Plan.

- (a) If the applicant exercises his rights under the Fair Hearing Plan of these Bylaws, the Executive Committee Shall review and consider the report and recommendations of the Ad Hoc Hearing Committee and the hearing record.
- (b) If the reconsidered recommendation of the Executive Committee is favorable to the applicant, the favorable reconsidered recommendation Shall be transmitted to the Board for its action.
- (c) If such recommendation continues to be adverse, the President Shall so notify the applicant within ten (10) Days of such recommendation. The President Shall also forward such recommendation and documentation to the Board but the Board Shall not take any action thereon until after the applicant has exercised or has been deemed to have waived his right to an appellate review as provided in the Fair Hearing Plan.

#### 6.2.8 Board Action

At its next regular meeting after receipt of the recommendation, the Board or its Executive Committee Shall act on the application.

- (a) If either body's decision is adverse with respect to appointment or Clinical Privileges, the Hospital President promptly Shall give written Notice of the Board's action to the applicant.
- (b) Except as otherwise provided in Article 9, either body's decision with respect to appointment and Clinical Privileges Shall be final; however, the Board May defer final action by referring the matter back to the Executive Committee, as appropriate, for reconsideration or clarification of any issue.
- (c) All decisions to appoint will include a delineation of the Clinical Privileges which the applicant May exercise and Shall assign the Practitioner to a Department.
- (d) When either body's decision is final, the Hospital President Shall notify the President, the Chair of the appropriate Department, and the Chief of the appropriate Division, the applicant, and all appropriate Hospital personnel. The names of those individuals approved Shall be published in the monthly Medical Staff newsletter.

### 6.2.9 Reapplication

An initial applicant who has failed to be appointed May not reapply for Staff Membership or Clinical Privileges, nor Shall the Hospital or Medical Staff have any obligation to provide an application or review any materials submitted until two (2) years have elapsed since the initial denial or completion of any and all procedures pursuant to the Fair Hearing Plan, including judicial review thereof.

## 6.3 Provisional Initial Appointments

All initial appointments to the Staff Shall be provisional for a period of one (1) year from the time of appointment and subject to formal clinical observation by the Department Chair. During the initial period of provisional appointment, the Member Shall complete Medical Staff orientation in accordance with the Hospital and Medical Staff orientation schedule. Failure to complete such orientation Shall be considered a voluntary relinquishment of appointment with no right to a Fair Hearing.

Upon completion of the one-year provisional appointment and Initial Professional Practice Evaluation (IPPE), the Chair of the Department(s) Shall make specific recommendations to the Executive Committee concerning whether regular appointment should be granted and concerning the delineation of Privileges granted to the Physician or Dentist.

### 6.3.1 Evaluation of Provisional Period

The recommendation Shall be based upon observation of clinical competence during the provisional period and the other criteria used in evaluating an applicant for Membership or additional Privileges.

- (a) The Executive Committee Shall recommend whether regular appointment and the Privileges requested Shall be granted. This recommendation Shall be recorded in the Executive Committee minutes, and the Board Shall be notified in writing of the Executive Committee's action by the President.
- (b) At its next regularly scheduled meeting, the Board will act on the application. The Hospital President Shall notify the President and the applicant of the Board's action.
- (c) The Executive Committee May decide to extend the period of provisional Membership for an additional one year, at the end of which the failure to advance from provisional to regular Membership Shall be deemed an automatic termination of the initial appointment.
- (d) A provisional appointee whose Membership is terminated Shall have the rights accorded by these Bylaws under Article 9.

- (e) The requirement for provisional appointment Shall not apply to newly appointed Departmental Chairs or newly appointed Division Chiefs.

#### 6.4 Procedure for Reappointment

Every Member of the Medical Staff Shall be subject to reappointment at least every two (2) years. Reappointments Shall be for a period of not more than two (2) years from the date of the previous appointment. All terms, conditions relating to initial appointment apply to an individual's ongoing appointment and clinical Privileges and to reappointment.

##### 6.4.1 Application for Reappointment

For those candidates for reappointment, the CVO Shall provide each reappointment candidate electronically with an application for reappointment.

- (a) Each current Member or privileged practitioner who is eligible to be reappointed to the Medical Staff Shall be responsible for completing a reappointment application.
- (b) To be eligible to apply for reappointment, an individual must have:
  - (i) completed all medical records in accordance with the Rules & Regulations;
  - (ii) met all Medical Staff responsibilities and fulfilled all duties assigned by the Department Chair and Chief;
  - (iii) continued to meet all qualifications and criteria set forth in the Bylaws, Policies, and Rules and Regulations of the Medical Staff.
- (c) At least one hundred and twenty (120) days prior to the expiration date of the current appointment, the CVO Shall provide each eligible Practitioner with an application for reappointment.
- (d) Each applicant for reappointment shall return the completed reappointment application form and applicable fee to the CVO no later than seventy-five (75) days prior to the expiration of the applicant's current appointment and/or clinical Privileges.
- (e) Failure of the reappointment Member or privileged Practitioner to complete and return the application for reappointment with requested information to the CVO more than seventy-five (75) days prior to the expiration of current appointment (during which time no less than three (3) reminder requests for incomplete information shall be made by the CVO) except for extraordinary circumstances as described below shall be deemed a voluntary resignation and shall result in automatic termination of

Staff Membership, together with all Clinical Privileges at the expiration of the member or privileged Practitioners current term. For good cause and under extraordinary circumstances a reappointment application may be accepted by CVO within seventy-five (75) days prior to the expiration of the Member or privileged Practitioners current appointment and/or Clinical Privileges and CVO Shall make best efforts to process the application for approval, however in no circumstances shall current term be extended beyond a two (2) year period. Such failure to meet the relevant timeframes shall be deemed the Member's voluntary resignation from the Medical Staff. Such resignation shall not entitle the person resigning to any of the rights in Article 8 Corrective Action or the Hearing and Appeals Procedure – Article 9. An applicant whose Staff Membership is terminated hereunder shall be reinstated only by completing the initial appointment process set forth in Article 6.1.

#### 6.4.2 Basis for Reappointment

Each recommendation for reappointment Shall be based upon:

- (a) the individual's demonstrated clinical competence and professional performance in the treatment of patients during the preceding year or years as evaluated by the Hospital's performance improvement activities and the Professional Practice Evaluation process, his ethics and conduct;
- (b) his attendance at meetings and participation in Staff activities;
- (c) his compliance with the Hospital Bylaws and the Staff Bylaws, Rules and Regulations, including maintenance of board certification or eligibility for board certification;
- (d) his compliance with the continuing medical education requirements established by the Executive Committee;
- (e) his cooperation with Hospital personnel;
- (f) his economic and efficient use of Hospital facilities;
- (g) his relationships with other Physicians, Podiatrists and Dentists, his general attitude toward patients, the Hospital and the public;
- (h) an appraisal of his present physical and mental capabilities, including any deterioration in physical strength or health or in mental acuity or emotional stability which might adversely affect his ability to treat patients or participate in Staff affairs;
- (i) a claims history of involvement in any professional liability action;

- (j) a medical examination as directed by the Executive Committee, the Credentials Committee, the President or the President-Elect whenever a question of physical or mental competency is raised;
- (k) his conformity with relevant state and federal regulatory standards.

#### 6.4.3 Division Review

The Chief of the applicable Division will complete his review as set forth in 6.2.1.

#### 6.4.4 Departmental Review

The Chair of the Department Shall complete his review as set forth in 6.2.2.

#### 6.4.5 Credentials Committee Review

At its next regularly scheduled meeting, the Credentials Committee Shall make written recommendations to the Executive Committee concerning the reappointment of each of those Members of the Staff being processed and include with those recommendations the specific Clinical Privileges to be granted to each appointee for the ensuing period. If non-reappointment or a change in Clinical Privileges is recommended, the reasons for such Shall be stated.

#### 6.4.6 Executive Committee Review

At its next regularly scheduled meeting, the Executive Committee Shall make written recommendations to the Board concerning the reappointment of each individual being processed. These recommendations Shall include the specific Clinical Privileges to be granted to each reappointee for the ensuing period. If non-reappointment or a change in Clinical Privileges is recommended, the reasons for the recommendation Shall be stated.

- (a) The recommendations of the Executive Committee will be forwarded to the Board, or the Executive Committee of the Board, by the President for review at its next meeting.
- (b) Thereafter, the procedures relating to recommendations of the Executive Committee on applications for Membership or additional Privileges at 6.2.4 through 6.2.8 Shall be followed.

## 6.5 Leave Of Absence

A Practitioner shall apply for a leave of absence from the Staff at any time the Practitioner is unable to perform Practitioner's Staff duties and responsibilities for a period of greater than sixty (60) days. Leaves of absence Shall be requested in writing by a Practitioner for reasons of health, except for maternity leave, or temporary absence from the community. Leave of absence requests Shall be reviewed by the Executive Committee of the Staff and the Board. Approval of the leave of absence Shall specify the duration of the leave of absence. A Practitioner who is on leave of absence Shall be relieved of all Medical Staff responsibilities for the duration of the leave, except that if his reappointment becomes due during such leave, he Shall be required to complete the reappointment process.

### 6.5.1 Returning from Leave

In order to return to the Staff from a leave of absence and regain Clinical Privileges, the individual Shall apply in writing to the Executive Committee for reinstatement prior to the end of the leave of absence.

- (a) If requirements for obtaining specific Clinical Privileges have changed during the leave, the individual Shall meet the new criteria which are applicable at the time reinstatement is requested.
- (b) Only under unusual circumstances will a leave of absence extend beyond one year.
- (c) A Practitioner who has been on a leave of absence for sixty (60) days or greater may be moved into FPPE, the scope and duration of which may be determined by the Chief and/or Chair.
- (d) If a leave of absence expires without the Practitioner seeking reinstatement prior to its expiration, any Membership and Clinical Privileges Shall automatically be terminated; and if he seeks to be a Member again he Shall complete a full application. Any termination of Membership and Clinical Privileges hereunder is not subject to review or any fair hearing rights.
- (e) Prior to reinstating the Practitioner, the Executive Committee May require a complete physical examination and/or a psychiatric evaluation in cases other than maternity leave.

### 6.5.2 Basis for Reinstatement from Leave

A Practitioner returning from a leave of absence Shall provide in writing, with the request to return, interval information addressing any changes in the information in his last application for appointment or reappointment and a statement as to the conduct of his clinical activities, if any, during his leave. The material submitted Shall be reviewed by the Credentials Committee at its next regularly scheduled meeting after receipt of the material from the Executive Committee. The

Credentials Committee Shall recommend to the Executive Committee whether the reinstatement from leave should be permitted. The Executive Committee Shall act thereon at its next regularly scheduled meeting after receipt of the Credentials Committee's recommendation. If the Executive Committee denies reinstatement, the matter Shall proceed in accordance with the provisions at 6.2.7 and 6.2.8.

### 6.5.3 Reapplication After Leave

If a Practitioner's appointment to the Medical Staff expires during a leave of absence and he does not timely complete the reappointment process, he Shall follow the full process for initial appointment under 6.2 and Shall not be eligible for reinstatement under 6.5.



## ARTICLE 7

### CLINICAL PRIVILEGES

#### 7.1 Clinical Privileges Restricted

Every person practicing at this Hospital Shall be entitled to exercise only those Clinical Privileges specifically granted to him by the Board, except as provided in Sections 7.5 and 7.6 of these Bylaws.

#### 7.2 Clinical Privileges Delineated

All Clinical Privileges for any Practitioner in this Hospital Shall be specifically delineated. Specific Clinical Privileges Shall be recommended by the Clinical Departments. Every application for appointment and for Clinical Privileges Shall contain a request for the specific Privileges desired by the applicant on a form approved by the Board after consultation with the Executive Committee. The applicant Shall have the burden of establishing his qualifications and competency for the Clinical Privileges requested.

#### 7.3 Scope of Privileges Available

The scope of Privileges available in the Hospital Shall be determined by the Board, taking into consideration the recommendations of the Medical Staff.

##### 7.3.1 Request

A Department Chair or Division Chief May request expansion of a Department's or Division's delineation of Privileges list to include the (a) availability of a procedure, study, technology or technique that has previously been within the domain of another Department or Division, or (b) expansion of their own delineation of Privileges list to include a new procedure, study, technology or technique that is new to the Hospital, by making a request in writing to the President of the Medical Staff. If a Member of the Medical Staff believes that such a request should be made but the Department Chair or Division Chief has not acted within thirty (30) Days of receipt of a written request, he May discuss his concern with the President of the Medical Staff who Shall discuss the matter with the Department Chair or Division Chief and Shall notify the Member of any action to be taken or that none will be. If the President of the Medical Staff believes such request should be made he Shall convene an ad hoc committee under 7.3.2.

### 7.3.2 Clinical Privilege Delineation Committee

In response to a request made pursuant to Section 7.3.1, or as further set forth in 7.3.1, the President of the Medical Staff Shall appoint an ad hoc Committee (the “Clinical Privilege Delineation Committee”) composed, at a minimum, of the following: (a) three (3) Medical Staff Members who are not Members of any Department or Division that has available or is requesting addition of the Privilege(s) at issue (“Affected Department”) and who do not depend upon the specialists or sub-specialists involved for referrals; (b) one (1) Member from each Affected Department; (c) the Chairperson of the Credentials Committee or another Member of the Credentials Committee if the Chairperson is a Member of an affected Division; and (d) the Senior Vice President and Chief Clinical Officer who Shall serve Ex Officio without vote. The President-Elect Shall chair any such ad hoc committee, unless he is a Member of an affected Department, in which case he Shall designate a substitute from outside the affected Department(s) to serve as Chairperson. This committee does not address Department or Division - only procedures which Clinical Privileges Shall be established by such Department or Division.

### 7.3.3 Duties of the Committee

The Clinical Privilege Delineation Committee, in each instance, is charged with conducting and concluding a comprehensive evaluation of (a) the propriety of the request for expansion of the Department’s or Division’s delineation of Privileges list, and (b) the standards and criteria that are and/or should be applied in determining the current clinical competence of applicants who request the Privilege(s) at issue, and making written recommendations to the Medical Executive Committee regarding the request and the standards and criteria.

### 7.3.4 Process of Review

The Clinical Privilege Delineation Committee Shall convene its first meeting within thirty (30) calendar Days of the appointment of its Membership. At that meeting, the Committee Shall discuss the request and formulate a plan for evaluating the request, including without limitation, (a) reviewing credible medical literature; (b) reviewing standards of applicable specialty boards; (c) interviewing the applicable Department Chairs and/or Division Chiefs; (d) interviewing Physicians at other institutions where the Privilege(s) at issue is exercised, if deemed appropriate; (e) interviewing experts in the Privilege(s) at issue, if deemed appropriate; and (f) making such additional inquiries as it deems necessary and appropriate to a thorough evaluation of the request.

### 7.3.5 Report of the Committee

Within ninety (90) calendar Days of its initial meeting, the Clinical Privilege Delineation Committee Shall issue a written report to the Medical Executive Committee. That report will contain, at a minimum, a description of the information reviewed and the individuals interviewed in connection with its evaluation, the Committee's conclusions based on that evaluation, and recommendations regarding the appropriateness of granting the request and, if the request is to be granted, the standards and criteria that should be applied when evaluating the current clinical competence of applicants requesting the Privilege(s) at issue. If at the conclusion of ninety (90) Days the Committee is still awaiting information it considers material to its determinations, it Shall document such need, report it to the President of the Medical Staff, and have thirty (30) Days thereafter to complete its report.

### 7.3.6 Medical Executive Committee Action

The Medical Executive Committee Shall review the report of the Clinical Privilege Delineation Committee at its next regularly scheduled meeting. The Medical Executive Committee Shall deliver the report of the Clinical Privilege Delineation Evaluation Committee, together with its written recommendations, to the Hospital President for transmission to the Board.

### 7.3.7 Board Action

The report of the Clinical Privilege Delineation Committee and the Medical Executive Committee's recommendations Shall be considered at the next regularly scheduled Board meeting unless business to be conducted at that meeting would make consideration of the request impracticable, in which case, the request will be placed on the agenda of the following Board meeting. The Board Shall review the information provided and either (a) adopt the recommendations of the Medical Executive Committee; (b) reject the recommendations of the Medical Executive Committee and take an alternative action (such as, for example, adoption of the recommendations of the Clinical Privilege Delineation Committee if contrary to those of the Medical Executive Committee); or (c) remand the matter back to the Medical Executive Committee with instructions for additional investigation and/or evaluation. Any Member of the Board who is a Member of either of the departments or Divisions at issue May be present at the discussion of the request to answer questions but must formally recuse themselves. In the reviews hereunder, if at any time the reviewing body believes that its decision would benefit from expertise not otherwise available from the Medical Staff, with the prior approval of the Medical Executive Committee, it Shall have the right to engage the services of outside consultants.

#### 7.4 Basis for Granting Clinical Privileges

Evaluation of all requests for Clinical Privileges Shall be based upon information including but not limited to the applicant's education, training, experience, demonstrated current competence, physical and mental health status appropriate to perform the Clinical Privileges requested, professional peer references, other relevant information, and, in the case of reappointments, results of quality management activities and observed clinical performance. The delineation of Clinical Privileges under this Article May be granted subject to such conditions as the review process and bodies established hereunder determine are appropriate under the individual circumstances.

##### 7.4.1 Basis for Clinical Privileges upon Initial Appointment

Clinical Privileges Shall be granted based upon criteria, including but not limited to the following upon initial appointment:

- (a) Participation in relevant continuing medical education programs; and other education and training;
- (b) Board certification or eligibility;
- (c) Peer references;
- (d) Review of the applicant's malpractice claims history;
- (e) Physical and mental status to perform the Privileges requested. To assure itself regarding this competence, the Credentials Committee and, Executive Committee, President and President-Elect Shall have the right to require the applicant to undergo a physical or mental health evaluation by a mutually agreed upon clinician.

##### 7.4.2 Basis for Clinical Privileges upon Reappointment

Clinical Privileges Shall be granted upon reappointment based on all the factors in 7.3.1 plus the following:

- (a) Observation of care provided, taking into account data developed pursuant to Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation;
- (b) Review of the records of patients treated in this or other hospitals;
- (c) Review of the records of the Staff which document the evaluation of the Practitioner's participation in the delivery of medical care;
- (d) Results of quality management activities in the Hospital;

- (e) Physical and mental status to perform the Privileges requested. To assure itself regarding this competence, the Credentials Committee, Executive Committee, President and President-Elect Shall have the right to require the applicant to undergo a physical and mental health evaluation by a mutually agreed upon clinician.

#### 7.4.3 Board Certification

In those specialties in which the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists is recognized, board eligibility or board certification Shall be required for the determination of specific Clinical Privileges. Maintenance of certification is required for Clinical Privileges in accordance with the requirements of the applicable specialty or sub-specialty board of the applicant, as set forth more fully in the Rules and Regulations.

- (a) If there is a significant difference in training, education or qualifications required by different boards covering the same specialty, the Clinical Department in which the specialty is a part Shall make recommendations to the Executive Committee as to the qualifications which should be required for each type of Clinical Privilege.
- (b) Such recommendations Shall be based on the need to insure competence and appropriate, quality patient care. The Executive Committee Shall make its recommendations to the Board whose decision Shall be final.
- (c) Adverse decisions concerning Privileges May be appealed according to the procedures specified in Article 9.

#### 7.4.4 Basic Qualifications

Each Practitioner Shall continuously meet all the qualifications set forth in this Article and Article 4 in order to maintain Clinical Privileges.

#### 7.4.5 Changes in Clinical Privileges

In order to obtain additional Privileges, a Practitioner Shall complete an application, which Shall state the type of Clinical Privileges desired and recent special training and experience. Such applications Shall be processed in the same manner as an initial application.

## 7.5 Emergency Privileges

Privileges may be granted on a temporary basis in the case of an emergency as defined in Section 7.5.1 below.

### 7.5.1 Circumstances

Individual Patient Care. In the case of an emergency which could result in serious harm to a patient, or in which the life of a patient is in immediate danger, and for which no qualified member of the Medical Staff with appropriate clinical privileges is available to treat the patient:

- (a) Any Medical Staff Member is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the physician's license, but regardless of Department or Division affiliation, category, or level of privileges. Such physician exercising emergency privileges is obligated to summon all consultative assistance considered necessary, to arrange appropriate follow-up care, and subsequently to provide a written statement to his/her Department Chair and the President of the Medical Staff explaining the circumstances giving rise to the emergency treatment.
- (b) A Dependent Medical Affiliate is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license and within the practitioner's area of medical expertise, specialty or subspecialty, as defined by the Pennsylvania Department of Health. Such provider exercising emergency privileges is obligated to summon all consultative assistance considered necessary, to arrange appropriate follow-up care, and subsequently to provide a written statement to his/her Supervising\Collaborative Physician, Department Chair and the President of the Medical Staff explaining the circumstances giving rise to the emergency treatment.

## 7.6 Disaster Privileges

In the case of a disaster, which means a government declared or hospital declared, local, state, or national disaster which requires the implementation of the Hospital Emergency Management Plan, if under the plan, the President of the Medical Staff with the Hospital President, determine that the resources of the Members of the Medical Staff have been exhausted, volunteers May be granted Clinical Privileges as set forth here. Any Physician, Podiatrist, Dentist or Dependent Medical Affiliate, as the situation warrants, to the degree permitted by his license to practice in any state in the United States, and regardless of Department or Staff status or lack of it, Shall be permitted to exercise Clinical Privileges.

#### 7.6.1 Approval of Disaster Privileges

The President of the Staff or the Hospital President or his or her designee(s) Shall be responsible for approving disaster Privileges after obtaining one of the following: a current license to practice medicine or other healthcare discipline and a valid picture ID issued by a state, federal or regulatory agency, or if presented by a current Medical Staff Member(s) with personal knowledge regarding Practitioner's identity.

- (a) Once approved, an identification badge or sticker Shall be worn by this individual during the entire event.
- (b) When the immediate situation is under control, the patient Shall be assigned to an appropriate Member of the Staff.

#### 7.6.2 Conditions of Disaster Privileges

Any volunteer Practitioner hereunder Shall be paired with a Member of the Medical Staff of the same specialty for proctoring or supervision as appropriate.

#### 7.6.3 Verification of Credentials

Any volunteer exercising disaster Privileges Shall be subject to verification of credentials in accordance with the Disaster Privileges Policy. The verification process Shall be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the organization.

### 7.7 Independent Medical Affiliates

Independent Medical Affiliates are those licensed allied health professionals who May receive Clinical Privileges to provide patient care in the Hospital. They May include other licensed allied health professionals who May be approved by the Board from time to time. Upon the adoption of these Bylaws, this category included neuropsychologists and audiologists.

#### 7.7.1 Clinical Privileges

The Clinical Privileges of Independent Medical Affiliates Shall be determined in accordance with Section 7.4 as applicable to the Practitioner. Each individual seeking Privileges as an Independent Medical Affiliate Shall make written application on the prescribed form and Shall comply with and be bound by the requirements of this Article Seven of these Bylaws.

- (a) Clinical Privileges granted to an Independent Medical Affiliate Shall be based upon his training, experience and demonstrated competence and judgment within his authorized scope of licensure, in accordance with the procedures set forth in Article Five of these Bylaws.

- (b) Each Clinical Department Shall recommend the type and scope of Clinical Privileges for each Independent Medical Affiliate who May come under that Department's jurisdiction. Such recommendations Shall be reviewed and approved through the usual credentialing mechanism.
- (c) All Independent Medical Affiliates Shall be required to have their Clinical Privileges reviewed and obtain reappointment in the same manner as Physicians, Podiatrists and Dentists.
- (d) They Shall be subject to Ongoing Professional Practice Evaluation (OPPE) and/or Focused Professional Practice Evaluation (FPPE).

#### 7.7.2 Basis for Privileges

Clinical Privileges Shall only be granted to individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations of a Clinical Department and Division. Only allied health professionals who: (i) maintain a current and unrestricted license to practice in the Commonwealth of Pennsylvania; (ii) graduated from an approved academic institution; (iii) maintain professional liability insurance as required by Pennsylvania law; and (iv) are board certified by an approved certifying agency for the individual's respective allied health profession Shall be eligible to exercise Clinical Privileges.

#### 7.7.3 Authorizations

The Independent Medical Affiliate May exercise independent judgment and May participate directly in the management and care of patients, within the scope of his licensure, Privileges and competence.

- (a) The admission and discharge of a patient of an Independent Medical Affiliate Shall be the responsibility of a Physician Member of the Staff. The Physician Shall be responsible for performing a history and physical examination of the patient, and Shall be responsible for the care of any medical problems present at the time of admission or arising during the hospitalization.
- (b) The Independent Medical Affiliate Shall document reports and progress notes on the patient's records and order treatment as required by these Bylaws, Rules and Regulations, within the scope of his licensure, Privileges and competence.

#### 7.7.4 Participation Rights

Independent Medical Affiliates are not Members of the Medical Staff and, therefore, have none of the duties or rights of Staff Members, except as specified herein or in the rules and regulations of the appropriate Clinical Department.



- (a) Independent Medical Affiliates are not entitled to vote or hold office on the Medical Staff. They May, at the discretion of each Clinical Department, be entitled to attend and vote at Department meetings.
- (b) Independent Medical Affiliates May serve on appropriate committees of the Medical Staff if approved by the Executive Committee. Such individuals May, as a condition of continued Privileges, be required to attend meetings involving the clinical review of patient care in which they have participated.
- (c) Independent Medical Affiliates are expected to comply with the Hospital Policies\Code of Conduct and Medical Staff Standards\Code of Conduct.

## 7.8 Dependent Medical Affiliates

Dependent Medical Affiliates are those licensed health professionals who May receive Clinical Privileges to provide patient care in the Hospital who are employed by, or under contract with, the Hospital or a Member of its Medical Staff or a group consisting of Medical Staff Members. The process for their evaluation is as under Article 6. They May include:

- (a) Licensed allied health professionals who May be approved by the Board from time to time.
- (b) Licensed Physicians, Podiatrists and Dentists who seek to perform only clinical duties which May lawfully be performed by non-Physicians.
- (c) Upon the adoption of these Bylaws, Dependent Medical Affiliates included Certified Registered Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, and Acupuncturists.

### 7.8.1 Hospital-Employed Dependent Medical Affiliates

The professional qualifications and clinical duties of Dependent Medical Affiliates employed by or under contract with the Hospital who are not independently licensed such as dental assistants, pathology assistants, scrub technicians, sonographers, nurse clinicians, and pacemaker technicians are subject to the Hospital's employment procedures, with the concurrence of the appropriate Clinical Department Chair, and do not require review through the Medical Staff processes.

### 7.8.2 Member-Employed Dependent Medical Affiliates

Any individuals enumerated in 7.7, but employed by a Member of the Medical Staff or group of such Members Shall be evaluated as Dependent Medical Affiliates under this section 7.7.

### 7.8.3 Basis for Privileges

Clinical Privileges Shall only be granted to individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations of a Clinical Department and Clinical Division. Only allied health professionals who: (i) maintain a current and unrestricted license to practice in the Commonwealth of Pennsylvania; (ii) graduated from an approved academic institution; (iii) maintain professional liability insurance as required by Pennsylvania law; and (iv) are board certified by an approved certifying agency for the individual's respective allied health profession (*i.e.*, American Nursing Credentialing Center, American Association of Nurse Practitioners, National Commission on Certification of Physician Assistants, American Midwifery Certification Board, National Board of Certification and Recertification of Nurse Anesthetists, the National Certification Commission for Acupuncture and Oriental Medicine, or such other certifying agency as approved by a Clinical Department from time to time) Shall be eligible to apply for Clinical Privileges.

### 7.8.4 Qualification for Privileges

An individual who qualifies as a Dependent Medical Affiliate Shall apply for Clinical Privileges in accordance with the process at Article 5 of these Bylaws. Clinical Privileges May be granted to individuals who qualify as Dependent Medical Affiliates based on the individual's education, training, experience, and demonstrated competence and judgment. In addition to the requirements contained in Article 5 and elsewhere in these Bylaws, a Dependent Medical Affiliate must meet the following requirements at all times:

- (a) Collaborate with, or be under the supervision of, a Member of the Staff with Clinical Privileges;
- (b) Earn continuing education credit hours as required by state law; and
- (c) Hold prescriptive authority, provided the Dependent Medical Affiliate's respective allied health profession is authorized to hold prescriptive authority under state law.

### 7.8.5 Limitations on Privileges

The Clinical Privileges of a Dependent Medical Affiliate are limited to those clinical duties specified: (i) by applicable federal and state laws and regulations; (ii) in the Rules and Regulations of the Clinical Department and Clinical Division to which the Dependent Medical Affiliate is assigned; and (iii) in the applicable collaboration or supervision agreement for the Dependent Medical Affiliate.

- (a) Notwithstanding any Clinical Department or Clinical Division rule or regulation, a patient who is admitted to the Hospital by a Dependent Medical Affiliate Shall be seen and evaluated by a Member who supervises or collaborates with that Dependent Medical Affiliate as clinically

indicated, but no later than twenty-four (24) hours after admission excluding uncomplicated normal vaginal deliveries. This provision does not pertain to a patient in observation status, regardless of their location in the Hospital. Departments and Divisions May establish stricter standards in their specific Rules and Regulations.

- (b) In addition, a patient assigned to a Dependent Medical Affiliate who is managing a patient as set forth in the Rules and Regulations Shall be seen and evaluated by a Member who supervises or collaborates with that Dependent Medical Affiliate when the patient's clinical status changes to require transfer to a unit as set forth in the Rules and Regulations.
- (c) Dependent Medical Affiliates May perform consults, however nothing in these Bylaws Shall limit the right of a Member to request a consult to be seen only by another Member.

#### 7.8.6 Provisional Status

Unless law or regulation requires a longer period of provisional status than required by these Bylaws, provisional Clinical Privileges will apply: (i) for the first six (6) months following the grant of Clinical Privileges for individuals with less than one (1) year of hospital-based clinical experience in the individual's respective allied health profession; or (ii) for the first three (3) months following the grant of Clinical Privileges for individuals with greater than one (1) year of hospital-based clinical experience in the individual's respective allied health profession. In addition, provisional Clinical Privileges for a period of three (3) months will apply to a Dependent Medical Affiliate who is granted Clinical Privileges in a new area of specialty.

- (a) Unless law or regulation requires additional oversight responsibilities of a Dependent Medical Affiliate on provisional status, provisional Clinical Privileges requires: (i) a Member or a non-provisional Dependent Medical Affiliate to independently and in a timely manner see and evaluate patients and discuss and review all histories and physicals, consults, and associated orders with the provisional Dependent Medical Affiliate; (ii) a Member or a non-provisional Dependent Medical Affiliate to discuss and review all discharges and discharge orders with the provisional Dependent Medical Affiliate; and (iii) completion of any other requirements determined by a Clinical Department or Clinical Division.
- (b) After the Dependent Medical Affiliate's provisional period, the Department Chair Shall make specific recommendations to the MEC concerning the Clinical Privileges granted to the Dependent Medical Affiliate.

#### 7.8.7 Ongoing Professional Practice Evaluation

Each Clinical Department or Clinical Division Shall implement OPPE and/or FPPE to periodically monitor the quality of patient care provided by Dependent Medical Affiliates.

#### 7.8.8 Termination of Privileges

The Clinical Privileges of a Dependent Medical Affiliate Shall automatically terminate in the event: (i) the Dependent Medical Affiliate is no longer employed by, or under contract with, the Hospital or a Member of the Staff; or (ii) the Dependent Medical Affiliate's collaborating or supervising Physician is no longer a Member of the Staff.

#### 7.8.9 Participation Rights

Dependent Medical Affiliates are not Members of the Staff and have none of the duties and rights of Members, except as otherwise provided in these Bylaws. They are expected to comply with Hospital Policies\Code of Conduct and Medical Staff Standards\Code of Conduct.

#### 7.8.10 Corrective Action

Basis for corrective action against a Dependent Medical Affiliate are those set forth under 8.1. Any Practitioner who has a concern about the performance of a Dependent Medical Affiliate Shall communicate it to the President. The President Shall notify the Dependent Medical Affiliate and his supervising or collaborating Physician. Both Shall be given an opportunity to respond to the concerns raised.

- (a) The President Shall transmit the concern to the Department Chair or Division Chief who Shall, after interaction with the Dependent Medical Affiliate and supervising or collaborating Physician, unless either fails or declines to respond, make a written recommendation to the President.
- (b) The President Shall report the recommendation to the Medical Executive Committee which Shall affirm, modify or reverse the recommendation.
- (c) There is no additional appeal of the MEC decision. None of the rights in Article 9 Shall pertain or be available.
- (d) A report Shall be made to the Board which Shall take whatever action it deems appropriate.
- (e) The provisions of 8.9 pertaining to automatic suspensions or limitations, and 8.10 pertaining to criminal activity Shall also apply to Dependent Medical Affiliates.

7.9 “Moonlighting” Privileges For Fellows Not Affiliated With Lancaster General Hospital Residency Programs

Physicians who have completed residency training and continue specialized training in a fellowship sponsored by an American Board of Medical Specialties approved fellowship, not at the Hospital, May be privileged to provide coverage services (“moonlighting”) for Members of the Medical Staff when they are not available to attend their patients. Such moonlighting activities Shall be as permitted by the relevant Department or Division Rules and Regulations.

7.9.1 Application

A physician seeking Moonlighting Privileges Shall complete an application as under 7.2 and such application Shall be processed in accordance with the process set forth in Article 6.

7.9.2 Basis for Privileges

An application for Moonlighting Privileges Shall be reviewed in accordance with the standards in 7.4.1 and 7.4.2 as applicable.

7.9.3 No Membership

Moonlighting Physicians are not Members of the Medical Staff and no Fair Hearing rights Shall pertain to the termination of their Clinical Privileges for any reason.

7.10 Telemedicine Privileges

A Practitioner who is granted Telemedicine privileges shall be appointed to the Telemedicine Staff category of the Medical Staff if the Practitioner provides clinical services at the Hospital only from a distance via electronic communications, but if the Practitioner also applies for and is granted other Clinical Privileges then he/she Shall be placed in another appropriate Medical Staff category for which the Practitioner is eligible and qualified.

7.10.1 Application

Requests for initial or renewed Telemedicine privileges Shall be processed through one of the following options, as determined by the Medical Executive Committee:

(a) Standard Credentialing

A request for Telemedicine privileges may be processed through the standard procedure for Medical Staff applications, as set forth in Section 7.3. In such case, the Practitioner must satisfy all qualifications and

requirements set forth in these Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(b) Credentialing by Proxy

If the Practitioner requesting Telemedicine privileges is practicing at a Distant Site Entity that participates in Medicare and is accredited by the Joint Commission, a request for Telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the Distant Site Entity. In such cases, the Hospital must ensure that, through a written agreement, the Distant Site Entity will comply with all applicable Medicare regulations and accreditation standards. The Distant Site 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 twelve (12) months and has done so in a competent manner;
- (iv) a signed attestation that the applicant satisfies all of the Distant Site Entity's qualifications for the clinical privileges granted;
- (v) a signed attestation that all information provided by the Distant Site 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 Medical Executive Committee for review and recommendation to the Board for final action.

7.10.2 Duration of Privileges

Telemedicine privileges, if granted, shall be for a period of not more than two (2) years.

7.11 Roles of Registered Dietitians

A Physician Member of the Medical Staff shall, within twenty-four (24) hours of a Patient's Hospitalization, order initial dietetic orders for the patient. Thereafter, a Member May delegate to a registered dietician, as consistent with the laws of the Commonwealth of Pennsylvania, the authority to alter, modify or change the original order.

## ARTICLE 8

### CORRECTIVE ACTION

#### 8.1 Peer Review Privilege

All corrective action discussed within this Article, Article 9, and these Bylaws shall be peer review privilege protected in accordance with the LGH Peer Review Policy, the Pennsylvania Peer Review Protection Act, 63 Pa. Stat. Ann. Tit 63 Sect. 425.2 et. seq., and the Healthcare Quality Improvement Act of 1986, 42 U.S.C. § 11101 et. seq.

#### 8.2 Bases for Corrective Action

The circumstances set forth in this Article Shall be the bases for corrective action against a Member with Clinical Privileges. This Article Shall provide the basis for corrective action against a medico-administrative Member only with respect to Staff Membership and Clinical Privileges and not administrative functions subject to an employment contract.

##### 8.2.1 Violations

A basis for corrective action exists whenever a Member is believed to have violated these Bylaws or the Rules and Regulations of the Medical Staff.

##### 8.2.2 Failure to Meet Quality Standards

A basis for corrective action exists whenever a Member fails to meet clinical standards of his profession, his specialty, his sub-specialty, his Division, his Department, the Medical Staff, or of the Hospital.

##### 8.2.3 Unprofessional or Unethical Conduct

A basis for corrective action exists whenever a Member engages in acts, makes statements, or exhibits demeanor or unprofessional or unethical conduct, either within or outside the Hospital, which action does not conform to professional standards as determined by the Hospital.

##### 8.2.4 Disruptive Behavior

A basis for corrective action exists whenever a Member engages in any action or behavior which is disruptive or is reasonably likely to be disruptive of Hospital operations, or to be detrimental to patient safety or delivery of good patient care.

#### 8.2.5 Breach of Confidentiality

The purposes of the Medical Staff set forth at Article 8 of these Bylaws and the responsibilities delegated to it by the Board Shall be implemented through these Bylaws in all respects by all Members in a manner which safeguards the confidentiality of the information considered, created or transmitted by an individual or committee operating pursuant to these Bylaws. Any breach of such confidentiality by any individual Shall be considered a basis for corrective action.

#### 8.2.6 Failure to Cooperate

A basis for corrective action exists whenever a Member fails to cooperate in accordance with 4.3.5.

#### 8.2.7 Reporting Violations

If any Member becomes aware of activities, conduct, or behavior of any other Member which May be considered unprofessional, disruptive of the operations of the Hospital, otherwise not in keeping with standard of conduct required of Members, violative of these Bylaws, or violative of the Rules and Regulations of the Staff or Hospital, it Shall be his professional duty to report such activities, conduct, or behavior to the President of the Staff.

### 8.3 Peer Resolutions

It is the intention of the Medical Staff to informally resolve issues regarding Member performance through Member interactions including, but not limited to, those provided through the Peer Review Committee and the Professionalism Committee. Documentation of such interaction Shall be placed in the Member's Peer Review file. Any informal resolution proposed by these committees May not be of such a nature as to rise to a corrective action under 8.8.1(f-j). All corrective action review, including documentation and processes, is conducted pursuant to the Medical and Dental Staff Peer Review Policy. Where there is a conflict between these Bylaws and the Policy, the Bylaws Shall control.

### 8.4 Presidential Investigation

Whenever the President becomes aware of activities, conduct, or behavior of any Member which May be considered unprofessional, disruptive of the operations of the Hospital, otherwise not in keeping with the standards of conduct required of Members, violative of these Bylaws, or violative of the Rules and Regulations of the Staff or Hospital, he Shall notify the Hospital President concerning such matters.

#### 8.4.1 Involving Others

The President May consult with other Members of the Staff, the involved Member, appropriate administrative officers of the Hospital and Members of the Board or he May appoint an individual to seek to determine the facts.



#### 8.4.2 Notice to Member

He Shall inform the Member that he is engaged in an informal investigation.

#### 8.4.3 Action on Information

Based on the information gathered pursuant to 8.2, the President May dismiss, modify the basis for corrective action, or move forward under 8.4.

#### 8.4.4 Resolution

The President Shall meet with the Member to attempt to resolve the matter without further action. He May propose any of the actions set forth in 8.7.1(a)-(e).

- (a) If the Member accepts the proposed resolution, the matter Shall be documented in the Member's Peer Review file. The Member Shall have the right to submit a statement for inclusion in his Peer Review file.
- (b) If the Member does not accept the proposed resolution, an Investigating Committee Shall be convened under 8.7.

#### 8.5 Timeframes

Any timeframes set forth in this Article will be met with all reasonable efforts, but failure to strictly meet a timeframe Shall not be grounds for appeal, nor for challenge in any way, in any form, to the resulting decision(s).

#### 8.6 Outside Consultants

In their reviews hereunder, if the Investigating Committee under 8.6 or the Executive Committee under 8.7 believes their decisions would benefit from expertise not available within the Medical Staff, they Shall have the right to engage outside consultants to advise them.

#### 8.7 Investigating Committee

An Investigating Committee of three (3) Members of the Medical Staff, appointed by the President or his designee, Shall conduct an investigation and within sixty (60) Days, the Committee Shall report their recommendations, including for specific corrective action, if any, in accordance with 8.7.1, to the President.

### 8.7.1 Conduct of Investigation

The Investigating Committee Shall seek to determine the facts in the matter and Shall interview relevant individuals as necessary to the investigation and Shall review such Hospital records as the Committee deems relevant to the circumstances.

- (a) The Committee Shall provide written Notice to the Member of the general nature of the allegations against him and he Shall be invited to discuss, explain or refute them.
- (b) The Member about whom the investigation was initiated Shall have an opportunity for an interview with the Committee.
- (c) The interview Shall be scheduled at the Committee's discretion, taking into consideration the Member's schedule. 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 hearings Shall apply thereto. No attorneys Shall participate in the interview in an advisory or representative capacity.
- (d) A written summary of such interview Shall be made and included in the report to the President and the Hospital President.
- (e) The failure of a Member to participate in the interview Shall be documented in the report.
- (f) In the course of the investigation, the Committee Shall accept from the Member for review and consideration any other information which the Member feels May be relevant to the allegations.
- (g) The failure or inability of a Member to secure any documents he has requested Shall be documented in the report. When this occurs, no inferences Shall necessarily be drawn, but the circumstances involved Shall be taken into consideration by the President and the Hospital President.
- (h) At the conclusion of the investigation, the Investigating Committee Shall prepare a written report setting forth the findings of the investigation along with recommendations, including corrective action where appropriate. A copy of the written report Shall be given to the President and the Member.

### 8.7.2 Meeting with the Member

Within thirty (30) Days of receipt of the Investigating Committee Report, if the President agrees with the findings and recommendations of the investigation, he and the President of the Hospital Shall discuss the same with the Member involved.

- (a) This meeting is informal.
- (b) No attorneys Shall participate.
- (c) None of the procedural rights of a Fair Hearing Shall apply.
- (d) It is the goal of the meeting to resolve the matter through informal resolution including such corrective actions as do not entitle the Member to a Fair Hearing.
- (e) If the Member accepts the recommendations, and any proposed corrective action which the President Shall suggest in his discretion, the matter need not be submitted to the Executive Committee for further action. The President May proceed to impose the corrective action on the Member.

### 8.7.3 Report to Executive Committee

If the matter cannot be resolved pursuant to the meeting under 8.7.2, the President Shall report the matter to the Executive Committee within forty-five (45) Days. The report of the investigation, together with any comments from the President of the Staff and Hospital President, Shall be forwarded to the Executive Committee for action.

- (a) The Member Shall be notified in writing by the President that the matter is being forwarded to the Executive Committee.
- (b) The Notice Shall include the date upon which the Executive Committee will review the matter, and a statement that the Member May submit a written rebuttal of the investigation report to the Executive Committee for its consideration.
- (c) If the Member does not submit a written rebuttal to the Medical Staff Office prior to the date of the Executive Committee meeting referenced in the Notice, the Member Shall be deemed to have waived any right to submit a written rebuttal to the Executive Committee.

## 8.8 Executive Committee Action

The Executive Committee Shall act upon the report within forty-five (45) Days of its receipt. If upon review of the report the Executive Committee seeks additional information, the Executive Committee May direct or conduct additional investigation which Shall be concluded and acted upon no later than forty-five (45) Days from the receipt of the report.

### 8.8.1 Types of Action

The Executive Committee May accept, reject, or modify the basis for the request for corrective action. If accepted, the Committee Shall recommend a specific sanction which May include but is not limited to the following:

- (a) A warning, letter of admonition or reprimand.
- (b) Time limited terms of probation which Shall require monitoring of the Member's actions with additional episodes of the basis for corrective action necessitating further sanction or penalty.
- (c) Requirement for remedial activity including additional education.
- (d) Referral to a professional for counseling or to the Physician's Health Program.
- (e) Voluntary suspension pending medical consultation/evaluation by a physician or health care provider mutually acceptable to the Member and the President.
- (f) Involuntary suspension of Membership and/or Privileges other than under 8.9.
- (g) Involuntary reduction, suspension or revocation of Clinical Privileges other than under 8.9.
- (h) Sustaining or expanding an already imposed corrective action, including suspension of Clinical Privileges pending investigation.
- (i) Requirement for clinical supervision of care, consultation on categories of care, or co-Privileges with another Member.
- (j) Suspension or revocation of Staff Membership.
- (k) Modification of an already imposed corrective action not consistent with actions set forth at 8.8.1(f-j).
- (l) Other specific sanctions as appropriate to the circumstances.

### 8.8.2 Procedural Rights

Any Executive Committee recommendation set forth at 8.8.1(f-k) and any other action under 8.8 which would be reportable to the National Practitioner Data Bank Shall entitle the affected Member to the procedural rights provided in the Fair Hearing Plan.

### 8.8.3 Recommendation Not Subject to Fair Hearing

When the Executive Committee recommends an adverse action which does not entitle a Member to the procedural rights afforded by the Fair Hearing Plan, at the next regular business meeting of the Board after such recommendation, the President or designee Shall present the Executive Committee's recommendation to the Board for final action.

- (a) The President Shall promptly notify the Member in writing of the action taken by the Executive Committee.
- (b) The recommendation of the Executive Committee Shall be presented to the Board for consideration.
- (c) Unless the Member has been suspended pursuant to 8.8, any recommendations for corrective action by the Executive Committee or the Board Shall not be implemented until either: (i) the Acting Body under Article 9 has acted, the Member has received notification of the action pursuant to 9.4 and the Member has failed to request a hearing within the time period allotted; or (ii) the Member has exhausted the hearing and appeal procedure described in Article 9.

### 8.9 Suspension Pending Investigation

Whenever a Member's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of imminent threat to the health or safety of any patient, Staff Member, employee or other person, the Hospital President, the President, the President-Elect or the Department Chair, with the concurrence of any other of the foregoing Shall have the authority to suspend all or any portion of the Clinical Privileges and/or Membership status of a Member, pending investigation, and such suspension Shall become effective immediately. The individual initiating the suspension Shall immediately notify the suspended Member, the Hospital President and the President.

#### 8.9.1 Notice

The President Shall provide immediate notice to the affected Member and Shall provide formal written Notice to the Member, which states the scope of the suspension.

#### 8.9.2 Provision of Patient Care

Immediately upon the imposition of a suspension pending investigation, the Department Chair Shall have the authority to provide for alternative medical coverage for the patients of the suspended Member still in the Hospital at the time of such suspension. To the extent feasible, the wishes of the patients Shall be considered in the selection of such alternative Member.

#### 8.9.3 Suspension of Member's Care

A Member under suspension is prohibited from providing services at the Hospital on an inpatient or outpatient basis, including admitting, attending patients, performing consultations, scheduling, performing or assisting in procedures and ordering services at the Hospital.

#### 8.9.4 Executive Committee Review

The Executive Committee or a specifically delegated Ad Hoc Subcommittee of the Executive Committee as appointed by the President Shall review any suspension pending investigation as soon as practicable after imposition, but in no event more than fourteen (14) Days after imposition. The Committee Shall conduct such investigation as it can within the foreshortened timeframe. The Committee May recommend modification, continuance or termination of the terms of the suspension pending investigation.

#### 8.9.5 Member Rights

Unless the Executive Committee or Subcommittee immediately lifts the suspension or ceases all corrective action, the suspension Shall continue in effect and the Member Shall be entitled to the rights, and the matter Shall proceed as set forth in the Fair Hearing Plan pertaining to an adverse determination of the Executive Committee.

### 8.10 Automatic Suspensions or Limitations

A Member's Privileges Shall automatically be revoked, limited or suspended, as appropriate, upon the occurrence of the following circumstances.

#### 8.10.1 License Impairment or Restriction

Whenever a Member's license, certificate or other legal credential authorizing him to practice in the Commonwealth of Pennsylvania is revoked, his Staff Membership and/or Clinical Privileges Shall be automatically revoked. Whenever the relevant licensing or certifying authority limits, restricts, or suspends such license or other legal credential

for reasons related to his professional activities or such license or credential lapses for administrative reasons, his Clinical Privileges within the scope of the limitation, restriction or suspension Shall also be automatically suspended, at least for the duration of the limitation, restriction or suspension.

- (a) In the case of limitation, restriction or suspension, at the termination of such limitation the Executive Committee Shall review the matter as if a suspension pending investigation in conformity with 8.9.4 and 8.9.5.
- (b) Whenever a Member is placed on probation by the applicable licensing or certifying authority, his voting, and office-holding prerogatives and responsibilities, if any, Shall be automatically suspended effective upon, and for at least, the term of the suspension. Further action on the matter Shall proceed as if a suspension pending investigation in conformity with 8.9.4 and 8.9.5.

#### 8.10.2 Drug Enforcement (DEA) Number

Whenever a Member's DEA number is revoked or suspended he Shall immediately and automatically be divested at least of his right to prescribe medications covered by the number, effective upon such revocation or suspension, and in the case of suspension, for at least the duration of the suspension. In any of these situations, or in the case of probation related to a DEA number, the Executive Committee Shall review the matter as if a suspension pending investigation in conformity with 8.9.4 and 8.9.5.

#### 8.10.3 Failure to Complete Medical Records

Automatic suspension in the form of withdrawal of a Member's Privileges Shall be imposed after Notice of delinquency in completed medical records in accordance with the Rules and Regulations of the Medical Staff. When the medical records are completed, the Member's Privileges suspended upon that basis Shall be reinstated. A solo Member so affected Shall be permitted to continue to care for hospitalized inpatients in his care at the time the suspension was imposed. Except for the preceding sentence, a suspension hereunder Shall be subject to the provisions of 8.9.4 and 8.9.5

#### 8.10.4 Loss of Medical Professional Liability Insurance

An automatic suspension Shall occur whenever a Member does not meet the medical professional liability insurance requirement under Article 4.2.4 of these Bylaws. Such suspension Shall be reviewed by the Executive Committee as if a suspension pending investigation and in conformity with 8.9.4.

#### 8.10.5 Notification to Board

In any instance of a suspension pending investigation or automatic suspension, the Hospital President Shall notify the Board within five (5) Days that such action has occurred.

#### 8.11 Criminal Activity

A review of Privileges Shall occur whenever the Executive Committee determines that a Member has been charged in a criminal action. A suspension of Membership and/or Privileges May be imposed pending review as if a suspension pending investigation pursuant to 8.9. A continuation of such suspension Shall be permitted only after review in conformity with 8.9.

#### 8.12 Reappointment While Under Suspension

If a Member's reappointment would occur while he is suspended, he Shall continue to have the rights set forth in Articles 8 and 9, but his reappointment Shall not be processed nor be considered until the conclusion of all applicable processes under Articles 8 and 9.



## ARTICLE 9

### HEARING AND APPEAL PROCEDURE

#### 9.1 Right to Hearing and to Appellate Review

When any Practitioner receives Notice of a recommendation of the Executive Committee, that, if ratified by decision of the Board, would adversely affect his appointment to or status as a Member of the Medical Staff or his exercise of Clinical Privileges, as provided for in these Bylaws, he Shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff which Shall make its recommendations to the Executive Committee. The processes set forth herein shall also be known as the Fair Hearing Plan.

##### 9.1.1 Appellate Review from Executive Committee Decision

If the recommendation of the Executive Committee following such hearing is still adverse to the affected Practitioner, he Shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.

##### 9.1.2 Hearing and Appellate Review by the Board

When any Practitioner receives Notice of an adverse decision by the Board that will affect his appointment to or status as a Member of the Medical Staff or his exercise of Clinical Privileges or other Adverse Action under 9.2.2, and such decision is not based on a prior adverse recommendation by the Executive Committee with respect to which he was entitled to a hearing and appellate review, he Shall be entitled to a hearing by a committee appointed by the Board, and, if such hearing does not result in a favorable recommendation, to an appellate review by the Board before it makes a final decision on the matter.

##### 9.1.3 Timeframes

Any timeframes set forth in the Article will be met with all reasonable efforts, but failure to strictly meet a timeframe Shall not be grounds for appeal, nor for challenge in any way, in any form to the resulting decision(s).

#### 9.2 Basis for Action

This Fair Hearing Plan Shall apply only to Adverse Actions which are enumerated below.

### 9.2.1 Adverse Recommendations Defined

A recommendation which is not yet final but, if implemented, would be an Adverse Action under 9.2.2 Shall be deemed adverse only in the following circumstances:

- (a) When it has been recommended by the Executive Committee;
- (b) When it is taken by the Board contrary to a favorable recommendation by the Executive Committee under circumstances where no right to hearing existed; or
- (c) When it is taken by the Board on its own initiative without benefit of a prior recommendation by the Executive Committee.

### 9.2.2 Adverse Actions Enumerated

The following Shall be considered Adverse Action:

- (a) Denial of initial Medical Staff appointment.
- (b) Denial of Medical Staff reappointment.
- (c) Denial of reinstatement after a leave of absence.
- (d) Involuntary suspension of Medical Staff appointments.
- (e) Revocation of Medical Staff appointment.
- (f) Denial of requested Clinical Privileges.
- (g) Involuntary reduction of Clinical Privileges.
- (h) Suspension of Clinical Privileges.
- (i) Revocation of Clinical Privileges.
- (j) Involuntary imposition of a consultation requirement or co-admission requirement.

### 9.2.3 No Right to Procedures Herein

Notwithstanding the above, the actions described in 9.2.2, Shall only be considered Adverse Action, giving the Practitioner the procedural rights set forth in Article 9, if the Practitioner would otherwise meet the eligibility standards established by the Medical Staff, or one of its Departments or Divisions, for such appointment, Clinical Privileges, or rights to perform patient care services.

- (a) A Practitioner who does not meet the eligibility standards established by the Medical Staff, or one of its Departments or Divisions, is not entitled to the procedural rights set forth in Article 9.
- (b) If an individual applies for Active Staff Membership but does not hold an M.D. or D.O. degree, the individual does not meet approved guidelines, and therefore is not entitled to the procedural rights set forth in Article 9.
- (c) If an individual does not meet approved guidelines for insurance requirements, board certification, or minimum residency requirements, he Shall not be entitled to the procedural rights set forth in Article 9.

#### 9.2.4 Not Adverse Actions

The following actions do not entitle a Practitioner to a Fair Hearing or appellate review:

- (a) Failure to advance from provisional appointment to full appointment.
- (b) Denial of requested appointment to or change in Staff category.
- (c) Involuntary change in Staff category.
- (d) Denial of requested Department affiliation.

### 9.3 Procedural Rights

All hearings and appellate reviews Shall be in accordance with the procedural safeguards set forth in this section to assure that the affected Practitioner is accorded all rights to which he is entitled. Notwithstanding any other provision of these Bylaws, no Practitioner Shall be entitled as a right to more than one hearing and one appellate review on any matter which Shall have been the subject of an Adverse Action. No other actions except those specified in Section 9.2.2 Shall give rise to any Practitioner's right to a hearing or an appellate review. Any Practitioner entitled to the procedural rights in this Fair Hearing Plan Shall exhaust such remedies before proceeding in any other forum.

### 9.4 Notice, Request and Waiver for Hearing

When an adverse recommendation is made by the Executive Committee, any Notice Shall be provided by the President. When an adverse recommendation has been made by the Board, any Notice Shall be provided by the Hospital President. This distinction Shall apply throughout this Article. The body taking such action, whether the Executive Committee or Board, Shall be referred to as the Acting Body.

#### 9.4.1 Notice

The applicable President Shall give written Notice of an adverse recommendation to any affected Practitioner who is entitled to a hearing or to an appellate review

within fifteen (15) Days of such adverse recommendation. The Notice Shall include the reasons for the action, the right to a hearing, time limits to request a hearing, a summary of hearing rights, and a copy of the current Medical Staff Bylaws.

#### 9.4.2 Waiver

The failure of a Practitioner to request a hearing to which he is entitled by these Bylaws timely and in the manner herein provided Shall be deemed a waiver of his right to such hearing or other further review to which he might otherwise have been entitled on the matter. A hearing request Shall be submitted in writing to the applicable President within thirty (30) Days of receipt of Notice.

#### 9.4.3 Effect of Waiver

When a hearing is waived, the Adverse Action of the Acting Body which created the right to hearing Shall become and remain effective against the Practitioner pending the Board's decision on the matter.

- (a) In any waiver under this provision, the applicable President Shall notify the affected Practitioner of his status within ten (10) Days.
- (b) When the waived hearing relates to an Adverse Action by the Board, that recommendation Shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Board provided for in 9.10.
- (c) When the Practitioner has waived his right to a hearing upon an Executive Committee recommendation, at the next regular business meeting of the Board at least ten (10) Days after the determination of waiver and Notice to the Practitioner under 9.4.3(b), the President or designee will present the Executive Committee's recommendation for final action by the Board.

### 9.5 Notice of Hearing

Within thirty (30) Days after receipt of a request for a hearing from a Practitioner entitled to the same, the Acting Body Shall schedule and arrange for such a hearing and Shall notify the Practitioner of the time, place and date so scheduled.

#### 9.5.1 Date of Hearing

The hearing date Shall be not less than thirty (30) Days, nor more than sixty (60) Days from the date of Notice of the hearing and no more than ninety (90) Days from the date of receipt of the hearing request. An exception May be granted by the Acting Body upon a request by the affected Practitioner for good cause shown as determined in the Acting Body's sole discretion.

### 9.5.2 Contents of Notice

The Notice of hearing Shall state in concise language the acts or omissions with which the Practitioner is charged, the specific medical records, if any, which provide the basis for the adverse recommendation or the other reasons or subjects that were considered in making the adverse recommendation, a list of the witnesses, if any, expected to testify in support of the adverse recommendation, and a list of the proposed members of the Hearing Committee. A witness not listed May be called at the hearing provided that the Practitioner is given Notice prior to the witness testimony. The Notice Shall further include the Practitioner's rights including the right to be represented by counsel, to present evidence and witnesses, to cross-examine witnesses, to challenge and rebut witnesses and evidence, to obtain a copy of the transcript of the hearing, and to submit a written statement at the close of the hearing.

## 9.6 Composition of Medical Staff Hearing Committee

When a hearing relates to an adverse recommendation of the Executive Committee such hearing Shall be conducted by an ad hoc Hearing Committee (the "Hearing Committee") of not less than three (3) Members of the Medical Staff or Medical Staff Alumni appointed by the President with the concurrence of the Hospital President. Whenever possible, at least one Shall be from the Department of the subject Practitioner. One of the Members so appointed Shall be designated as Chairperson by the President with the concurrence of the Hospital President.

### 9.6.1 Single Hearing Officer

In unusual circumstances, when deemed appropriate by the President, with the concurrence of the Hospital President, he May appoint a single hearing officer to conduct the Fair Hearing. When the hearing is to be heard by a Hearing Officer, "Hearing Officer" Shall be substituted for all references to "Hearing Committee" in these Bylaws, unless the context clearly indicates otherwise. In the case of a Hearing Officer, the Hearing Officer Shall not be a Member of the Medical Staff, nor of the Hospital administration, but should have knowledge of the health care industry and/or hospital operations.

### 9.6.2 Qualifications

Insofar as possible, no Member of the Credentials Committee, Executive Committee, Investigating Committee under 8.6 or Board who participated in a credentials decision being challenged, nor any Staff Member or Alumni who has actively participated in the consideration of the adverse recommendation, or the initiation or investigation of the underlying matter at issue at any earlier stage of the proceedings, Shall be appointed a Member of the Hearing Committee; nor Shall any individual who is in direct economic competition with the Practitioner be appointed to this committee. The President Shall consider and resolve issues of conflict raised by the affected Practitioner with any Member of the hearing panel.

### 9.6.3 Hearing Committee Advisor

In the case of a Hearing Committee, in addition, a Hearing Committee Advisor May be appointed whose role Shall be advisory and who Shall provide guidance regarding procedural issues. The Hearing Committee Advisor Shall not be a Member of the Hearing Committee and Shall not have a vote.

### 9.6.4 Challenge to Panelists

Upon receipt of Notice of the hearing, the Practitioner Shall have fifteen (15) Days to challenge the appointment of a Member of the panel in a written statement setting forth the specific basis for such challenge. If he does not so challenge the panel, he Shall be deemed to have waived the right to do so at a later date. The President Shall review the submission of the Practitioner and Shall rule thereon in his reasonable discretion. He May appoint substitute Hearing Committee Members.

### 9.6.5 Alternate Panelists

If a qualified panel cannot be constituted solely with Medical Staff Members, in the discretion of the President with the concurrence of the Hospital President, individuals unaffiliated with the Medical Staff May be appointed to serve with Members of the Medical Staff on the Hearing Committee. In any instance, a majority of the panel Shall be Physicians.

## 9.7 Composition of Board Hearing Committee

When a hearing relates to an adverse recommendation of the Board that is contrary to the recommendation of the Executive Committee, the Board Shall appoint a Hearing Committee of not less than three individuals. At least one Member of the panel Shall be a Physician who need not be a Member of the Board, and one Shall be a Board Member. No Board Member who is in direct economic competition with the Practitioner Shall be appointed to such committee. The Board Shall consider and resolve issues of conflict raised by the affected Practitioner with any Member of the hearing panel. The provisions of 9.6.4 Shall pertain to such issues of conflict with the Chairperson of the Board acting on such matters.

## 9.8 Conduct of Hearing

The hearing Shall be conducted in accordance with the rules set forth herein. If in the course of the hearing a matter arises which these Bylaws do not address, the Hearing Committee Chairperson Shall be authorized to determine how to proceed.

### 9.8.1 Committee Presence

There Shall be at least a majority of the Members of the Hearing Committee present when the hearing takes place. No Member May vote by proxy. If the affected Practitioner is a provisional Member of the Medical Staff or an initial

applicant to the Staff, it Shall be the obligation of the affected Practitioner to overcome a presumption in favor of the adverse recommendation or decision of the Executive Committee. The affected Practitioner Shall have the burden of proving by substantial evidence that the adverse recommendation or decision of the Executive Committee was arbitrary and capricious. If the affected Practitioner has advanced from Provisional to full Staff status, the affected Practitioner Shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or decision of the Executive Committee was arbitrary and capricious.

#### 9.8.2 Practitioner Presence

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 same manner and with the same effect as provided in 9.4.2.

#### 9.8.3 Record of Proceedings

An accurate record of the hearing Shall be kept by transcription by a court stenographer, the cost of which Shall be borne by the Hospital.

#### 9.8.4 Hearing Postponement

Postponement of a hearing beyond the time set forth in these Bylaws Shall be made only with the approval of the Hearing Committee. Granting of such postponements Shall only be for good cause shown and in the sole discretion of the Hearing Committee.

#### 9.8.5 Evidence

The hearing need not be conducted strictly according to the 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 over objection in civil or criminal action. The Hearing Committee Shall have the right to consider any pertinent material contained on file in the Hospital and any other information which it considers pertinent. The Practitioner Shall have Notice of and an opportunity to rebut any such information considered.

- (a) The Hearing Committee May take official Notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any other facts which May be judicially noticed by the courts of this Commonwealth.

- (b) All such material Shall be deemed part of the record before the Hearing Committee without the need for any further authentication or formal introduction into the record.
- (c) A continuance of the hearing Shall be made only for good cause and Shall be granted at the sole discretion of the Hearing Committee.

#### 9.8.6 Affected Practitioner Rights

The affected Practitioner Shall have the following rights:

- (a) To call and examine witnesses.
- (b) To introduce written evidence or exhibits.
- (c) To cross-examine any witness on any matter relevant to the issue of the hearing.
- (d) To challenge any witness and to rebut any evidence.
- (e) To obtain a copy of the transcript of the hearing.
- (f) If the Practitioner does not testify in his own behalf, he May be called and examined as if under cross-examination.
- (g) To review all documents and recommendations upon which the decision was based.

#### 9.8.7 Chairperson of the Hearing Committee

The Chairperson of the Hearing Committee Shall preside over the hearing. The Chairperson or Hearing Officer Shall have the following powers and responsibilities:

- (a) To decide matters of procedure during the pre-hearing stage, as well as during the hearing.
- (b) To conduct pre-hearing conferences and rule on pre-hearing matters, including but not limited to the exchange of witness lists and exhibits.
- (c) To impose limitations, including time limitations, upon the parties and the presentation of their cases.
- (d) To make rulings on the admissibility of evidence.
- (e) To perform such other duties as deemed necessary to maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence.



#### 9.8.8 Representation

The affected Practitioner Shall be entitled to be accompanied by and represented at the hearing by a representative of his choice, including an attorney. The Acting Body Shall appoint one of its Members and/or an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses.

#### 9.8.9 Hearing Procedure

The Acting Body Shall proceed with its case first.

- (a) The Hearing Committee May, without special Notice, recess the hearing and reconvene the hearing for the convenience of the participants or for the purposes of obtaining new or additional information or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing Shall be closed and the Hearing Committee Shall, at a time convenient to itself, conduct its deliberations in private.
- (b) The Practitioner and the Acting Body Shall submit a written statement summarizing their views of the case within fifteen (15) Days of the conclusion of testimony and closing statements.

#### 9.8.10 Deliberations, Recesses and Adjournment

The basis for the Hearing Committee's determination May include oral testimony, memoranda of fact, law and authorities, and any information available to the Hearing Committee so long as the information has been admitted into evidence and the affected Practitioner has had the opportunity to comment on it, as well as other documented evidence including medical records and the like. The Hearing Committee Shall have the right to have access to consultants outside the Hospital. Upon conclusion of the presentation of oral and written evidence, the hearing Shall be closed. The 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, and any representatives of any of the parties.

#### 9.8.11 Written Report

Within fifteen (15) Days after final adjournment of the hearing, the Hearing Committee Shall make a written report, recommendations, and statement of the reason(s) in support of the recommendations to the Acting Body and to the involved Practitioner and the applicable President.

#### 9.8.12 Action on Hearing Committee Report

At its next regular meeting at least ten (10) Days after receipt of the Hearing Committee Report, the Acting Body Shall act to affirm, modify or reverse the original adverse recommendation, or take any other action it deems appropriate. The Acting Body Shall have the right to have access to consultants outside of the Hospital. This information May be shared with the Practitioner at the discretion of the Acting Body.

#### 9.8.13 Acting Body Remand

If the Acting Body decides to remand the decision for further review by the Hearing Committee, it Shall notify the Hearing Committee or, if the Board is the Acting Body, it Shall notify the Executive Committee and the Practitioner within fifteen (15) Days of its receipt of the Hearing Committee Report. The Notice Shall state any matter to be determined and a deadline for a decision which Shall in no event exceed thirty (30) Days from the date of the Notice.

#### 9.8.14 Effect of Favorable Action

If the Acting Body's action on the Hearing Committee report is favorable to the Practitioner, the applicable President Shall transmit the result within seven (7) Days to the Board for final action. At its next regularly scheduled meeting at least ten (10) Days from receipt of the report, the Board Shall act. If the Board takes action favorable to the Practitioner, it Shall be final action and the matter Shall be closed. "Favorable" to the Practitioner Shall mean the decision includes no Adverse Action or partial Adverse Action that would entitle the Practitioner to a Fair Hearing under 9.2.2. If the Practitioner was under suspension of Membership or Clinical Privileges at the time of the Favorable decision, the Acting Body May, with the concurrence of the Hospital President in the case of the Executive Committee, or the President in the case of the Board, provisionally reinstate such Membership or Clinical Privileges subject to final Board action.

#### 9.8.15 Effect of Adverse Action

If the Acting Body takes action which is adverse to the Practitioner as set forth at 9.2.2, the applicable President Shall within fifteen (15) Days notify the Practitioner of his right to appellate review.

#### 9.8.16 Unfavorable Board Action After Favorable MEC Action

If the MEC takes favorable action under 9.8.14, but the Board then takes unfavorable action on the same matter, the Practitioner Shall be entitled to the appellate review. The Hospital President Shall notify the Practitioner within fifteen (15) Days of his right to appellate review.

#### 9.8.17 Notice

The Notice Shall state the action taken, the right to appellate review, time limits to request review and a summary of appellate review rights.

#### 9.9 Appellate Review

Within fifteen (15) Days from the date the decision of the Acting Body is forwarded to the involved Practitioner, he May request appellate review by the Board by delivering to the Hospital President a written request for a review. If appellate review is not timely requested, the Board Shall ratify the recommendation of the Acting Body as final action. Any request for appellate review Shall state the basis for appellate review hereunder. The granting of appellate review Shall be within the sole discretion of the Board as under 9.9.3.

##### 9.9.1 Limits on Appellate Review

Appellate review Shall be limited to the following:

- (a) There was a substantial and prejudicial failure to comply with the procedures in Article 9 of these Bylaws; or
- (b) As a matter of law, the decision of the Acting Body was arbitrary and capricious.

##### 9.9.2 Waiver of Appeal

If such appellate review is not requested timely, 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 9.4.2 of this Fair Hearing Plan. In any waiver under this provision, the President of Hospital Staff Shall notify the affected Practitioner within five (5) Days of his status.

##### 9.9.3 Request for Appellate Review

The request for review Shall state the reasons upon which the appeal is based. Mere recitations that there was a failure to comply with the Bylaws or that the decision was not supported by substantial evidence Shall not be adequate to satisfy the specificity requirement of this paragraph. Any error not raised in the request for review Shall be deemed waived.

- (a) Upon receipt of the request for review, the Hospital President Shall immediately forward a copy to the President.

- (b) The Hospital President Shall review the record in light of the error asserted and within fifteen (15) Days of receipt of the request Shall make a written report to the Board recommending the request for appellate review be granted or denied.
- (c) The Board Shall act on such report within thirty (30) Days of receipt. If the request is denied, the action creating the right to request appellate review Shall become final Board action. If the request is granted, the process Shall follow the process herein.

#### 9.9.4 Composition of the Appeal Panel

The appellate review Shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than three (3) members, appointed by the Chairperson.

#### 9.9.5 Scheduling the Appeal

Within fifteen (15) Days after approval of a request for appellate review, the Board Shall schedule a date for such review and Shall, through the President, notify the affected Practitioner of the same. The date of the appellate review Shall not be less than thirty (30) Days nor more than sixty (60) Days, from the date of receipt of the request for appellate review.

#### 9.9.6 Process of Review

The Review Committee Shall review the entire record, including the transcript of the hearing. At the Review Committee's discretion, it May request the Acting Body and the Practitioner involved to submit written statements for consideration; however, new or additional matters not presented in previous proceedings Shall not be introduced.

- (a) The Review Committee proceedings Shall be completed within sixty (60) Days from the appointment of the Committee. Upon completion of its review of the record, the Review Committee Shall submit a written report with recommendations to the Board.
- (b) At its next meeting at least ten (10) Days following the submission of the recommendation of the Review Committee, the Board Shall make a decision. If the Board decides to affirm its original decision, the matter Shall be final. If the Board decides to modify the original decision, the matter Shall be referred to the Executive Committee for review and recommendation at its next meeting at least ten (10) Days later. At its next meeting, after receipt of the recommendation of the Executive Committee, at least ten (10) Days later, the Board Shall make its final decision. Written Notice of the final decision Shall be given promptly to the Practitioner.

#### 9.9.7 Practitioner Rights

The affected Practitioner Shall have access to the report and transcript of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him.

#### 9.9.8 Written Submissions

Each party to the review, as determined by the Board, Shall have the right to submit a written statement to the Board setting forth the factual and procedural positions each advocates. Any such written statement May cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel May participate in its preparation.

- (a) The Practitioner Shall provide his submission to the Board within fifteen (15) Days after he receives Notice of the date of the appeal. Failure to timely submit such statement Shall be a basis for the Review Committee to act immediately.
- (b) The Acting Body May submit a written rebuttal to the Review Committee within fifteen (15) Days of receipt of the Practitioner's submission. No other written submissions will be accepted unless requested by the Board in its sole discretion.
- (c) Any party making any submission to the Board under this section Shall simultaneously provide a copy of the submission to the other party.
- (d) The failure of any party to timely submit a statement under this section Shall constitute a waiver of such right.

#### 9.9.9 Scope of Review

The Board or its appointed Review Committee acting as the appellate body Shall review the record created in the proceedings and Shall consider the written statements submitted pursuant to the preceding section, for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was arbitrary or capricious.

#### 9.9.10 Oral Argument

Review Shall be on the record unless the affected Practitioner requests, and the Board in its sole discretion grants, permission for oral argument or if the Board on its own motion determines that oral argument is appropriate.

- (a) The Practitioner's request for oral argument Shall be submitted within fifteen (15) Days of the receipt of Notice of the appellate review.

- (b) A request for oral argument Shall indicate with specificity why oral argument would enhance consideration of the appeal.
- (c) The Review Committee Shall rule on the request for oral argument within ten (10) Days of its receipt and Shall provide written Notice of its determination to the Practitioner.
- (d) The Review Committee Shall have the right on its own motion, without Practitioner request, to require oral argument. If it makes such a motion it Shall notify the parties of its decision no later than ten (10) Days prior to the date of the appellate review.
- (e) If oral argument is permitted or required, the Practitioner Shall be present, Shall be permitted to speak against the adverse decision or recommendation, and Shall answer questions put to him by any Member of the Review Committee.
- (f) The failure of the Practitioner to appear Shall be deemed a waiver of all rights associated with, related to, or arising out of such appearance.
- (g) With Board approval, a representative designated by the Acting Body Shall be permitted to speak in favor of the adverse recommendation or decision and Shall answer questions put to him by any Member of the Review Committee.
- (h) Attorneys at Law Shall be permitted to represent any party in an oral argument.

#### 9.9.11 Appellate Review Committee Determinations

The Appellate Review Committee Shall issue its determination within fifteen (15) Days of the adjournment of its proceedings and Shall present its findings in writing to the Board. It May recommend that the Board affirm, modify or reverse the prior decision.

#### 9.9.12 Exhaustion of Appellate Review

Appellate review Shall be deemed concluded only when all the procedural steps provided in 9.9 have been completed or waived. Any failure of the affected Practitioner to timely exercise his procedural rights Shall be deemed a waiver of such rights. Any actions required of the review panel Shall not be delayed except for good cause which Shall be documented in the record of the appeal.

9.10 Final Decision by the Board

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 Executive Committee, and, through the President, to the affected Practitioner. As required by law, adverse final decisions by the Board Shall be reported to the Pennsylvania State Board of Medicine and the National Practitioner Data Bank.

9.11 Failure to Act

Failure of a committee or the Board to take action within the time frames suggested by these Bylaws Shall not be grounds for appeal or for voiding action subsequently taken.

## ARTICLE 10

### DEPARTMENTS

#### 10.1 Departments

Each Department of the Medical Staff Shall be organized as a separate part of the Staff and Shall have a Chair who is selected as set forth herein and has the authority, duties and responsibilities as specified herein. A Department May have clinical Divisions and/or Sections.

##### 10.1.1 Establishment of Departments and Divisions

Departments Shall be established by the Executive Committee. Divisions Shall be established based upon the recommendation of the Department subject to approval by the Executive Committee.

##### 10.1.2 Changing Department or Division Membership Status

The Board Shall notify the Executive Committee of any planned changes as set forth herein and Shall seek its input. The following changes in the Membership of Departments or Divisions Shall only occur after Notice to the Medical Staff for discussion at a special meeting called for such purpose no less than thirty (30) Days before the Executive Committee is required to provide feedback to the Board:

- (a) Making an open Department or Division subject to an exclusive contract;
- (b) Closing a Department or Division to additional Members;
- (c) Changing Membership of the Department or Division to require employment of the Members by an affiliate of Lancaster General Health;
- (d) Changing the party holding an exclusive contract for Privileges in the Department or Division.

##### 10.1.3 Functions of Departments

Each Department Shall conduct activities that contribute to quality improvement and efficiency of patient care provided in the Department. All issues related to peer review shall be addressed in accordance with the LGH Peer Review Policy.



#### 10.1.4 Departments and Their Divisions

The Clinical Departments of the Staff Shall be as follows:

- (a) Department of Anesthesiology
- (b) Department of Emergency Medicine
- (c) Department of Family and Community Medicine

Divisions include:

- (i) General Family Medicine
  - (ii) Geriatrics
  - (iii) Occupational Medicine
- (d) Department of Medicine

Divisions include:

- (i) Allergy and Immunology
- (ii) Cardiology
- (iii) Dermatology
- (iv) Endocrinology
- (v) Gastroenterology
- (vi) General Internal Medicine
- (vii) Hematology / Oncology
- (viii) Infectious Diseases
- (ix) Nephrology
- (x) Neurology
- (xi) Physical and Rehabilitation Medicine

(xii) Pulmonary Medicine

(xiii) Rheumatology

(e) Department of Obstetrics and Gynecology

Divisions include:

(i) Gynecological Oncology

(ii) Reproductive Endocrinology and Infertility

(iii) Female Pelvic Medicine and Reconstructive Surgery (FPMRS)

(iv) Maternal Fetal Medicine

(f) Department of Pathology and Laboratory Medicine

(g) Department of Pediatrics

(h) Department of Psychiatry

(i) Department of Radiology and Diagnostic Imaging

Divisions include:

(i) Radiation Oncology

(j) Department of Surgery

Divisions Include:

(i) General Surgery

(ii) Neurosurgery

(iii) Ophthalmology

(iv) Oral and Maxillofacial Surgery and Dentistry

(v) Orthopedic Surgery

(vi) Otorhinolaryngology, Head and Neck Surgery

(vii) Peripheral Vascular Surgery

(viii) Plastic Surgery

- (ix) Podiatric Surgery
  - (x) Thoracic-Cardiovascular Surgery
  - (xi) Trauma
  - (xii) Urology
- (k) Any other Clinical Department as subsequently created by the Staff with the approval of the Board.

#### 10.1.5 Departmental Meetings

Each Department Shall hold meetings at least four (4) times per year for the purpose of conducting pertinent business and to review and analyze on a peer group basis the clinical work of the Department. The Department Shall maintain minutes of its meetings which Shall be submitted to the Executive Committee.

#### 10.1.6 Departmental Clinical Privileges

Each Department Shall recommend its own criteria for the granting of Clinical Privileges and for holding office within the Department consistent with the policies of the Medical Staff and the Board. In the event of conflict, the Executive Committee Shall make a recommendation to the Board, which Shall take final action.

#### 10.1.7 Attendance

Each Member of a Department Shall attend at least fifty percent (50%) of Departmental Staff meetings. Attendance at these meetings is an integral part of a Medical Staff appointment and a Practitioner's failure to meet attendance requirements Shall be taken into account in the reappointment process.

### 10.2 Department Chair

Each Chair of a Department Shall be a Member of the Active Medical Staff and be a Member of the Department which he is to lead. Each Chair Shall be qualified by training, experience, interest and demonstrated current ability in the Department's clinical area covered, Shall be board certified, and Shall be willing and able to discharge the administrative responsibilities of his office. No Chair Shall serve as Chair at any other institution. No Chair Shall be employed by any other healthcare institution or health system.

#### 10.2.1 Selection of Chair

Each Chair Shall be elected by majority vote of the Department Members eligible to vote after the conclusion of the process set forth herein. The election of Department Chair Shall be subject to appointment by the Board.

- (a) When a Department Chair position becomes open, the position requirements and expectations will be made known to the Staff.
- (b) Candidates for the position May be nominated by others, self-nominated, or specifically solicited for nomination.
- (c) A Review Committee of six (6) Members will be appointed, and will consist of: the President; two (2) Members selected by the President; the Hospital President or designee; and two (2) Members selected by the Hospital President. Any two Shall be from the Department. The Human Resources Department of the Hospital will act as staff to the Review Committee.
- (d) It will be the responsibility of the Review Committee to screen, interview, and develop recommendations on all applicants.
- (e) The Review Committee will then consider all the information which it has received on the candidates, and provide feedback, including a recommendation on one or more candidates. The vetting process is to ensure well qualified candidates move forward for Department consideration.
- (f) The Department will then be presented with the candidate or candidates recommended by the Review Committee. The Department Shall vote on the candidates. A majority vote of all Active Staff Members of the Department voting is required to advance a candidate for consideration by the Hospital President. Such a vote Shall be by secret ballot at a meeting of the Department or electronically within thirty (30) Days of such a meeting.
- (g) Once an appropriate Agreement has been successfully negotiated with the final candidate, the President will present the candidate to the Board, which Shall appoint a Chair.

#### 10.2.2 Term of Office

A Department Chair elected after the adoption of these Bylaws Shall serve for a period of five (5) years commencing with his appointment and May be reappointed to succeed himself without limit. After a second term, the process in 10.2.1 Shall be repeated. The Chair will be subject to annual performance appraisals. At the end of the third year of each five (5)-year term, the Chief Clinical Officer Shall conduct a comprehensive review of the Chair's performance using an approach so that a wide array of Members of the Staff and Administrators can provide feedback. The results of the review Shall be shared with the Chair, Department Members and the President. At the conclusion of the initial five (5)-year term, the Department Shall be offered the opportunity to vote on whether the Chair Shall continue. Such vote Shall be by secret ballot at a meeting of the Department or electronically within thirty (30) Days after such meeting. A majority of all the votes cast by either method Shall determine the result.

### 10.2.3 Removal from Office

Chairs are subject to removal by: (i) a vote of two-thirds of the Active Staff Members of the Department; or (ii) upon review and recommendation by the Executive Committee to the Hospital President and the President and their mutual agreement thereto.

### 10.2.4 Vacancy in Office

If there is a vacancy in a Department Chair position, on an interim basis, the President Shall in consultation with the Hospital President and the Division Chiefs within the Department select an individual to serve as Interim Department Chair until such time as a new Department Chair is selected in accordance with the process described above.

### 10.2.5 Duties of Department Chair

The Department Chair Shall be administratively responsible for the functions of his Department. The Chair Shall be accountable for all professional, clinical, educational, research and administrative activities within the Department. His duties include but are not limited to the following:

- (a) Recommendation to the Executive Committee of a Division Chief for each Division within the Department;
- (b) Appointment of committees for the necessary functions of the Department;
- (c) Review of the professional performance of each Member of the Department, recommend Clinical Privileges for each Member of the Department, monitor IPPE, OPPE and FPPE performed by Division Chiefs, and conduct IPPE\OPPE\FPPE where a Chief is the subject of review;
- (d) Review of all prospective applicants for Membership in the Department and recommendations of Clinical Privileges for the same;
- (e) Responsibility for conducting Departmental meetings at least quarterly and presenting a brief review of clinical activities and peer review at this meeting;
- (f) Submission at least quarterly of a report of the Department's activities to the Executive Committee;
- (g) Service on the Executive Committee when mandated by the Bylaws;
- (h) Responsibility for quality management activities within the Department;

- (i) Responsibility for the establishment and maintenance of Departmental rules and regulations to reflect the current practice of the Department;
- (j) Responsibility for promoting and ascertaining appropriate and efficient utilization of hospital resources within the Department;
- (k) 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 required consultations when necessary;
- (l) Implement within his Department actions taken by the Executive Committee of the Medical Staff;
- (m) Assist in the preparation of such annual reports including budgetary planning for the Department as May be required by the Hospital President, or the Board;
- (n) Have the discretion to appoint a Vice Chair;
- (o) Serve on the Hospital's Clinical Effectiveness Teams;
- (p) Ensure that all Members of the Department/Division cooperate and assist in process improvement and compliance efforts with all applicable accreditation, monitoring and licensing standards or requirements including, but not limited to those expectations set by the Centers for Medicare and Medicaid Services, the Joint Commission, the Department of Health and the policies and procedures of the Hospital.

#### 10.2.6 Additional Accountability

The duties and responsibilities of the Chair Shall be incorporated into a job description and Shall be provided to the Chair. The Chief Clinical Officer and the President Shall work with each Chair to set annual goals, and review progress against goals.

#### 10.3 Functions of Division

As set forth in 10.1.4, some Departments Shall be further sectioned into Divisions. Divisions Shall conduct the functions of evaluating and monitoring quality improvement and efficiency of patient care provided in the Divisions. All issues related to peer review shall be addressed in accordance with the LGH Peer Review Policy.

## 10.4 Division Chiefs

Each Division Shall have a Chief who is a Member of the Active Staff. Each Division Chief Shall be qualified by training, experience, interest and demonstrated current ability in the Division's clinical area covered, Shall be board certified, and Shall be willing and able to discharge the administrative responsibilities of his office.

### 10.4.1 Duties

The duties of the Division Chief Shall be to:

- (a) Be responsible for the leadership, supervision, direction, and integration of specific specialty services;
- (b) Guide and supervise the Physicians and other clinicians with Clinical Privileges who are involved in delivering services to patients of the service line;
- (c) Participate in education and teaching programs and assist in the review of the appropriate and efficient utilization of services within the Division;
- (d) Review all prospective applicants for Staff Membership and recommend Clinical Privileging;
- (e) Conduct IPPE\OPPE\FPPE on privileged providers within the division;
- (f) Ensure that all Members of the Division cooperate and assist in process improvement and compliance efforts with all applicable accreditation, monitoring and licensing standards or requirements including, but not limited to those expectations set by the Centers for Medicare and Medicaid Services, the Joint Commission, the Department of Health and the policies and procedures of the Hospital.

### 10.4.2 Appointment of Division Chiefs

The Division Chief Shall be selected as set forth herein.

- (a) When a Division Chief position becomes open, the Chair of the Department Shall make known to all Members of the Division the requirements and expectations of the position.
- (b) The Department Chair Shall employ an inclusive review process to formally review candidates with Division Members to get input. The Department Chair May consult with other Members of the Staff, the Administration, use a search committee, or employ any other process to meet the needs of the Department and Division.
- (c) The Department Chair Shall select the candidate for Division Chief for approval by the Executive Committee.

- (d) If the Executive Committee does not approve the candidate, the selection process Shall be reinitiated to produce a different candidate.

#### 10.4.3 Term of Office

Division Chiefs appointed after the adoption of these Bylaws Shall be appointed for a term of five (5) years, and such terms May be renewed thereafter. Chiefs Shall be subject to an annual performance appraisal conducted by the Chair. A new Chair has the authority to appoint a new Division Chief.

#### 10.4.4 Removal from Office

Chiefs are subject to removal by: (i) a vote of two-thirds of the Active Staff Members of the Division subject to appeal by the Chief to the Executive Committee; or (ii) by the Chair with the approval of the Executive Committee, based on feedback from Division Members.

#### 10.4.5 Vacancy in Office

If there is a vacancy in a Division Chief position, the Department Chair in consultation with the President and the Members of the affected Division Shall select an individual to serve until such time as a new Division Chief is selected in accordance with the process described above.

#### 10.4.6 Additional Accountability

The duties and responsibilities of each Chief will be incorporated into a job description and will be provided to each Chief.

### 10.5 Rules and Regulations

Each Department and Division Shall adopt rules and regulations under which it operates.

#### 10.5.1 Proposed Rules and Regulations

A proposal for a new Division rule or regulation May be introduced in writing at any time during a regular meeting of the Division. After such a proposed rule or regulation has been approved by the Division, it Shall be presented in writing to the relevant Department for introduction during a regular meeting.

#### 10.5.2 Approved Rules and Regulations

If approved by the Department, the rule or regulation Shall be introduced for approval at a regular meeting of the Executive Committee. If approved, the rule or regulation Shall be submitted for final approval by the Board. New Department rules and regulations require the same approval beginning with approval at a regular meeting of the Department.



### 10.5.3 Annual Review

A review of Department and Division Rules and Regulations Shall be conducted annually.

### 10.5.4 Grandfathering Clause

In the event that a newly adopted Department or Division rule or regulation negatively affects a Member's ability to meet Department or Division initial board certification requirements, the Member will be held to the standard in place at the time of their initial credentialing.

### 10.6 Voting for Chair

Notwithstanding any other provisions in these Bylaws to the contrary, any votes required or permitted at Divisions or Departments pursuant to this Article 10 May in the discretion of the President, be held either in person by written ballot or by electronic ballot.

### 10.7 Sections

A Section is a component of a Department or Division organized around a subspecialty, clinical practice setting or service line for the purpose of coordinating activities pertinent to a subset of a Department's Practitioners.

#### 10.7.1 Section Leader

The Leader is the individual with organizational responsibility for the activities of a Section as assigned by the Department Chair or Division Chief.

#### 10.7.2 Operations

The frequency of meetings and scope of authority of any Section is determined by the Department Chair.

## ARTICLE 11

### OFFICERS AND COMMITTEES

#### 11.1 Officers

The officers of the Staff Shall be President, President-Elect and Treasurer.

##### 11.1.1 Qualifications for Elective Office

All candidates for elective office Shall be Members of the Active Medical Staff at the time of election and Shall remain Active Members in good standing during their term of office. Failure to maintain such status Shall immediately terminate that individual's tenure in office and Shall create a vacancy in the office involved.

##### 11.1.2 Nominations for Elective Office

Candidates for office, for at-large Members of the Executive Committee and for the Organized Medical Staff Section of the Pennsylvania Medical Society Shall be nominated by the Nominating Committee consistent with 11.12. The Nominating Committee Shall offer one or more nominees for the officers and submit them to the Medical Staff no later than thirty (30) Days before the September meeting. Nominations May also be made from the floor during that meeting prior to the closing of nominations. Nominations for at-large Executive Committee Members and for the Organized Medical Staff Section Shall be as set forth in 11.7.3.

##### 11.1.3 Elections

Elections for President-Elect and Treasurer Shall be held at the September Annual Meeting of the Medical Staff by a majority of votes cast by Members present at the meeting. Only Members of the Active Staff Shall be eligible to vote. Elections Shall be conducted by the Plurality with Elimination Method whereby all candidates Shall be offered on the first ballot. If no candidate receives a clear majority of votes, depending on the number of candidates, the candidates with the lowest votes Shall be eliminated from the second ballot, and so forth until a candidate receives a majority of the votes.

##### 11.1.4 Term of Office

The officers Shall serve three (3) year terms. The President-Elect Shall ascend to the Presidency. The Medical Executive Committee Members At Large Shall have a term of office of three (3) years. Officers Shall assume office in January of the upcoming year.

## 11.2 Duties of Officers

The Officers of the Medical Staff Shall perform the duties set forth in these Bylaws and such other functions as May be from time to time assigned by the President of the Medical Staff or the Executive Committee.

### 11.2.1 The President

- (a) Shall preside at all meetings of the Staff, unless he appoints a designee;
- (b) Shall be Chairperson of the Executive Committee and Member Ex Officio of all other committees;
- (c) Shall appoint all committees with the approval of the Executive Committee and the Board;
- (d) Shall inform the Hospital President of all suggestions, recommendations or resolutions emanating from either the Staff or the Executive Committee;
- (e) Shall act in coordination and cooperation with the Hospital President or his designee with regard to issues of mutual concern within the Hospital;
- (f) Shall be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are imposed and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
- (g) Shall represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer of the Hospital and the Board of Trustees;
- (h) Shall receive and interpret the policies of the Board of Trustees to the Medical Staff and report to the Board of Trustees on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
- (i) Shall be the spokesman for the Medical Staff in its external professional and public relations;
- (j) Shall serve on the Board of Trustees Ex Officio with vote;
- (k) Shall perform IPPE, OPPE and FPPE where a Department Chair is the subject of review.

### 11.2.2 President-Elect

The President-Elect, in the absence of the President, or in the event of a vacancy of the office of the presidency, Shall assume the duties and have the authority of the office. He Shall be a Member of the Executive Committee, and Clinical Privileges Delineation Committee, with full voting Privileges and Shall attend all meetings. He Shall serve on the Patient-Safety, Performance Improvement, the Clinicians' Health Committee and Hospital Mortality Committees. He Shall be Chairperson of the Bylaws Committee.

### 11.2.3 Treasurer

The Treasurer Shall report to the Medical Staff on the financial status of the Medical Staff. He Shall be a Member of the Executive Committee with full voting Privileges and Shall attend all meetings. The amount of the Staff dues Shall be set each year at the annual meeting and Shall be collected by the Treasurer of the Staff. The Treasurer Shall be the authorized signatory on checks for Medical Staff expenses.

### 11.2.4 Current Department Chair Serving as Officer of the Medical Staff

A Medical Staff Officer Shall not serve as a Department Chair. In the event that a sitting Department Chair is elected to Medical Staff Office, the involved Department Shall elect another individual to serve as Department Chair.

### 11.2.5 Vacancies in Office

A vacancy in the office of Treasurer Shall be filled by appointment of the Executive Committee. If there is a vacancy in the office of the President in the first year of his term, the President-Elect Shall ascend to the Presidency and Shall serve for the remainder of the President's term. If the office of the President is vacated after one year, the President-Elect Shall ascend and complete that term and thereafter Shall serve his own three (3) year term, if he chooses. A vacancy in the office of the President-Elect Shall be filled by a special election following the procedures in 11.1.3.

### 11.2.6 Removal of Officers

In the event any officer of the Staff fails to carry out his duties as required by these Bylaws, the directives of the Board, the Hospital's Bylaws or the Rules and Regulations of the Staff, or otherwise Shall be unable to perform the functions of his office, he Shall be subject to removal from office by the Staff. If the Board believes there are grounds for removal of an officer of the Staff, it Shall request the Staff to initiate removal procedures. A two thirds vote of the Active Staff present at a special meeting called for such purpose is necessary to remove any officer.

### 11.3 Hospital Committees

The following are Hospital Committees to which Medical Staff Members are appointed by the President of the Medical Staff: Patient Safety, Performance Improvement, Blood Utilization Review, Tissue, Sedation Oversight, Biomedical Ethics, Cancer, Infection Control and Prevention, Nutrition and Dietary Therapeutics, and Trauma Quality Management.

### 11.4 Medical Staff Committees

Committees of the Staff Shall be Standing and Special. Special Committees May be appointed by the President whenever they are needed. All Standing Committees other than the Executive Committee Shall be appointed by the President with the approval of the Executive Committee. All Medical Staff-Committees Shall report to the Medical Executive Committee in accordance with their charters or for a Special Committee the resolution establishing it.

#### 11.4.1 Committee Chairpersons and Meetings

The President Shall designate a Member of each committee to be Chairperson unless otherwise stated in these Bylaws. Committees Shall meet as specified in these Bylaws or as often as required to carry out their designated responsibilities. All committees Shall meet at least annually. Committees Shall report the actions of each meeting in writing to the Executive Committee.

#### 11.4.2 Committee Terms

Members of the Standing Committees Shall serve at the pleasure of the President with the consent of the Medical Executive Committee unless otherwise specified.

#### 11.4.3 Committee Qualifications

All Members of the Staff are eligible for committee assignment. Termination of Staff Membership Shall automatically terminate the Member's appointment to any committee. Non-Staff Members May be appointed to committees. Except in cases where the Hospital or Staff Bylaws require the Hospital President be a Member of a committee, the President of the Staff Shall have the right to approve the appointment of any non-Staff Member. Voting Privileges of non-Physician Members of Staff committees Shall be at the discretion of the committee Chairperson.

#### 11.4.4 Committee Minutes

All committees Shall maintain minutes and attendance records. The following Standing Committees Shall be created and maintained according to the charter for each committee: Bylaws, Credentials, Executive, Impaired Physicians, Graduate Medical Education, and Nominating.

#### 11.4.5 Peer Review Protection

It is the specific intent of these Bylaws to provide the maximum protection available under the law to the peer review activities of the Medical Staff. In circumstances where there is a question as to the applicability of the Peer Review Protection Act, the Healthcare Quality Improvement Act, or any successor or similar law providing for confidentiality and immunity for peer review activities, the actions of the Medical Staff acting pursuant to these Bylaws Shall be conducted to safeguard protections available under law.

(a) Closed Committee Meetings

The meetings of the following committees Shall be closed as appropriate to safeguard peer review confidentiality:

- (i) Executive;
- (ii) Medical and Dental Staff Peer Review Committee and sub-committees pursuant to the LGH Peer Review Policy; and
- (iii) All committees described in Articles 8 and 9.

(b) Access

Members of the Medical Staff seeking to attend any closed meeting May submit a request in writing to the Medical Executive Committee which Shall have sole discretion to decide issues of access, subject only to a specific direction from the Board of Trustees or the Hospital's attorney.

#### 11.5 Bylaws Committee

Membership to this Committee is appointed by the President-Elect of the Medical Staff, who Shall also serve as Committee Chairperson. The Committee Shall have no less than seven (7) Members. The Membership Shall include: between four (4) and six (6) Members of the Medical Staff; the General Counsel for the Hospital (or his designee); a representative of the administration of the Hospital in the position of Chief Clinical Officer; and the Manager of Medical Staff Office.

##### 11.5.1 Duties

Regularly review and update the Bylaws and the Rules and Regulations of the Medical Staff.

##### 11.5.2 Meetings

The Bylaws Committee Shall meet at least bi-annually, and more often as necessary.

## 11.6 Credentials Committee

The Credentials Committee Shall include seven (7) Members from the Medical Staff. The Chairperson Shall be an Active Member of the Medical Staff. A Hospital attorney Shall attend all meetings without vote.

### 11.6.1 Duties

The Credentials Committee Shall review all applications for appointment to all categories of the Staff. The committee Shall consult with the appropriate Department Chairperson and recommend assignment of Staff Members to Departments.

- (a) After consultation with the appropriate Department Chairperson, the Credentials Committee Shall recommend the specific Privileges to be granted to applicants for Staff appointment.
- (b) It Shall act in consultation with the Executive Committee whenever requested in the investigation of a Member considered for disciplinary action.
- (c) When necessary, the Committee Shall have the right to utilize outside consultants upon approval by the Executive Committee.
- (d) After proper investigation of the credentials of an applicant, its recommendation Shall be submitted to the Executive Committee for action.
- (e) This Committee Shall be responsible for the biannual reappraisal and recommendation of reappointment for each Member of the Staff.

### 11.6.2 Meetings

The Credentials Committee Shall meet at such frequency as shall be determined by the Medical Executive Committee.

## 11.7 Executive Committee/Medical Executive Committee (MEC)

The Executive Committee Shall consider matters involving the Medical Staff and has power to act before such matters are presented to the Medical Staff. It Shall present matters for discussion to the Staff accompanied, when possible, with its recommendations.

### 11.7.1 Duties

Its functions and responsibilities are:

- (a) To coordinate the activities of the Staff and assure that the duties delegated by the Board to the Staff are reasonably performed;
- (b) To coordinate the activities and general policies of the Staff and Clinical Departments;
- (c) To act for the Staff as a whole under such limitations as May be imposed by the Staff and these Bylaws, Rules and Regulations;
- (d) To receive and act upon the reports of all committees of the Medical Staff;
- (e) To supervise the maintenance of medical records at the required standard of completeness and review on at least a quarterly basis data pertaining to Medical Staff whose medical record practices fail to conform with necessary record keeping requirements. This committee Shall serve as the sanctioning body for non-compliance;
- (f) To consider and recommend action to the Hospital President;
- (g) To make recommendations to the Board, gather information and conduct investigations concerning appointment, reappointment and request for corrective action as described elsewhere in these Bylaws;
- (h) To provide liaison between the Hospital President, the Medical Staff, and the Board;
- (i) To review the credentials of all applicants and to make recommendations directly to the Board of Trustees for Staff Membership, reappointment and delineation, renewal or changes in Clinical Privileges;
- (j) To review the quality of medical care as it relates to the delivery of both medical and institutional services and to evaluate care management and resource efficiency activities;
- (k) To serve as the review body for all Medical Staff matters and to fulfill the Medical Staff's accountability to the Board;
- (l) To make recommendations to the Board of Trustees concerning:
  - (i) The structure of the Medical Staff;
  - (ii) The mechanisms to review credentials and delineate privileges;



- (iii) The organization of the care management activities of the Medical Staff;
- (iv) The mechanisms by which Medical Staff Membership May be terminated;
- (v) The mechanism for Fair Hearing procedures;
- (m) To report at each general Staff meeting.
- (n) To take such actions as described in these Bylaws or actions delegated by the Board.

#### 11.7.2 Meetings

This committee Shall meet at least monthly.

#### 11.7.3 Membership

The Executive Committee of the Medical Staff Shall consist of voting and non-voting Members. Voting Members Shall include the President, President-Elect, and Treasurer of the Medical Staff, the Immediate Past President; The Chair or their designee of the Departments of Anesthesiology, Emergency Medicine, Family & Community Medicine, Medicine, Ob/Gyn, Pathology, Pediatrics, Psychiatry, Radiology and Diagnostic Imaging and Surgery. Voting Members Shall also include the Trauma Medical Director and the Chief Clinical Officer.

- (a) In addition to the above, the Executive Committee Shall have three (3) at-large voting Members elected by the Staff in November in accordance with the process set forth at 11.1.3. Nominations for at-large Members (and for the Organized Medical Staff Section) Shall be made by the Nominating Committee in time for an October election. Only Members of the Active Staff in good standing Shall be eligible to be elected as an at-large Member of the Executive Committee. All three at-large Members Shall be from different Departments. At least one Shall be an independent Physician, not employed by a Hospital affiliate. The newly elected Member will be seated at the January Executive Committee meeting.
- (b) Non-voting Members Shall include the Hospital President, the Chief Operating Officer, the Chief Nursing Officer, the Chairperson of the Pharmacy and Therapeutics Committee, the Patient Safety Officer, the Chief Quality Officer and the Chief Medical Information Officer, the Director of Advanced Practice Providers, the General Counsel of the Hospital or their designees.

- (c) Committee Members Shall serve their appointed term unless they resign or are removed by a simple majority vote of those voting committee Members present (excluding the Member in question). The vote Shall be held on recommendation from the Medical Staff President after consultation with the Hospital President (or his\her designee) and four (4) other Medical Executive Committee Members selected by the President.

#### 11.7.4 Executive Committee of the MEC

The MEC shall establish the Executive Committee of the MEC for the sole purpose of acting for the MEC to review and approve applications for appointment, reappointment, and privileges between MEC meetings. For these purposes only, a report or action of this committee shall have all the validity of the same action taken by the MEC.

- (a) This committee shall consist of the President, the President-Elect, and the Chairs of the Departments of Medicine and Surgery.
- (b) This committee shall meet every other week when the MEC does not meet for the sole purpose of reviewing pending applications, if any.

#### 11.8 Clinicians' Health Committee

The Clinicians' Health Committee Shall be composed of five (5) Members of the Medical Staff, including the President-Elect who Shall chair the committee, with one Member being a psychiatrist. Members Shall serve a maximum of four (4) years. The Chairperson Shall serve for three (3) years. No more than two (2) Members Shall be replaced each year. The Clinicians' Health Committee is established by these Bylaws as a peer review organization pursuant to the LGH Peer Review Policy and the Pennsylvania Peer Review Protection Act. The Committee Shall be convened as necessary.

##### 11.8.1 Duties

The Committee exists to receive and evaluate concerns the Medical Staff have about fellow Members and Medical Affiliates regarding abilities of clinicians in question to function because of impairment caused by: (i) drug or alcohol abuse; (ii) psychological concerns; (iii) health problems.

- (a) The Committee Shall function in an informal environment, as an advisory, non-disciplinary, non-administrative Committee. The Committee Shall be a clinician advocate, and Shall oversee and follow-up any therapeutic intervention that is indicated for the impaired clinician. It Shall not be involved in providing the therapy, but Shall be more of an intervener.
- (b) The Committee May enlist the aid of other Medical Staff, as well as Physicians who are part of the Pennsylvania Medical Society Physician Impairment Program -- not necessarily Members of the Medical Staff of the Lancaster General Hospital.

### 11.8.2 Other Service

Issues of professional competence are not the responsibility of this Committee. Members of the Clinicians' Health Committee Shall refrain from participating in deliberations of any committee reviewing the clinical performance and competency of a Staff Member who is at that same time being evaluated by the Clinicians' Health Committee.

### 11.8.3 Procedures

Concerns about clinicians Shall be directed to the Chairperson of the Clinician's Health Committee, who Shall review the complaint with the entire Committee. The source of the complaint Shall be kept confidential and not revealed to the Staff Member in question unless agreed to by the complainant.

- (a) Once complaints are evaluated and found to be of substance, the Committee Shall meet with the appropriate Department Chair and the President of the Medical Staff before approaching the clinician involved.
- (b) If therapy is felt to be appropriate, the Committee Shall recommend specific care, follow the progress of therapy, and aid in re-establishing the Member as an active participant of the Medical Staff.
- (c) If the complaint is because of impairment due to a non-correctable condition, such as infirmities of age, consultation with Staff Members of the appropriate medical field Shall be sought. The results of this consultation Shall be considered before rendering a decision as to impairment.
- (d) As long as the subject Physician is cooperative, the deliberations of the Clinician's Health Committee Shall remain informal and confidential.
- (e) If a Physician is uncooperative or exhibits an impairment in his ability to perform the Clinical Privileges granted him, his case Shall be forwarded to the President of the Medical Staff for appropriate action.
- (f) After approval of the initial plan the Committee Shall review at appropriate intervals (not less than annually) and make recommendations for modifications to the Executive Committee, Staff and Board.

### 11.8.4 Additional Duties of this Committee

This Committee will also carry-out the functions outlined in the LGH Late Career Practitioner Policy, in accordance with that policy.

## 11.9 Medical Staff Peer Review Committee (PRC)

The Medical Staff Peer Review Committee Shall have at least twelve (12) voting members who are Active Members and also the Department Vice Chair and an adult hospitalist. If a Department has no Vice Chair, then the Chair Shall appoint a designee to serve. Additional Practitioners may be invited to a PRC meeting as needed. Sitting MEC Members Shall not serve on the PRC. Other aspects of the conditions of Membership on the PRC are as stated in the PRC Policy and Charter (the “Policies”).

### 11.9.1 Duties

The PRC Shall meet at least ten (10) times per year. Quorums for action are as stated in the Policies. The activities, responsibilities and procedures of the PRC are as set forth in the Policies.

### 11.9.2 Reports and Protections

The PRC Shall operate in accordance with the strongest protections available for its processes, procedures and findings under both the Health Care Quality Improvement Act (42 USC 11101 et seq) and the Pennsylvania Peer Review Protection Act (63 PS 425.1 et seq) and any successor laws.

## 11.10 Professionalism Committee

The Professionalism Committee Shall be made up of the President of the Medical Staff, President-Elect, Department Chairs, Division Chiefs, and the immediate past-President.

### 11.10.1 Duties

The Professionalism Committee Shall serve as a sub-committee to the Peer Review Committee to resolve performance and disciplinary issues through Member interaction.

### 11.10.2 Reports and Protections

The PRC Shall operate in accordance with the strongest protections available for its processes, procedures and findings under both the Health Care Quality Improvement Act (42 USC 11101 et seq) and the Pennsylvania Peer Review Protection Act (63 PS 425.1 et seq) and any successor laws. The Professionalism Committee Shall operate in accordance with the Peer Review Policy. Documentation of any Member interactions Shall be placed in the Member’s Peer Review File. Reports reflective of the activities of the Professionalism Committee Shall be communicated to the LGH Peer Review Committee.

### 11.11 Graduate Medical Education Committee

The Committee Shall consist of no less than nine (9) Members of the Staff, at least two (2) of whom Shall be Members of the Department of Family and Community Medicine. The Vice President of Academic Affairs, the Residency Program Director, the Resident Coordinator and Chief Resident of the respective residencies and a representative of the Hospital President Shall be Members also. All Members Shall have voting Privileges.

#### 11.11.1 Duties

The Graduate Medical Education Committee Shall act in an advisory and supportive capacity to the Vice President of Academic Affairs and the Residency Program Director in matters pertaining to educational policies and assignment of teaching personnel to provide the necessary training of residents, and to provide continuing education for the Staff.

- (a) The recruitment of Residents Shall be the joint responsibility of the committee, the Chief Clinical Officer and the Residency Program Director.
- (b) The Committee Shall act in an advisory capacity to the President of the Staff and the Hospital President in the selection, government and discipline of Residents.

#### 11.11.2 Reporting

The Chairperson of the Graduate Medical Education Committee Shall report to the Medical Executive Committee on a quarterly basis concerning the safety and quality of patient care provided by, and the related educational and supervisory needs and performance of the Residents.

### 11.12 Nominating Committee

A Nominating Committee Shall be appointed at the May Medical Staff meeting by the President. The Committee Shall review nominations made by Medical Staff Members during the sixty (60) Days following the May meeting. The Committee Shall consist of no less than three (3) Members of the Staff knowledgeable about Staff activities. This committee Shall present a list of nominees for all elective offices in writing to all Members of the Staff at least thirty (30) Days before the September meeting of the Staff. Additional candidates May be nominated from the floor at the September meeting.

### 11.13 Pharmacy And Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee evaluates the clinical use of drugs, develops policies for managing drug use and drug administration, and manages the formulary system. The P&T committee Shall be composed of at least the following voting Members: Physicians, Pharmacists, Nurses, Administrators, Clinical Nutritionists, Risk Managers, Care Managers and others as appropriate. Committee Members Shall be appointed by the President of the Medical Staff.

#### 11.13.1 Purposes

The committee formulates policies regarding evaluation, selection, and therapeutic use of drugs and related devices. The formulation of programs designed to meet the needs of professional Staff (Physicians, nurses, pharmacists, and other healthcare Practitioners) for complete current knowledge on matters related to drugs and use; and the application of various techniques to ensure high quality and cost-effective drug therapy through the formulary system.

#### 11.13.2 Organization and Operation

The President of the Medical Staff Shall appoint a Chairperson from among the Physician representatives. The Director of Pharmacy Services Shall serve as secretary.

#### 11.13.3 Meetings

The Committee Shall meet regularly, at least six (6) times per year, preferably monthly.

### 11.14 Multidisciplinary Angiography Committee

The Multidisciplinary Angiography Committee is to review and evaluate the standard of care provided to patients requiring peripheral angiography, including all vessels except those involved in the coronary circulation presenting to the Hospital, maintain current evidence based protocols, provide peer review of cases representing opportunities for improvement, and make recommendations to facilitate safe, consistent and reliable care for patients and to recommend credentialing of physicians performing angiography in all areas.

#### 11.14.1 Membership.

The Multidisciplinary Angiography Committee shall be composed of representatives from the following areas:

- (a) Cardiology
- (b) Radiology
- (c) Vascular surgery
- (d) Neurosurgery
- (e) Cardiothoracic surgery
- (f) Medical Quality Management Coordinator

- (g) Representation from:
  - (i) Senior Vice President and Chief Clinical Officer
  - (ii) Vice President, Nursing & Operations of, Radiology, Cardiology & Surgery
- (h) Senior Director of Patient Safety & Quality
- (i) Such other persons appointed by the Committee;
  - (i) The Chairperson position has a term of two (2) years.
  - (ii) Voting: each physician member may vote, except when two (2) physicians representing the same group practice are present, and then only one vote per group practice is permitted.

#### 11.14.2 Meetings.

The Multidisciplinary Angiography Committee shall meet at least quarterly. Additional meetings may be called by the Chairperson of the Committee. Minutes of each meeting will be taken and distributed to each member no later than the next regularly scheduled quarterly meeting.

#### 11.14.3 Duties.

The Multidisciplinary Angiography Committee shall be responsible, at a minimum, for each of the following:

- (a) To provide a planned and systemic process for continuously measuring and assessing the quality and appropriateness of patient care;
- (b) To identify areas for changes/additions/deletions in practice standards and processes that will positively affect patient outcomes and satisfaction;
- (c) To maintain a higher caliber service through rigorous evaluation and recommendation to the Credentials Committee through ongoing evaluation of practitioner performance;
- (d) To provide multidisciplinary review for cases involving patients with peripheral angiography;
- (e) To review protocols annually and as required by changes in process.

## 11.15 Multidisciplinary Interventional Pain Committee

The Multidisciplinary Interventional Pain Committee is to review and evaluate the standard of care provided to patients requiring pain management presenting to the Hospital, maintain current evidence based protocols, provide peer review of cases representing opportunities for improvement, and make recommendations to facilitate safe, consistent and reliable care for patients and to recommend credentialing of Physician's performing pain management in all areas.

### 1.15.1 Membership.

The Multidisciplinary Interventional Pain Committee shall be composed of representatives from the following areas:

- (a) Anesthesia
- (b) Physiatry
- (c) Orthopedic surgery
- (d) Neurosurgery
- (e) Radiology
- (f) Hospice & Palliative Care
- (g) Representation from:
  - (i) Hospital and Nursing Administration
  - (ii) Patient Safety & Quality
  - (iii) Such other persons appointed by the Committee

### 11.15.2 Leadership.

The Chairperson is appointed by the President of the Medical Staff for a three (3) year term.

### 11.15.3 Meetings.

The Multidisciplinary Interventional Pain Committee shall meet at least quarterly, at a standard day and time established by the Committee. Additional meetings may be called by the Chairperson of the Committee. Minutes of each meeting will be taken and distributed to each member no later than the next regularly scheduled quarterly meeting and reported up to the Medical Executive Committee.



#### 11.15.4 Duties.

The Multidisciplinary Interventional Pain Committee shall be responsible, at a minimum, for each of the following:

- (a) To provide a planned and systemic process for continuously measuring and assessing the quality and appropriateness of patient care. This activity is supported by:
  - (i) Recommending Privileges for procedures based on adequate training and clinical experience;
  - (ii) Establishing and implementing clinical care indicators and associated measurement;
  - (iii) Defining and assessing appropriateness of case selection;
  - (iv) Analyzing and evaluating the effectiveness, indications and complication rates of the delivery of care based on acceptable practice standards and performance thresholds of the clinical care indicators;
  - (v) Recommending timely and specific action(s) on physician practice as warranted.
- (b) To identify areas for changes/additions/deletions in practice standards and processes that will positively affect patient outcomes and satisfaction;
- (c) To maintain a high caliber service through rigorous evaluation and recommendation to the Credentials Committee through ongoing evaluation of practitioner performance;
- (d) To provide multidisciplinary review for cases involving patients with peripheral pain;
- (e) To review protocols annually and as requiring specialized pain management.

#### 11.16 Quorum

Unless otherwise provided, the presence of fifty percent (50%) of the Membership of a Standing Committee but not less than two Members of the Medical Staff Shall constitute a quorum.

11.17 Attendance Requirements

Members of all committees Shall attend at least fifty percent (50%) of the meetings of any committee to which they are appointed or elected. Committee service is an integral part of a Medical Staff appointment and a Practitioner's failure to meet attendance requirements Shall be taken into account in the reappointment process.

11.18 Conduct of Meetings

Meetings Shall be conducted according to the Modern Rules of Order.

## ARTICLE 12

### MEETINGS

#### 12.1 The Annual Meeting

The annual meeting of the Staff Shall be held in September. Officers Shall be elected and installed in accordance with Article 11.

#### 12.2 Regular Meetings

Regular meetings of the Staff Shall be held six (6) times a year on the second Wednesday of January, March, May, July, September and November at a time and place to be announced by the President.

#### 12.3 Special Meetings

Special meetings of the Staff May be called at any time by the President on the written request of five (5) voting Members of the Staff. The purpose of the special meeting Shall be stated in the Notice and only stated matters Shall be considered at the meeting. Special meetings requested by the Members Shall be held no sooner than one (1) week and no later than two (2) weeks after the date the request was received.

#### 12.4 Quorum

Those Members of the Active Staff who are present Shall constitute a quorum.

#### 12.5 Authority

The Modern Rules of Order Shall be the authority governing all meetings and actions of the Staff.

#### 12.6 Minutes

Minutes Shall be taken at all Medical Staff Meetings and Shall be distributed to the Medical Staff.

## ARTICLE 13

### IMMUNITY FROM LIABILITY

#### 13.1 Application for Appointment and Reappointment

The following Shall be express conditions to any Practitioner's application for appointment to the Medical Staff and/or Clinical Privileges at the Hospital and continuation of any such appointment and/or Privileges.

##### 13.1.1 Privilege

Any act, communication, report, recommendation, or disclosure, with respect to any Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and/or maintaining quality patient care in this or any other health care facility, Shall be privileged to the fullest extent permitted by law.

- (a) Such Privilege Shall extend to Members of the Hospital's Medical Staff and the Board, the Executive Committee, the Hospital Administration, employees and agents of the Hospital, and to third parties, who supply information to any of the foregoing authorities to receive, release, or act upon the same.
- (b) For the purpose of this Article 13, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Medical Board or the Medical Staff.

#### 13.2 Immunity

To the fullest extent permitted by law, there Shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure. Such immunity Shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's activities including, but not limited to: (1) applications for appointment or Clinical Privileges, (2) periodic reappraisals for reappointment or Clinical Privileges, (3) corrective action, including summary suspension and hearings thereon and any actions pursuant to Articles 6, 7, 8 or 9, (4) medical care evaluations, (5) utilization reviews, and (6) other hospital, Department or committee activities related to quality patient care and professional conduct or other provisions of these Bylaws.

#### 13.3 Scope

The acts, communications, reports, recommendations, and disclosures referred to in this Article 13 May relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might be relevant to the Practitioner's appointment to the Medical Staff, his or her Privileges, or patient care.

#### 13.4 Releases and Waivers

In furtherance of the foregoing, each Practitioner Shall, upon request of the Hospital, execute releases, waivers of liability, confidentiality statements or other documents in accordance with the tenor and import of this Article 13, immunizing individuals and organizations specified in 13.1.1(a), subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as May be applicable under federal, state and local statutes, rules and regulations.

## **ARTICLE 14**

### **DUES**

The Medical Staff May assess its Active and Courtesy Members for such dues as it deems necessary. The amount of the dues Shall be determined by the Executive Committee and notice of any change shall be provided to the Medical Staff at least thirty (30) days before it becomes effective. Dues Shall be due on January 1 of each year and Shall be billed and collected by the Treasurer. Any Member of the Active or Courtesy Staff delinquent in payment of dues ninety (90) Days after January 1 Shall be referred to the Executive Committee for appropriate action.

## **ARTICLE 15**

### **RULES AND REGULATIONS**

The Staff Shall adopt such rules and regulations as May be necessary for the proper conduct of its work. Such rules and regulations May be amended without previous Notice by a majority vote of those present and eligible to vote at any regular meeting at which a quorum is present. Such amendments Shall become effective when approved by the Board.

## ARTICLE 16

### BYLAWS REVIEW AND AMENDMENTS

#### 16.1 Review

These Bylaws and the Rules and Regulations Shall be reviewed by the Bylaws Committee at least bi-annually and a report of the review Shall be made to the Executive Committee. The Bylaws May be reviewed more often as necessary.

#### 16.2 Amendments

A proposal for amendment of the Bylaws May be introduced at any regular meeting of the Staff and presented to the Executive Committee in writing at any time.

##### 16.2.1 Bylaws Committee Review

Any proposed amendment Shall be referred to the Bylaws Committee for its study and recommendation. The Bylaws Committee Shall report its recommendations to the Executive Committee.

##### 16.2.2 Medical Staff Approval

After a proposed amendment has been approved by the Executive Committee, the proposed amendment Shall be presented in writing to all Members of the Staff at least thirty (30) Days before the next regular meeting of the Staff. A proposed amendment May be approved by either of the following methods:

##### 16.2.3 Process to Amend

These Bylaws May be amended as set forth herein.

- (a) By two thirds of the voting Members present at a meeting where a quorum exists; or
- (b) By written ballot, subject to the following conditions. When a proposed amendment is voted upon by written ballot, a ballot Shall either be mailed to each voting Member at the address of the Member then on file with the Medical Staff office or emailed to him at the most recent email address then on file with the Medical Staff Office. The ballot Shall contain or attach the proposed amendment, and Shall specify when ballots Shall be returned to be counted. Members Shall be given no more than thirty (30) Days in which to return ballots. A ballot May be returned by mail, hand delivery, or by priority delivery (e.g., UPS, Fed Ex, etc.). A ballot will only be counted if it arrives in the Medical Staff office no later than 5 pm on the return date designated on the ballot. In order for the amendment to



be approved, two thirds of all voting Members returning ballots Shall vote in favor of the amendment.

- (c) Voting method will be determined on an individual basis by the Executive Committee. If not so designated as a ballot vote by the Executive Committee the Staff May request a ballot vote by a majority vote of those present.

### 16.3 Board Approval

Amendments so made Shall become effective when approved by the Board.

### 16.4 Urgent Amendment

Should the need arise for an urgent amendment necessary to comply with law or regulation, the Executive Committee, is delegated by the voting Members of the Medical Staff, to provisionally adopt an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Executive Committee. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Executive Committee is implemented. If necessary, a revised amendment is then submitted to the Board for action.

### 16.5 Amendment without Executive Committee

The Medical Staff May propose a Bylaws amendment directly to the Board upon approval of such amendment and such process by a majority of the voting Members of the Medical Staff. Such approval Shall require a vote at a regularly scheduled or special meeting of the Medical Staff at which a quorum is present.

### 16.6 Adoption

These Bylaws May be adopted at any regular meeting of the Staff. They Shall replace any previous Bylaws, Rules and Regulations, when they have been made effective by the approval of the Board. These Bylaws are effective upon approval of the Board.

### 16.7 Effect Of Conflict

If there is a conflict between the Bylaws and the Medical Staff Rules and Regulations, the Bylaws will prevail. If there is a conflict between the Medical Staff Bylaws and the Hospital Bylaw or policies, the Medical Staff Bylaws Shall prevail as the only mutually adopted document.

## ARTICLE 17

### CONFLICT MANAGEMENT PROCESS

#### 17.1 Types of Conflicts

The following conflict management process Shall be followed in the event of conflict between the Executive Committee and the Medical Staff regarding a proposed or adopted Medical Staff Bylaw, Medical Staff Rule or Regulation, or associated Medical Staff policy, or other significant matter under the purview of the Executive Committee.

##### 17.1.1 Petition

A written petition to trigger the conflict management process signed by at least seventy-five (75) voting Members of the Medical Staff Shall be submitted to the President. The petition Shall include (a) a clear statement of the reason for the conflict and the terms of any alternative Bylaw, Rule and Regulation or associated policy, and (b) the designation of three (3) Members of the Medical Staff as selected by the petitioners to serve as the petitioner's representatives.

##### 17.1.2 Resolvers

Within one week after receipt of the petition, the President Shall convene a meeting between the three (3) petitioners' representatives and three (3) Physician voting Members of the Executive Committee as selected by the President. The three (3) Physician Members of the Executive Committee Shall be Members of the Medical Staff.

#### 17.2 Meeting

The representatives of the Executive Committee and the petitioners Shall exchange information relevant to the conflict and Shall work in good faith to resolve differences within thirty (30) Days of their first meeting, in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Executive Committee and the safety and quality of patient care at the Hospital.

##### 17.2.1 Resolution

Resolution of the matter Shall require a majority vote of the 3 representatives of the Medical Staff and a majority vote of the 3 petitioners' representatives. If such a resolution proposes a Medical Staff Bylaw that has not been previously submitted to the Medical Staff, such resolution Shall follow the process outlined in Article 16.

### 17.3 Failure to Resolve

If the parties' representatives are unable to reach a resolution, they May, by mutual agreement, utilize the Chief Clinical Officer and/or other persons skilled in conflict management to assist in resolving their conflict. Differences that remain unresolved after the expiration of the above thirty (30) day period Shall be submitted to the Board for its consideration in making a final decision with respect to the proposed Medical Staff Bylaw, staff policy, or other matter. The Board Shall determine the method by which unresolved conflicts are submitted to the Board.

### 17.4 Principles

At all times the participants in the conflict management process Shall observe the following principles:

- (a) Resolution of all conflicts Shall be undertaken in a manner that promotes productive, collaborative, and effective teamwork, and in an atmosphere of mutual respect and understanding.
- (b) Resolution of the conflict Shall be consistent with the organization's mission, values, strategic objectives, policies and organizational ethics; Shall protect patient safety and quality of care; and Shall best serve the interests of the patient.
- (c) All discussions regarding the issues that are the subject of the conflict Shall be confined to internal communications, and the highest level of confidentiality Shall be maintained with respect to such discussions and issues. Communication to the public with respect to the issues is not appropriate.

ADOPTED by the Medical Staff on July 21, 2016.

Revised: April 1, 2018, 1/17/2019, 11/19/2020, 5/20/2021, 5/18/2022

# **Medical Staff Rules & Regulations**

Lancaster General Hospital

May 18, 2022

Previous version May 20, 2021

The Lancaster General Hospital

Medical and Dental Staff

**RULES AND REGULATIONS**

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**Principle:**

The Medical Executive Committee May waive any requirement in the Rules and Regulations for good cause shown, which it Shall document.

**Definitions:**

The capitalized terms used in this document Shall have the definitions set forth in the Medical Staff Bylaws and as defined herein.

**Admit:** To make the initial decision and write the order to hospitalize a patient.

**Attending Physician:** The Physician who has principal responsibility for the patient’s care in the Hospital including diagnosis, writing orders, coordination of care, selecting resources for Referrals and discharge of the patient.

**Attending Physician Group:** The Physician Group of the Attending Physician.

**Day Surgery:** Surgery performed on a patient who is not an Inpatient.

**Extreme Emergency:** Extreme Emergency is defined as any circumstance that is an acute threat to life, organ, or limb. In an Extreme Emergency the Physician Shall document the nature of the situation.

**Hospital Policy:** A policy adopted by the Hospital Administration that May or May not affect the Medical Staff and Practitioners.

**Hospitalized/ Hospitalization:** The admission of a patient to Inpatient status, Day Surgery, or the placement of a patient into Observation Status.

**Inpatient:** A patient who is formally admitted to the Hospital for care and is not in Observation Status.

**Medical Staff Policy:** A policy adopted by and approved by the Medical Executive Committee and reviewed annually, which affects Members of the Medical Staff and Practitioners and May affect others in the Hospital.

**Observation Status:** A patient who is being assessed on a short-term basis to determine whether he will become an Inpatient.

<b>Order Sets:</b>	A collection of Orders related to a specific clinical condition, treatment or procedure.
<b>Physician Group:</b>	A combination of Physicians and Dependent Medical Affiliates who work together providing medical services under one entity regardless of its form (e.g. professional corporation, professional limited liability company, partnership, etc). It does not include a network or individual practice association (IPA).
<b>Protocols:</b>	A series of pre-established, Physician approved orders for services, to be provided by other clinicians to a patient with a defined clinical condition during a single encounter (i.e., Hospitalization). Protocols are established by Departments subject to approval by the Medical Executive Committee.
<b>Referral:</b>	A transfer of care to a person or institution.
<b>Resident:</b>	A medical school graduate who participates in an approved Graduate Medical Education (GME) program or a Physician who is not in an approved GME program but who is authorized to practice only in a Hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the Medicare fiscal intermediary.
<b>Standing Orders:</b>	Provider Orders that permit treatment or diagnostics to be initiated in emergent situations that are time critical, without a prior specific Order from the treating provider when a patient's condition meets pre-defined criteria. Must be approved by the Executive Committee (which includes Department Chairs, P&T Committee Chair, and CNO) prior to implementation.

## **1.0 PAGER RESPONSE**

- 1.1 The Member is responsible to inform the Division Chief or, if no Division, the Department Chair of their on-call schedule. The Member is responsible to ensure all subsequent daily schedule and nightly on-call changes are reported timely to the Hospital operators and/or accurately appear in the online schedule. The Member may delegate this responsibility to their office staff but they are still ultimately responsible.
- 1.2 All pages, whether by cell phone, text or beeper/pager, Shall be answered in a timely fashion. Failure to respond to an initial page will result in a second page twenty (20) minutes after the initial page. Failure to respond to the second page will result in further pages in ten (10) additional minute intervals. Failure to respond within forty (40) minutes from the initial page will result in attempts to reach the Member's back-up coverage and may be grounds for a Code of Conduct investigation. If a Practitioner is physically unable to answer the page (i.e. scrubbed in or doing a procedure) they Shall designate someone to answer the page to facilitate any needed actions.

## **2.0 CONSULTATIONS**

- 2.1 The Medical Executive Committee Shall establish a policy determining those circumstances when a consultation is mandatory.
- 2.2 A Member of the Medical Staff, Independent Medical Affiliate or Dependent Medical Affiliate may request a consultation from another Physician who has the appropriate privileges. A consultation order Shall be dated, signed and state the reason for the consultation. In addition, the urgency of the consult Shall be designated as follows:
  - (a) "Stat": Consultations that require immediate/urgent evaluation. The ordering Practitioner must have a conversation at the time of the order with the consultant. The consultant is expected to evaluate the patient within one (1) hour, unless another time frame is agreed upon during discussion with the ordering Practitioner.
  - (b) "Today": The consultation Shall be completed within that calendar day, unless it is ordered after 1700, at which time the ordering Practitioner Shall have a conversation with the consultant when the order is placed. However, if the order is conveyed to the consultant between 1700-2400 hours, the consultant May complete it by no later than noon the following day.
  - (c) "In the AM": The consultant Shall complete the consultation by noon. In a circumstance where the consultant will not meet that standard, he must determine and document the nature of the patient's condition and urgency of the consult, along with the time by which the consult will be completed.
- 2.3 The consultation Shall be completed, documented and authenticated by the consultant in accordance with the timeframes in 2.2 above, and Shall include:
  - (a) Reference to chart review and/or patient interview;
  - (b) Patient examination;
  - (c) Impression and recommendations.



- 2.4 When procedures are involved, the consultation note Shall be documented prior to the procedure, except in an emergency. When the request is for an intra-operative/intra-procedural consultation, the consultant Shall document the consultation as part of the procedural note.
- 2.5 Practitioners are expected to order consults as clinically appropriate. If a Practitioner fails to call an appropriate consult, the Department Chair, Vice Chair or the President of the Medical Staff May intervene.
- 2.6 Dependent Medical Affiliates May perform consults in accordance with 7.7.5 of the Medical Staff Bylaws; however nothing in these Rules and Regulations Shall limit the right of a Medical Staff Member to request that a consult be seen only by another Medical Staff Member.
- 2.7 When the consult request comes from an Emergency Department (ED) Physician to help make a decision regarding Hospitalization, the consultant is expected to respond to the call within twenty (20) minutes, for a conversation with the requesting ED provider, unless there are mitigating circumstances which Shall be documented. If after the conversation the ED provider requests a formal consultation, the consulted Physician or members of his Physician Group has sixty (60) minutes to respond to the Emergency Department to begin the consult and management of the patient.

### **3.0 HOSPITALIZATION**

- 3.1 The decision and order to Hospitalize a patient May be made by a Member of the Active or Courtesy Medical Staff with admitting privileges.
- 3.2 The decision for Hospitalization May be elective or planned, unplanned or urgent direct, or from the ED. Patients who are registered as outpatients are not considered Hospitalized.
- 3.3 The selection of the Physician to Hospitalize and/or consult on an ED patient is made by the ED provider in accordance with the following priorities:
  - (a) Patient Choice
  - (b) Payer Network, if known
  - (c) Historical Pattern of Referral by the Primary Care Physician
  - (d) From the List of Physicians On-Call
- 3.4 The receiving Physician has the discretion to accept an unplanned direct Hospitalization.
- 3.5 A receiving Physician has the discretion to accept a transfer of a patient from another Hospital subject to the review by the Utilization Management Department.

- 3.6 Except in exceptional circumstances, which the Attending Physician’s Group Shall document, the Attending Physician Group Shall see the patient in the Hospital within the following time frames, unless the patient was seen within the previous ten (10) hours by the Attending Physician Group and they performed a history and physical examination then.

<u>Admissions</u>	<u>Maximum Acceptable Timeframe</u>
Critical Care (ICU, TNU, NICU)	1 hours
IICU	2 hours
OB	6 hours
Behavioral Health	16 hours
Normal newborns	24 hours
All Other Hospitalizations:	
Elective or Planned	12 hours
Unplanned Direct	2 hours
From the ED	10 Hours

- 3.7 At a minimum, all patients Shall, within four (4) hours of the time of Hospitalization, have a set of preliminary Orders by the Attending Physician Group sufficient to provide appropriate care. Time of Hospitalization is when the bed assignment is decided upon by the Attending Physician.

- 3.8 A patient may be managed by a Dependent Medical Affiliate to the same extent of responsibility for the patient’s care as an Attending Physician consistent with the Dependent Medical Affiliate’s licensure and in compliance with the Medical Staff Bylaws and Rules and Regulations. Notwithstanding a Dependent Medical Affiliate’s ability to manage the care of a patient as provided in this Section 3.8, a member in the Attending Physician Group or appropriate consulting group Shall make all reasonable attempts to see a Hospitalized patient who is transferred to a higher level of care (for example, from a monitored bed to the ICU) within one (1) hour of the transfer except in exceptional circumstances. In addition, a Physician member of the Attending Physician Group Shall see Hospitalized patients within the following timeframes: (i) in the ICU, TNU and NICU at least daily; (ii) in the IICU at least every two (2) days; and (iii) on all other units, at least once every four (4) days.

#### **4.0 TREATMENT OF FAMILY MEMBERS**

Members of the Medical Staff Shall not treat, admit, prescribe controlled substances or perform invasive procedures in the Hospital on themselves, members of their immediate families, or other individuals whose relationship with the Member might compromise the Member’s professional objectivity. Acceptable exceptions to this rule are limited to the following: in an emergency or isolated setting where there is no other qualified Physician available.

Immediate family member or Physicians’ 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.

## **5.0 INFECTIONS**

A Practitioner with a communicable disease Shall report that fact to Infection Control in accordance with Hospital Policy. Such Practitioner May be barred from seeing patients in accordance with Hospital Policy. A Practitioner with any potential for a communicable disease or precautions identified by the Center for Disease Control and Prevention (CDC), World Health Organization (WHO), or other comparable agencies to be applied and implemented. Details available on StarNet or by contacting the Medical Staff Office.

## **6.0 MANDATORY REPORTING OF SERIOUS EVENTS**

A Practitioner who participates in willful or malicious misconduct impacting patient safety, fails to report an event truthfully or in a timely fashion to the Patient Safety Officer, or makes an egregious error demonstrating a lack of fundamental knowledge necessary to carry-out his job responsibilities, Shall be subject to corrective action under the Medical Staff Bylaws.

In accordance with Hospital Policy serious events include, but are not limited to, wrong site surgery, unintended retention of a foreign object and death or serious injury related to a medication error. Failure to report a serious event May result in the reporting of any licensed health care professional to his respective state of professional licensure Board in accordance with Pennsylvania's Medical Care Availability and Reduction of Error Act (Act13). Details available on StarNet or by contacting the Medical Staff Office.

## **7.0. ORDERS**

- 7.1 All orders for treatment Shall be completed in the Electronic Health Record (EHR) by the responsible Practitioner unless the EHR is unavailable in which case paper forms will be available on all units. Only Practitioners with clinical privileges in this Hospital and Residents May sign orders within the medical record. No written order Shall be implemented unless it is signed. Orders May be entered, but not signed, by medical students, physician assistant students and nurse practitioner students according to the Hospital approved requirements for their respective professional education program. These orders Shall be signed by a Medical Staff Member or Residents, or by the relevant Dependent Medical Affiliate of the same discipline as the student, before they are executed.
- 7.2 Written Orders include manually handwritten Orders not yet entered into the EHR, which Shall be entered into the EHR by a nurse or a pharmacist when the Order includes medication.
- 7.3 In accordance with the restrictions set forth here, verbal and telephone Orders for medication or treatment Shall be accepted only when it is impractical for such Orders to be entered into the EHR by the responsible Practitioner.
  - (a) Each recorded oral Order Shall include the date, time, full signature and title of the person taking the Order; Shall be read-back to and verified with the ordering Practitioner; and Shall be countersigned by the prescribing Practitioner within seven (7) Days.

- (b) Verbal or telephone Orders Shall not be issued or accepted for initiation of antineoplastic agents.
- 7.4 The following are authorized to accept verbal or telephone Orders for treatment or medication within each respective professionals' scope of practice:
- (a) certified registered nurse anesthetists;
  - (b) graduate nurses;
  - (c) nurse midwives;
  - (d) nurse practitioners;
  - (e) occupational therapists;
  - (f) pharmacists;
  - (g) physical therapists;
  - (h) physician assistants;
  - (i) radiology technologists relating to imaging studies;
  - (j) registered nurses;
  - (k) registered dietician nutritionists;
  - (l) residents;
  - (m) respiratory therapists;
  - (n) speech-language pathologists.
- 7.5 A Protocol, Standing Orders and Order Sets Shall be ordered by a Practitioner for a specific patient, and Shall be dated, timed and authenticated.
- 7.6 Physicians or other health care providers Shall not text Orders to a member of the care team. Texting Orders is not permitted under the Center for Medicare & Medicaid Services (CMS) standards.
- 7.7 Practitioners with prescribing privileges Shall comply with P & T policies, including the Automatic Stop Orders/Automatically Expiring Medications Policy regarding specified medications.
- 7.8 All Do Not Resuscitate (DNR) Orders Shall be reviewed with the patient/patient representative prior to performance of a surgical/interventional procedure or initial renal dialysis. A note of the content of the discussion and decision regarding the DNR Order Shall be made by the performing Physician or designee.
- 7.9 Physician Orders for Life-Sustaining Treatment (POLST) for patients who choose to express their end-of-life treatment expectations Shall be documented as an Order in the EHR. Details available on StarNet or by contacting the Medical Staff Office.
- 7.10 A Medical Staff Member May, but is not required to, sign the Order of another Medical Staff Member. A Practitioner May sign the Order of another Practitioner of the same discipline and licensure. A Resident Physician May sign for another Resident at or below the Resident's PGY level.
- 7.11 A Member Shall order restraints for patient only in accordance with Hospital Policy. Details available on StarNet or by contacting the Medical Staff Office.

- 7.12 A Practitioner Shall cooperate with the process when there are areas of concern to nursing regarding patient care issues and, the nurse attempts to resolve the concern by following the medical chain of command as set forth in the flowgram “Patient Care Concern for Non-Emergent Problems.” (See Appendix A).
- 7.13 Patients Shall be discharged only upon Order of the Attending Physician or a Practitioner with privileges to discharge.
- 7.14 Post-Op Orders Shall be completed prior to transfer from PACU/other procedural area.

## **8.0 MEDICAL RECORDS**

- 8.1 Members of the Medical Staff Shall ensure that their documentation in the medical record is timely as more fully set forth herein, and accurate. The medical record Shall contain sufficient information to identify the patient; support the diagnosis; justify the treatment; document the course and results of treatment; and facilitate continuity of patient care.
- 8.2 The medical record Shall contain objective and relevant documentation that pertains to the care of the patient. The medical record Shall not contain reference to an Event Report. The record Shall be clinical in content with no extraneous observations nor statements criticizing or demeaning to the patient, the family, or other care givers, nor pejorative language.
- 8.3 Only abbreviations approved by the Forms Committee Shall be used in the medical record. The unapproved and approved abbreviation lists are available on StarNet or by contacting the Medical Staff Office.
- 8.4 A complete medical record includes the following elements completed within the timeframe set forth for each:
- History and Physical Examination (H&P) (twenty (24) hours)
  - Consults (as prescribed in 2.0)
  - Emergency Department (ED) records (twenty (24) hours of discharge from ED)
  - Progress Notes (four (4) hours from the visit)
  - Operative or Procedural Notes at least the brief note prior to transfer from the procedural area (twenty (24) hours for complete Note)
  - Orders (as prescribed in 7.0)
  - Discharge Summary (forty-eight (48) hours)
  - Death Summary (forty-eight (48) hours)
- (a) The process of notifying Practitioners of medical record status Shall be approved by the Medical Executive Committee and administered by the Health Information Management Department. Suspension of clinical privileges Shall occur when a Practitioner has incomplete medical records that are older than twenty-one (21) Days after the completion deadline above. Exceptions May be granted only by the President for good cause shown by the Practitioner.

- (b) Clinical Privileges Shall remain suspended until the delinquency is rectified.
  - (c) Members whose Clinical Privileges are suspended for failure to complete medical records Shall not be entitled to a fair hearing or appellate review of the Bylaws.
- 8.5 All Hospital medical records, both written and electronic, are the property of the Hospital and Shall be used only in accordance with Hospital Policy and User Agreements. Details available on StarNet or by contacting the Medical Staff Office.
- 8.6 A History and Physical (H&P) Examination Shall be documented in the EHR within twenty-four (24) hours after the patient physically arrives for registration and within twenty-four (24) hours prior to procedures involving moderate sedation, anesthesia or any High Risk Procedure as set forth in Appendix B.
- 8.7 A prior H&P Report May be utilized if it has been performed within thirty (30) days prior to Hospitalization, observation, or procedures and contains the elements in 8.8. If the pre-admission H&P is older than thirty (30) days, a complete H&P report Shall be recorded in the medical record meeting the timeframes specified in:
- (a) All H&P Reports done within thirty (30) days prior to Hospitalization or procedures in Appendix B Shall be updated within twenty-four (24) hours after the patient physically arrives for registration but prior to any procedures. Updates May be added to the Progress Notes, under 8.11 by amending the H&P, or Consult Note with an interval note in the EHR. The update is to assess and document, if there has been any change to the health status of the patient since the H&P was performed and/or to assess any areas where more current data was requested or available. The Practitioner Shall use his/her clinical judgment based on assessment of the patient's medical condition and medical history when deciding the depth of the assessment that needs to be performed and what information needs to be included in the updated note.
  - (b) When the H&P is not documented prior to the time stated for an operative or invasive procedure, the procedure Shall be canceled unless the Practitioner documents in the medical record that such delay would constitute a hazard to the patient (i.e. Extreme Emergency).
  - (c) In an Extreme Emergency the Practitioner Shall communicate the preoperative diagnosis and other appropriate information to the Operating Room personnel or other specialized interventional units and Anesthesia. Complete documentation Shall be recorded as soon as possible thereafter.

8.8 Minimum Elements of a Documented H&P for all Hospitalizations:

- Chief Complaint
- History of Present Illness
- Relevant Past Medical History
- Relevant Family History
- Relevant Social History
- Review of Systems
- Pertinent data including drug allergies and medications
- Physical Examination-include relevant positive and negative
- Findings
- Diagnostic Impressions and Plans

8.9 Short Form H&P Allowed for Outpatient Procedures:

- Diagnostic Impression and Plan
- Chief Complaint
- History of Present Illness
- Relevant past Medical History
- Current Medications
- Allergies
- Physical Exam including relevant positive and negative Data
- Patient Data

8.10 History and Physical (H&P) reports completed by first year Residents or Physician Assistants and Dependent Medical Affiliates under 7.7 of the Bylaws, are acceptable only if signed by the professional completing the H&P and counter-signed by the Attending Physician.

8.11 Pertinent progress notes Shall be recorded at the time of observation, sufficient to permit continuity of care wherever possible, each of the patient's active clinical problems Shall be clearly identified in the progress notes and correlated with specific Orders as well as results of tests and treatment. Daily progress notes by the Attending Physician Group are required. Progress notes Shall be documented by the Attending Physician at least daily on patients in the Critical Care Units requiring intensive care.

- (a) Progress notes Shall be entered and signed, in the EHR on the day of the visit to the patient.
- (b) Except in emergencies, at least the following data are recorded in the medical record of the patient prior to surgery:
  1. Verification of identity of patient
  2. Medical history and supplemental information regarding drug sensitivities and other pertinent facts
  3. General physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery

4. Provisional diagnosis
5. Laboratory test results
6. Consultation reports
7. Signed informed consent obtained by the surgeon
8. Pertinent imaging studies
9. Dental X-ray reports if applicable

8.12 A complete operative or invasive procedure note Shall be completed by the performing Practitioner in the EHR immediately upon completion of the procedure and Shall contain a description of the findings and a detailed account of the technique used and tissue removed. This includes procedures performed in the operating room, endoscopy suite, radiology/diagnostic imaging, interventional vascular unit, invasive bedside procedures, electrophysiology procedures and procedures performed in the cardiac catheterization laboratories. This applies only to those procedures which are listed in Appendix B or which require intravenous sedation. Invasive procedure note for procedures performed in radiology/diagnostic imaging may be included in the “imaging” section of the EHR.

(a) A complete note includes the following:

1. Admission Date
2. Operation Date
3. Preoperative Diagnosis
4. Postoperative Diagnosis
5. Operation Performed
6. Anesthesia
7. Surgeon
8. Assistant
9. Estimated Blood Loss
10. Findings
11. Specimens
12. Complications
13. Inherent Occurrences
14. Wound Classification
15. Description of the Procedure

(b) If the complete note cannot be entered by the time the patient is transferred from the procedural area, the performing Practitioner Shall document a post-procedure note immediately following the operation or procedure and include the following elements:

1. The name of the procedure performed
2. A description of the procedure
3. The name(s) of the Practitioner(s) who performed the procedure and his or her assistant(s)
4. Any estimated blood loss
5. Findings of the procedure
6. Any specimen(s) removed



7. The pre & post-operative diagnosis
8. Complications

8.13 A discharge summary Shall be completed in the EHR of each Hospitalized patient, including observation patients. Day Surgery patients Shall not require a discharge summary. The Attending Physician Group Shall record a death summary for any Inpatient who dies in the Hospital.

(a) The discharge summary Shall include, at a minimum, the following:

1. Reason for Hospitalization
2. Significant findings
3. Procedures and care, treatment and services provided
4. Patient's condition at discharge
5. Medications dispensed or prescribed on discharge
6. Discharge instructions to the patient and/or family
7. Provisions for follow-up care
8. Patient's discharge disposition

(b) The completion of the Newborn Discharge Summary form Shall be sufficient for healthy newborn infants. If such form is not completed, a newborn discharge summary Shall be recorded. In all instances, the content of the medical record Shall be sufficient to justify the diagnosis and warrant the treatment and end result.

(c) Co-signatures by Attending Physician are required on all discharge summaries completed by all Residents.

## **9.0 INFORMED CONSENTS**

Except in emergencies, a Practitioner Shall obtain an informed consent prior to (1) surgery, including anesthesia; (2) administering radiation or chemotherapy; (3) administering a blood transfusion; (4) inserting a surgical device or appliance; (5) administering experimental medications, using experimental devices or using an approved medication or device in an experimental manner; (6) prescribing opioids for minors; or (7) other conditions mandated by law in accordance with Hospital Policies. The Practitioner Shall present those risks and alternatives that a reasonable patient would require to make an informed decision. Details available on StarNet or by contacting the Medical Staff Office.

## **10.0 SURGICAL AND INVASIVE PROCEDURES**

10.1 The need for preoperative diagnostic studies Shall be delineated by the Department of Anesthesiology and the performing Practitioner.

10.2 A Member Shall perform Concurrent Surgeries only in accordance with Hospital policy. Details available on StarNet or by contacting the Medical Staff Office.

- 10.3 All appliances, tissues and foreign bodies removed at operation Shall be sent to the laboratory for analysis except in circumstances established by the Medical Executive Committee as set forth here: Foreign objects of forensic significance Shall be handled as set forth in Hospital Policy in the Trauma Manual, Protocol No. 1155. Details available via Starnet/Department & Teams/Trauma Service/Trauma Manual.
- 10.4 Abortion May be performed in accordance with the laws of the Commonwealth of Pennsylvania. No Physician Shall be required to perform, nor Shall any patient be forced to accept an abortion.

## **11.0 DISCHARGES**

- 11.1 The Attending Physician Group Shall evaluate the disposition of the patient early enough so that appropriate planning May be accomplished by both the patient and Hospital personnel.
- 11.2 The procedure for a patient leaving the Hospital against Medical Advice Shall follow Hospital Policy. The patient Shall be requested to sign a statement releasing the Hospital and the Practitioner from any responsibility. In the case of a minor, such a statement Shall be executed by his legal representative. In cases where this request is denied, details Shall be documented in the record. Details available on StarNet or by contacting the Medical Staff Office.
- 11.3 Organ Donations Shall be performed only in accordance with Hospital Policy. Details available on StarNet or by contacting the Medical Staff Office.

## **12.0 DEATH CERTIFICATES**

- 12.1 Death Certificates Shall be completed within twenty-four (24) hours of the patient expiring. The Attending Physician Group, to include Certified Nurse Practitioners and Physician Assistants Shall be responsible for ensuring document completion.
- 12.2 The Physician's Certified Registered Nurse Practitioner's, or Physician Assistant's principal responsibility in death registration is to complete the medical part of the death certificate.

## **13.0 AUTOPSIES**

- 13.1 A Practitioner who has treated the patient May seek from the patient's legal representative permission to perform an autopsy when an autopsy might provide a significant health care or educational purpose. Examples of this include:
- (a) Death in which autopsy May explain unanticipated medical or surgical complications.
  - (b) Deaths at any age in which it is reasonably believed that an autopsy would disclose a suspected illness which May have a bearing on survivors.

13.2 The following cases Shall be referred to the Lancaster County forensic medical jurisdiction (the Coroner or his designee):

- (a) Unexplained deaths occurring during or immediately following any dental, medical or surgical diagnostic procedure and/or therapy.
- (b) Other unexplained deaths including:
  - 1. Persons dead on arrival at hospital
  - 2. Unexplained death occurring within twenty-four (24) hours of admission
  - 3. Deaths in which the patient sustained or apparently sustained an injury while Hospitalized
  - 4. All obstetrical deaths
  - 5. All trauma deaths

#### **14.0 PATIENT PHOTOGRAPHY AND VIDEO IMAGING**

Photographing patients, using their images in webcasting, or other video recording Shall be permitted only in accordance with Hospital Policy. Details available on StarNet or by contacting the Medical Staff Office.

#### **15.0 USE OF ELECTRONIC COMMUNICATION EXTERNAL TO THE EHR**

Medical Staff Officers, Chairs, Chiefs, Committee Chairman and Committee Members Shall communicate regarding official Medical Staff business only through their official lghealth.org or pennmedicine.upenn.edu email account.

#### **16.0 LATE CAREER PROVIDER EVALUATIONS**

All providers aged seventy (70) or older applying for appointment or reappointment to the LGH Medical and Dental Staff and/or for privileges as a LGH provider shall undergo a performance screening examination including cognitive and motor screening, no earlier than one hundred and eighty (180) days and no later than forty-five (45) days, prior to the start date of the appointment or reappointment. Details available on StarNet or by contacting the Medical Staff Office.

#### **17.0 MEDICAL CLEARANCE REQUIREMENTS**

Documentation of medical clearance Shall be obtained prior to resuming clinical duties if an injury/illness has occurred that has restricted or placed limitations on a Practitioner's ability to practice medicine. Examples include, but are not limited to, head injury, broken bone, and surgical recovery. The Executive Committee, Credentials Committee, President and/or President-Elect (together if possible) Shall have the right to request an independent evaluation of the Practitioner prior to resuming clinical care. The evaluation Shall be at the expense of the Practitioner.

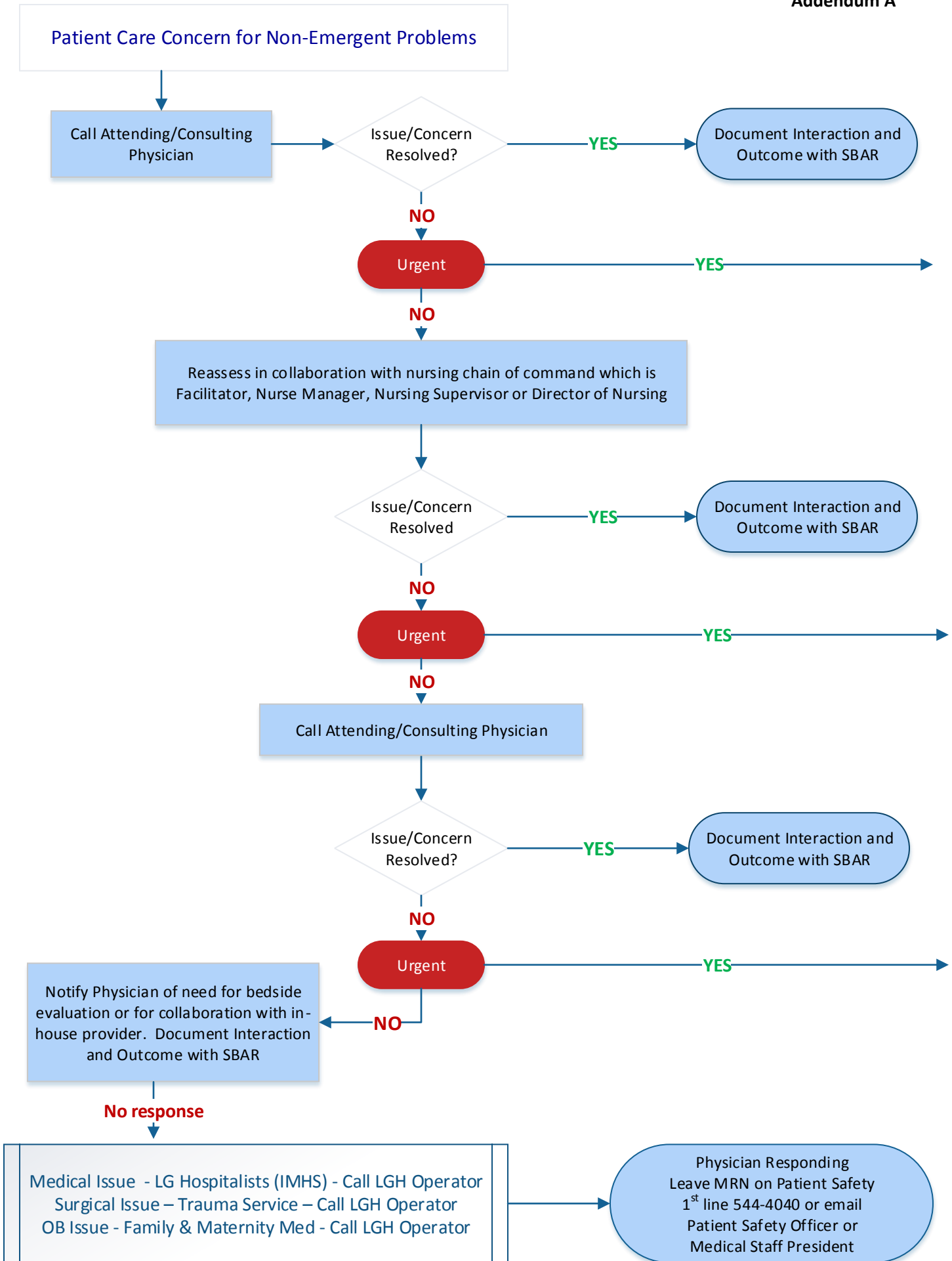
## **18.0 PROCTORING FOR NEW PRIVILEGES**

When a physician seeks to be approved for clinical privileges established under 7.4 of the Bylaws, such request shall be reviewed by the relevant Department Chair and the President or President-Elect.

- 18.1 Before such privileges may be granted, the physician shall be proctored by another physician with privileges equivalent to those sought for approval. If no Member of the Medical Staff has the requisite privileges, the proctor may be a physician with equivalent clinical privileges at another institution.
- 18.2 Before a Proctor from another institution may observe the physician performing such procedures, the Medical Staff Office shall verify the proposed Proctor's privileges at such other institution, his malpractice insurance coverage, and his licensure by querying the National Practitioner Data Bank. Therefore, a request for such on outside proctors shall be made no less than five (5) days in advance of the proposed proctoring.
- 18.3 The Department Chair shall determine the appropriate extent of such proctoring (eg. how many procedures to observe). The Proctor shall not engage in any aspect of patient care during the proctoring. Prior to permitting such outside proctoring, the proposed Proctor shall agree in writing to the conditions set forth here and to provide a written report of his observations, on a form provided by the Medical Staff Office, to the Department Chair no later than seven (7) days after the conclusion of the proctoring. The report shall state a review of the physician's capability to perform the procedure without proctoring.
- 18.4 Prior to any proctoring, the treating physician shall have obtained written consent from any patient who will receive a proctored procedure.

ADOPTED by the Medical Staff on July 21, 2016

Revised: 4/1/2018, 11/19/2020, 5/20/2021, 5/18/2022



Consider Rapid Response

## Medical & Dental Staff Rules and Regulations - Appendix B

### Medical Records – H&P Examination

A History and Physical (H&P) Examination shall be documented in the EHR within twenty-four (24) hours after the patient physically arrives for registration and within twenty-four (24) hours prior to procedures involving moderate sedation, anesthesia or any High Risk Procedure listed here:

- Amniocentesis
- Angioplasty and stenting procedures
- Bone marrow biopsies
- Catheter directed angiography
- Deep fine needle or deep core biopsy procedures (includes bone)
  - Does not include superficial biopsies such as subcutaneous lesions, thyroid nodules, breast lesions or superficial lymph nodes.
- Deep (intraperitoneal or retroperitoneal) fine needle aspiration
  - Fluid collection such as abscess, cyst, hematoma or seroma (excludes paracentesis for ascites or thoracentesis for pleural fluid).
- Elective Cardioversion
- External cephalic version
- Intravascular device placement
- Intravascular TPA and embolization procedures
- Invasive Angiography
- Liposuction
- Percutaneous cardiovascular diagnostic and interventional procedures
- Percutaneous transhepatic biliary drainage catheter placement or exchange
- Percutaneous sclerosing and ablative procedures within the chest, abdomen or pelvis
- Primary Central line placement
- Primary Chest tube placement
- Primary Percutaneous drainage except collections contained within subcutaneous fat
- Primary Percutaneous Nephrostomy tube placement
- Primary Percutaneous tube placement in GI tract
- Transesophageal echocardiogram
- Tunneled catheter exchange