Bylaws of the Medical Staff

of

St. Mary Medical Center
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St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
ST. MARY MEDICAL CENTER  
Langhorne, Pennsylvania  19047  

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, St. Mary Medical Center is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania; and

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

WHEREAS, the Medical Staff is to strive for patient care in the hospital at the recognized professional level of quality, that the Medical Staff is a component of St. Mary Medical Center and must work with and is subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, hospital management, and the Board are necessary to fulfill the objective of providing the desired quality of care to the hospital's patients;

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

DEFINITIONS

The term “Medical Staff” means all medical physicians and osteopathic physicians holding unlimited licenses in Pennsylvania, and duly licensed dentists and podiatrists who are privileged, through the Medical Staff process and who are subject to the Medical Staff Bylaws to attend patients in the hospital.

The term “Organized Medical Staff” means the self-governing entity accountable to the Governing Body that operates under a set of Bylaws, Rules and Regulations and policies developed and adopted by the voting members of the Organized Medical Staff and by the Governing Body.

The term “governing body” means the Board of Directors of the hospital.

The term “Executive Committee” means the Executive Committee of the Medical Staff unless specific reference is made to the Medical Executive Committee of the governing board.

The term “Chief Executive Officer” means the administrator appointed by the governing body to act in its behalf in the overall management of St. Mary Medical Center in Langhorne, Pennsylvania.

The term “practitioner” means an appropriately licensed medical physician, an osteopathic physician with an unlimited license, or appropriately licensed dentist or podiatrist and licensed or registered practitioners of allied services.

The term “patient encounter” for a non-procedure oriented specialist means an admission or a consult; for a procedure oriented specialist, it is an invasive procedure, which includes surgical procedures performed in the Operating Room or ASU, endoscopic procedures and/or vaginal and cesarean section deliveries.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
The term “Professional Review Action” (corrective action) is an action or recommendation of a professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of an individual practitioner (which conduct adversely affects the health or welfare of a patient or patients), which affects (or may affect) adversely the clinical privileges, or membership in a professional society of the practitioner. The action is not based on competence or professional conduct if it is based primarily on professional memberships, fees, advertising or other competitive acts, participation in health plans, participation in group practices, or any other matter that does not relate to the competence or professional conduct of a physician. The action includes, but is not limited to, determination of clinical privileges or membership to determine the scope of privileges or membership or to change or modify privileges or membership.”
Article I: NAME

The name of this organization shall be the Medical Staff of St. Mary Medical Center, Langhorne, Pennsylvania.

Article II: PURPOSES

The purposes of this organization are:

To insure that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive care that will be provided at the recognized professional level of quality, taking into account patient needs, the available hospital facilities and resources, and utilization standards in effect at the hospital.

To insure a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital.

To work with St. Mary Medical Center to provide an appropriate educational setting that will maintain scientific standards and encourage continuous advancement in professional knowledge and skill and continuous improvements in quality of patient care.

To initiate and maintain rules and regulations for self-government of the Medical Staff; and

To provide a means whereby issues concerning the Medical Staff and the hospital may be discussed by the Medical Staff with the governing body and the Chief Executive Officer.

Article III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of St. Mary Medical Center is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and who practice in accord with the ethics of their respective profession, who work cooperatively with others and who observe the Ethical and Religious Directives for Catholic Health Facilities at St. Mary Medical Center.

Section 2. Qualifications for Membership

To be eligible to apply for initial medical staff membership on or after Jan 1, 2008, all physicians, dentists and podiatrists, not members of the Staff at any time prior to January 1, 2008 must:

(a) Be board certified in their primary area of practice at St. Mary Medical Center. With the exception of General Dentistry as there is not a certifying Board. Those applicants who are not board certified at the time of application but who by virtue of completing their residency or fellowship training within the last five years are board eligible for their primary specialty, shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within the time period established by the applicant's specialty board.
(b) All individuals appointed to the medical staff before January 1, 2008, unless a waiver is previously granted, shall be governed by the department board certification and recertification requirements in effect as of Jan 1, 2008.

Waiver of Criteria:

(a) Any individual who does not satisfy one or more of the eligibility criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating the circumstances, and that his or her qualifications are equivalent to, or exceed, the eligibility criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant Department Chair, and the best interests of the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such. The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

(c) An application for appointment that does not satisfy an eligibility criterion will not be considered complete for processing until the Board has determined that a waiver should be granted. This application will expire after 120 days and no further action taken unless instructions for the withdrawal of the application are received from the candidate.

(d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. The Board may not act to grant an individual a waiver absent a recommendation from the Medical Executive Committee. A determination that an individual is not entitled to a waiver is not deemed a “denial” of appointment or clinical privileges since that application will not be complete and therefore will not be acted upon.

(e) The granting of a waiver in a particular case is not intended to set a precedent of eligible criteria for any other individual or group of individuals.

(f) The violation/breach of citizenship to include non-compliance of verbal orders, queries, delinquent op reports, etc., may result in restriction of your medical staff appointment and/or privileges.

Section 3. Conditions and Duration of Appointment

(a) Initial appointments and reappointments to the Medical Staff shall be made by the governing body. The governing body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in this Bylaws; provided that in the event of unwarranted delay (120 days from receipt of the fully completed application) on part of the Medical Staff, the governing body 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.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
(b) Initial appointments shall be for a period extending to not more than two years. Reappointments shall be for a period of not more than two years.

(c) Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the governing body, in accordance with these Bylaws.

(d) Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients, to abide by the hospital and Medical Staff Bylaws, rules and regulations, to practice in accordance with the Ethical and Religious Directives for Catholic Health Facilities at St. Mary Medical Center, to accept committee assignments and to accept consultation assignments.

(e) Medical Staff members will serve on the Emergency Room On-Call Schedule as assigned by the Department Chairperson, in conjunction with the Departmental Rules & Regulations.

(f) Physicians who are six months delinquent in their dues beyond the year for which their dues are assessed will have their privileges suspended until payment is received. If dues are not paid by the end of the year, he/she will be removed from the staff. In the event membership terminates for the reasons set forth in this paragraph, the procedures set forth in Articles VII and VIII do not apply.

(g) Leaves of Absence can be granted for medical, educational, military service and other special situations as deemed appropriate by the Medical Executive Committee. While on a Leave of Absence, no dues will be charged and there will be no reappointment process. These leaves may be granted for a period of up to one year. Reappointment will occur at the end of the Leave of Absence. Upon returning from a medical Leave of Absence, the physician must provide documentation from his/her treating physician that he/she is able to perform the essential Medical Staff duties appropriately with or without reasonable accommodation. While on an approved Leave of Absence a practitioner shall not be obligated to maintain professional liability insurance and current licensure.

A leave can be renewed by the Medical Executive Committee for one more year. If the leave extends for more than two years, the physician must apply as specified in Article V, Section 1 (Procedure for Appointment).

If the physician has completed a fellowship in another specialty during this leave of absence, he/she must reapply as specified in Article V, Section 1 (Procedure for Appointment).

(h) Medical Staff membership or particular Clinical Privileges shall not be granted or denied on the basis of gender, race, creed, color, national origin or other legally prohibited factors or on the basis of any other criterion lacking professional or ethical justification, including association with a prepaid group practice.

Section 4. Histories and Physicals

All Practitioners having privileges to admit patients to the Hospital shall perform, or arrange for another qualified Practitioner to perform, a physical examination and medical history no more than thirty (30) days before or twenty-four (24) hours after a patient is admitted to the Hospital, in accordance with such
regulations or procedures as may be set forth in Hospital or Medical Staff rules, regulations, policies or procedures.

Article IV: CATEGORIES AND CLASSIFICATIONS OF THE MEDICAL STAFF

Section 1. The Medical Staff

All appointments to the Medical Staff shall be made by the Board of Directors.

Section 2. Medical Staff Classifications Provisional Medical Staff

Medical Staff Classifications Provisional Medical Staff members will be appointed to the Medical Staff into one of the following groups: Primary Care, Hospital Oriented, Hospital Based, or Resource Specialist. The specialties included in each group are listed below. Within the Hospital Oriented Group and the Resource Specialist group, there will be procedure oriented specialties and non-procedure oriented specialties. The list is not all inclusive and any specialties not named will be assigned to a group by the Board of Directors upon recommendation by the Medical Executive Committee. The meeting and encounter requirements for Provisional Medical Staff members may be waived for those Provisional Medical Staff Members whose practice at the Hospital is limited to on call services provided:

1) The Provisional Staff Member meets the minimum procedures requirements at his/her primary hospital affiliation and;
2) Documentation verifying the competence of the Provisional Medical Staff Member is provided by the Physician’s primary hospital affiliation.

(a) Primary Care (Family Practice, General Internal Medicine, and Pediatrics).

(b) Hospital Oriented,


(c) Hospital Based (Anesthesia, Emergency Medicine, House Physicians, Medical Administrator, Neonatology, Pathology, Radiology).

(d) Resource Specialist.


(2) Nonprocedural Oriented - Allergy/Immunology, Dentistry, Dermatology, Endocrinology, Infectious Disease, Nutritionist, Perinatology, Psychiatry, Rheumatology.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
Section 3. Provisional Staff

All initial appointments to the Medical Staff, with the exception of the Consultant and Affiliate Staff, will be to the Provisional Staff. The provisional Medical Staff shall consist of physicians, dentists and podiatrists who have their initial appointment to St. Mary Medical Center Medical Staff, who have an office (where patient care is delivered) located within the service area of the hospital, and are being considered for active staff membership.

Members of the provisional staff shall be appointed to a specific department where their performance shall be observed for a two-year period by the chairperson of the department of his/her representative to determine the eligibility of such provisional members for active staff membership and for the appropriate exercise of the clinical privileges provisionally granted to them.

Provisional Primary Care physicians (Family Practice, General Internal Medicine and Pediatricians) and Hospital-Based physicians DO NOT have a patient encounter requirement, but are required to attend a minimum of 5 meetings per year.

Patient encounter requirements for the Hospital Oriented and Resource Specialist Provisional Staff are as follows for the two-year provisional period:

<table>
<thead>
<tr>
<th>PROVISIONAL STAFF</th>
<th>HOSPITAL ORIENTED Patient Encounter Requirement</th>
<th>RESOURCE SPECIALISTS Patient Encounter Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PROCEDURE ORIENTED</td>
<td>PROCEDURE ORIENTED</td>
</tr>
<tr>
<td>Minimum</td>
<td>20 Invasive Procedures</td>
<td>5 Invasive Procedures*</td>
</tr>
<tr>
<td>Maximum</td>
<td>No Maximum</td>
<td>No Maximum</td>
</tr>
<tr>
<td>Meeting Attendance Requirements</td>
<td>A minimum of 5 meetings per year</td>
<td>A minimum of 5 meetings per year</td>
</tr>
</tbody>
</table>

*Invasive Procedures include surgical procedures performed in the Operating Room or ASU, endoscopic procedures and/or vaginal and caesarean section deliveries.

Provisional members shall not be eligible to vote or to hold office or to take Emergency Room call unless so directed by the chairperson of their department. They are required to pay dues.

An assessment of the Medical Staff member's status will be made at the end of one year to advise the Medical Staff member of his/her performance and progress towards active staff membership, including his/her compliance with the requirements set forth in Article V, Section 3(d), the required number of encounters and meeting attendance.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
Provisional Medical Staff Members who fail to make their meeting and/or encounter requirements may be reappointed for one additional provisional year. They will not have voting privileges or the right to hold office. They may be eligible for Emergency Room Call in accordance with their Departmental Rules & Regulations. For the next calendar year they will pay triple the Medical Staff dues.

If they fail to meet their meeting and/or encounter requirements during the additional provisional year, they may either resign or will be removed from the Medical Staff. If they resign or are removed, they are not eligible to reapply for staff privileges for six months. In the event that Medical Staff Membership terminates for failure to meet the meeting and/or encounter requirements, the procedures set forth in Articles VIII do not apply.

Section 4. The Active Medical Staff

The Active Medical Staff shall consist of physicians, dentists and podiatrists who have met their provisional requirements, who have an office (where patient care is delivered) located within the service area of the hospital and who assume all of the functions and responsibilities of membership on the active Medical Staff, including where appropriate, Emergency Room call and consultation assignments.

Active Staff physicians are required to attend a minimum of 5 meetings per year during the two-year reappointment period. Members of the active staff shall be eligible to vote, to hold office, to take Emergency Room call as directed by the chairperson of their department, and to serve on Medical Staff committees. They are required to pay dues.

Section 5. The Associate Staff

The Associate Medical Staff shall consist of physicians, dentists and podiatrists qualified for staff membership who have an office (where patient care is delivered) in the service area of the hospital, but have only occasional patient encounters at the hospital.

Associate Medical Staff members shall be appointed to a specific department and shall be eligible to serve on Medical Staff committees as non-voting members. Associate members shall not be eligible to vote or hold office in the Medical Staff or take Emergency Room call unless so directed by the chairperson of their department. They are required to pay dues.

The meeting attendance requirement of Associate Medical Staff Members is 50% of the General Medical Staff meetings during the two-year reappointment period, **except Associate Staff Family Practitioners who have NO meeting attendance requirement.**

Section 6. The Affiliate Staff

Affiliate Staff shall consist of those physicians, dentists and podiatrists who wish to maintain an affiliation with the hospital. They shall have no admitting privileges, no consultation privileges and they shall not be authorized to manage patients in the hospital.

Members of this category may perform outpatient preadmission and history and physical, order outpatient diagnostic tests and services, visit patient in hospital, review medical records, consult with attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

Members are not required to be board certified or eligible for board certification. They are encouraged to attend medical staff meetings and department meetings but are not entitled to vote or hold office.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
Members of the Affiliate Staff Category will not be permitted to write any orders or document on the chart.

Members will not be required to have a two year provisional period, they will be appointed directly into said category. They will be credentialed and reappointed, as per bylaws, in the same fashion as the Active Staff, but we will not conduct FPPE or OPPE as these physicians will not be admitting patients nor having any official activity in the hospital. If a request is made to transfer from said category to any other category except Emeritus (must be recommended by a Medical Staff Member) the applicant will be processed as per Section 3 of the Bylaws and complete a Provisional period and all other requirements per the Bylaws. Applicants will pay an application fee and will be required to pay dues.

Section 7. The Emeritus Medical Staff

The Emeritus Medical Staff shall consist of physicians, dentists and podiatrists who are not active in the hospital but have given support and service to the hospital and have been recommended for this status by the Medical Executive Committee of the Medical Staff.

These may be physicians, dentists and podiatrists who have retired from active hospital practice. Emeritus staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing Medical Staff committees. Emeritus members shall not be required to pay dues.

Section 8. The Consultant Medical Staff

The Consultant Medical Staff shall consist of recognized specialists who are board certified in their specialty, have expressed willingness to accept such an appointment, and represent specialties that are needed for the purpose of providing complete medical care to the community. Those members of the medical staff who only have patient contact via telemedicine shall be considered members of the Consulting Staff and will be credentialed as other consultants.

Members of the Consultant Staff shall be limited to the performing of consultations upon request of a Medical Staff member. They shall not be eligible to vote, hold office, admit patients nor be required to serve on standing Medical Staff committees. They shall not be required to pay dues.

Consultant Staff members shall be subject to the same appointment and reappointment process as other Medical Staff members. Review of their qualifications will also include their continued necessity on the consultant staff.

Section 9. House Staff

All House Staff physicians shall be subject to the same appointment and reappointment process as other Medical Staff members.

Rules and regulations governing house staff physicians shall be developed by the department to which they have been assigned and approved by the Medical Executive Committee of the Medical Staff. The Vice President of Medical Affairs, in conjunction with the appropriate department chair, will be responsible for clinical oversight of the physician.

House Staff physicians shall not be required to attend Medical Staff meetings nor shall they have voting privileges. They shall not be required to pay dues.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
Section 10. Podiatrists

(a) The practice of Podiatry shall be defined as that practice which is limited to examination, diagnosis, treatment and care of conditions and functions of the human foot.

(b) Applicants for privileges in podiatry shall be graduates of a school of Podiatry approved by the Council on Education of the American Podiatry Association, and legally licensed to practice Podiatry in the Commonwealth of Pennsylvania. The applicant's office of practice shall be located within the service area of the hospital.

Applicants must be able to document background, experience, training, demonstrated competence, good reputation, and the ability to work with others with sufficient adequacy to assure the Medical Staff and governing body that any patient treated by them in the hospital will be given a high quality of podiatric care.

(c) Podiatrists must comply with all applicable Medical Staff Bylaws, rules and regulations, including the procedures governing qualifications, method of selection and the delineation of privileges. Their request for privileges, as outlined in the appropriate delineation of privileges form included in the application procedure, shall be processed through the normal Medical Staff mechanism to the governing body, which shall have final approval.

(d) Podiatrists granted clinical privileges shall be assigned to the Department of Surgery. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery.

(e) Admission to the Podiatric Service must be on a combined podiatric medical or podiatric surgical service. The care of the podiatric patient is the dual responsibility of the podiatrist and the physician, the former limited to his/her respective field as defined above, the latter will be responsible for the overall aspects of the patient's care throughout the hospital stay.

Furthermore, the physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of podiatric patients. The physician responsible for evaluating the general medical status of a podiatric patient shall determine, with consultation if necessary, the overall risk assessment and effect of the operation on the patient's health.

(f) An adequate medical history and physical examination by a physician member of the staff or his/her designee shall be required for all podiatric inpatients as is required for all other inpatients. The podiatrist may write medical orders within the scope of his/her license and the Medical Staff Bylaws, Rules and Regulations. He/she shall be responsible for the podiatric history and podiatry physical examination and all elements of the patient's record relating to podiatric care.

Section 11. Administrative and Medical-Administrative Officers

(a) A physician-administrative officer, licensed in Pennsylvania and with clinical responsibilities, must be a member of the Medical Staff, achieving this status by the procedure provided in Article V.

(b) His/her clinical privileges must be delineated in accordance with Article VI.
(c) The Medical Staff membership and clinical privileges of any physician-administrative officer shall not be contingent on his/her continued occupation of that position.

Section 12. Proctorship and Preceptorship

Proctor: Any individual who is/comes on-site, capable of providing physicians and/or Allied Health Professionals with guidance during a procedure. The responsibilities of the proctor shall be all of the following:

(a) Provide education as deemed necessary
(b) Provide feedback, both positive and negative, to maximize successful outcomes.
(c) Ensure proper case selection.
(d) Provide active intra-procedure guidance
(e) Will not have direct patient contact, unless the proctor is an active or provisionally active staff member credentialed for the procedure being proctored.
(f) Be knowledgeable in potential complications and bailout strategies.

If the Proctor is a physician or Allied Health Professional practitioner, then the individual shall be:

(a) Be licensed in the state of Pennsylvania.
(b) Subject to a background check.
(c) Subject to a NPDB query.
(d) Shall provide proof of liability coverage in the state of Pennsylvania

If the Proctor is a non-physician industry representative, then individual's responsibilities are:

(a) To be credentialed through an approved vendor verification system.
(b) To provide documentation which reflects appropriate and successful completion of training from their employer for the procedure in question.

The individual being proctored shall NOT initiate a procedure until the Proctor is physically present in the room.

Preceptor: A member of the Medical Staff or Allied Health Professional staff in good standing who has the expertise to provide a preceptee with education and training in procedural and non-procedural medical matters. The preceptor's responsibilities include:

(a) Being credentialed in the procedure or non-procedural discipline.
(b) Not allowing the preceptee, the individual being taught, to come in direct contact with the patient with the exception of the following:

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
(1) Be allowed limited palpation, with direct supervision, to understand normal from abnormal findings.

(2) Be allowed limited palpation during an open operative procedure, with direct supervision, to understand normal from abnormal findings.

(3) Be allowed limited auscultation for the purposes of learning normal from abnormal findings.

(c) Be allowed to directly observe the preceptor/patient visit, with the consent of the patient.

(d) Will not allow the preceptee to function as an independent practitioner.

(e) Will not allow the preceptee to actively engage the patient in conversation, unless directed by the preceptor.

(f) Accepts responsibility for the actions of the preceptee.

If the Preceptee is a physician or Allied Health Professional who is a member of the medical staff of allied staff, then the individual shall follow the guidelines as set forth in Proctorship section of this document.

If the Preceptee is a non-SMMC physician/allied health professional, then he/she will be subject to the following:

(a) Complete an application stating the reason for the privileges, the procedures and the name of the medical staff member who will be sponsoring them.

(b) They must be actively licensed in their respective state.

(c) Be subject to a background search.

(d) Be subject to a NPDB query.

(e) Must not act in a manner independent of the Preceptor.

(f) Must not engage in active conversation with the patient without the approval of the Preceptor.

The Department Chairman will be responsible for identifying if a physician proctor is required or a non-physician vendor proctor is acceptable.

After completion of the above requirements and upon recommendation of the Department Chairperson, The Chief Medical Officer or Designee will approve granting request for a period not to exceed twenty-four (24) months.

Any other Medical Staff member who wishes to train the Preceptee must meet the criteria as outlined in the preceptorship section and submit their request in writing along with a letter from the Primary Preceptor.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
Patients will be admitted to the service of a Medical Staff member. If the Preceptee will be participating in an invasive procedure, then it is the responsibility of the Preceptor to inform the patient of the Preceptee’s limited role during the procedure.

Article V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Application for Appointment

(a) All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the governing body after consultation with the Executive Committee. The application shall require detailed information concerning:

(1) the applicant's professional qualifications including relevant practitioner-specific data as compared to aggregate data,

(2) the name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

(3) information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, voluntarily relinquished, suspended, reduced or not renewed at any other hospital or institution;

(4) information as to whether his/her membership in local, state or national medical societies, or his/her license to practice any profession in any jurisdiction, has ever been suspended or terminated;

(5) information regarding involvement in any professional liability action, including final judgments and settlements;

(6) information regarding the applicant’s health status; and

(7) acts, communications, reports, recommendations, disclosures, and other information referred to in this Article V may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others, or any other matter that might directly or indirectly affect patient care or the efficient functioning of the hospital or the Medical Staff.

(b) The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

(c) The completed application shall be submitted to the Medical Staff Office within sixty (60) days. If the application is not received within this time period, it will be considered null and void. After collecting the references and other materials deemed pertinent, and after verifying that the Practitioner requesting approval is the same Practitioner identified in the credentialing documents by viewing a current picture hospital ID card or a valid picture ID issued
by a state or federal agency, the Medical Staff Office shall transmit the application and all supporting materials to the Credentials Committee for evaluations.

(d) The Medical Staff office shall also query the National Practitioner Data Bank when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

(e) By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of Medical Staffs of other hospitals or with others who may have information bearing on his/her competence, character and ethical qualifications.

Each applicant consents to the hospital's inspection of all records and documents and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests as well as of his/her moral and ethical qualifications for staff membership.

Each applicant releases from any liability to the fullest extent permitted by law, all representatives of the hospital performing their acts in substantial good faith and without malice in connection with investigating and evaluating the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

(f) The application form shall include a statement that the applicant has received and read the Bylaws, rules and regulations of the hospital and Medical Staff, and the Ethical and Religious Directives for Catholic Health Facilities that he/she agrees to be bound by the terms thereof at St. Mary Medical Center if he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

(g) By applying for Medical staff membership and reappointment, all Practitioners agree that they may not rebate a portion of a fee or accept other inducements in exchange for a patient referral; may not deceive a patient as to the identity of an operating surgeon or another medical practitioner providing treatment or services; and may not delegate the responsibility for diagnosis or care of hospitalized patients to another medical practitioner unless he believes the practitioner to be qualified to undertake this responsibility. Failure to complete the application form or any material misrepresentation, misstatement, or omission from the application is cause for rejection of the application.

Section 2. Appointment Process

(a) Within 120 days after receipt of the completed application for membership, the Credentials Committee shall make a written report of its investigation to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the practitioner and shall determine, through information contained in reference given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department in
which privileges are sought, whether the practitioner has established and meets all the necessary qualifications for the category of staff membership and the clinical privileges requested by him.

Every department in which the practitioner seeks clinical privileges shall make a recommendation, and these recommendations shall be made as part of the report. Together with this report, the Credentials Committee shall transmit to the Medical Executive Committee the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

(b) At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the governing body that the practitioner be provisionally appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

(c) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within ninety days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

(d) When the recommendation of the Medical Executive Committee is favorable to the practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation to the governing body.

(e) When the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the governing body until the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VIII of these Bylaws.

(f) If, after the Medical Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with subparagraph d. of this Section 2. If such recommendation continues to be adverse, the Chief Executive Officer shall promptly so notify the practitioner, by certified mail, return receipt requested. The Chief Executive Officer shall also forward such recommendation and documentation to the governing body, but the governing body shall not take any action thereon until after the practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article VIII of these Bylaws.

(g) At its next regular meeting after receipt of a favorable recommendation, the governing body or its Medical Executive Committee shall act in the matter. If the governing body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify him of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
the practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these Bylaws and until there has been compliance with subparagraph i. of this Section 2. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

(h) At its regular meeting after all of the practitioner's rights under Article VIII have been exhausted or waived, the governing body or its duly authorized committee shall act in the matter. The governing body's decision shall be conclusive, except that the governing body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the governing body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the governing body shall make a decision either to provisionally appoint the practitioner to the staff or to reject him for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

(i) When the governing body's decision is final, it shall send notice of such decision through the Chief Executive Officer to the secretary of the Medical Staff, to the chairman of the Medical Executive Committee and of the department concerned, and by certified mail, return receipt requested to the practitioner.

Section 3. Reappointment Process

(a) At least 120 days prior to the expiration date of the current staff appointment, reappointment forms will be mailed to members of the Medical Staff via certified mail. Completed reappointment forms shall be returned to the Medical Staff Office at least 60 days prior to the expiration date of the current staff appointment.

If a complete Reappointment Form is not received at least 60 days prior to the expiration date, written notice shall be sent to the applicant advising what information has not been received. A member of the Medical Staff, who fails without good cause as deemed by the Medical Executive Committee, to return their completed reappointment form by the end of their current appointment period, shall be deemed to have resigned membership in the Medical Staff. Failure to complete the application form or any material misrepresentation, misstatement, or omission from the application is cause for rejection of the application. In the event membership terminates for the reasons set forth in this paragraph, the procedures set forth in Articles VII and VIII of these Bylaws do not apply.

(b) If a reappointment form has not been fully processed by the end of the member's current staff appointment period for reasons other than the member's failure to timely complete and return their reappointment form or provide other required documentation, the staff member may be granted expedited privileges for a period not to exceed sixty days or until such time as processing is completed. Any extension of an appointment, pursuant to this section, does not create a vested right in the member for continued appointment through the entire next term but only until such time as processing of the reappointment form is concluded.

If the Medical Staff member is under suspension or restriction of privileges previously imposed, such suspension or restriction shall continue in effect until such processing is completed and a final decision is made by the Board.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
(c) Prior to the appropriate scheduled governing body meeting in the Medical Staff year, the Credentials Committee shall have reviewed all pertinent information available on each practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

(d) Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his/her ethics and conduct, his/her physical and mental capability, his/her attendance at Medical Staff meetings and participation in staff affairs, his/her compliance with the hospital Bylaws, Rules and Regulations, his/her cooperation with hospital personnel, his/her use of the hospital's facilities for his/her patients, his/her relations with other practitioners, and his/her general attitude toward patients, the hospital and the public.

(e) Prior to the final scheduled governing body meeting in the Medical Staff year, the Medical Executive Committee shall make written recommendations to the governing body, through the Chief Executive Officer, concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

(f) Thereafter, the procedure provided in Section 2, (d) through (i) of this Article V relating to recommendations on applications for initial appointment shall be followed.

(g) Practitioners requesting clinical privileges that have been awarded exclusively by St. Mary Medical Center to another provider or providers shall be notified in writing by the Medical Staff Office that their application for such exclusively awarded privileges cannot be considered. The practitioner’s request for such clinical privileges shall not be forwarded to the Credentials Committee for further consideration. Practitioners who are not permitted to apply for clinical privileges because such privileges have been awarded exclusively by St. Mary Medical Center to another provider(s), shall not be entitled to a hearing under these Medical Staff Bylaws.

Section 4. Governing Body Authority

Neither the Medical Staff nor its committees are empowered to make any final decisions respecting appointments or privileges. Such decisions are the sole responsibility of the Board.

Article VI: CLINICAL PRIVILEGES

Section 1. Clinical Privileges

(a) Every practitioner practicing at this hospital by virtue of Medical Staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the governing body, except as provided in Section 2 and 3 of this Article VI. No clinical privileges will be granted to applicants for whom the hospital is unable to provide adequate facilities and support services for the applicant and applicant's patients.

St. Mary Medical Center Medical Staff Bylaws (Ver. 6/2020)
(b) Every initial application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. This shall be outlined on the appropriate delineation of privileges section of the standard application form. The evaluation of such request shall be based upon the applicant's:

(1) education;
(2) training;
(3) experience;
(4) demonstrated competence;
(5) references;
(6) current licensure;
(7) health status;
(8) license/regulatory challenges;
(9) liability judgment;
(10) limitation/loss of privileges; and
(11) other relevant information including an appraisal by the clinical department in which such privileges are sought.

Each clinical department will make recommendations to the Credentials Committee of criteria for initial grant/renewal of clinical privileges. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

(c) Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care. Involuntary limitation, reduction, or loss of clinical privileges at another hospital, felony convictions, or exclusion of a provider by any federally funded programs, shall be reported in writing by the practitioner to the Credentials Committee within 45 days for convictions or above listed change in privileges and 7 days for exclusions from federally funded programs. Upon notification, a credentials review, as deemed appropriate by the Credentials Committee, will begin.

(d) Applications for additional clinical privileges must be in writing. To assure uniformity, they should be submitted on a prescribed form, on which the type of clinical privileges desired and the applicant's relevant recent training and/or experience must be stated. Such applications should be processed in the same manner as applications for initial appointment.

(e) Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. All dental patients, except those admitted to an oral surgeon's service, shall be admitted to a joint medical-dental service.

(f) A practitioner seeking appointment or reappointment who has received a final adverse decision shall not be eligible to reapply to the staff for a period of six months unless the
decision itself, or other provisions of these Bylaws, provide otherwise. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require, in demonstration that the basis for the earlier adverse action no longer exists.

Section 2. Temporary Privileges

(a) Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner, the Chief Executive Officer after receipt of a complete application that raises no concerns may, upon the basis of information then available including, proof of current malpractice liability insurance, relevant training and experience, ability to perform the privileges requested, current PA medical license in good standing, and query report from the National Practitioner Data Bank, which may reasonably be relied upon as to the competence and ethical standing of the applicant, no current or previously successful challenges to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges and with the written concurrence of the departmental chairperson concerned, the chairperson of the Credentials Committee and of the chairperson of the Executive Committee, grant temporary admitting and clinical privileges to the applicant for a period of no more than one hundred twenty (120) days pending the processing of the application. Temporary privileges may be granted in an emergency situation on a case-by-case basis.

(b) Temporary clinical privileges may be granted by the Chief Executive Officer on the recommendation of the Medical Staff designee or authorized representative for the care of a specific patient to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph a. of this Section 2, provided that there shall first be obtained such practitioner's signed acknowledgement that he/she has received and read copies of the hospital's and the Medical Staff's Bylaws, Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges.

Such temporary privileges shall be restricted to the treatment of not more than four patients in any one year by any practitioner, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

(c) The Chief Executive Officer may permit a physician serving as a locum tenens for a member of the Medical Staff in order to fulfill an important patient care, treatment and service need to attend patients without applying for membership on the Medical Staff for a period not to exceed 30 days, providing all of his/her credentials have first been approved by the departmental chairperson concerned and by the chairman of the Executive Committee and his current competence has been verified.

(d) Special requirements of supervision and reporting may be imposed by the departmental chairperson concerned on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer upon notice of any failure by the practitioner to comply with such special conditions.

(e) The Chief Executive Officer may at any time, upon the recommendation of the chairman of the Medical Executive Committee or the chairperson of the department concerned,
terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) then under his/her care in the hospital.

However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 2a of Article VII of these Bylaws, and the same shall be immediately effective. The appropriate departmental chairperson or, in his/her absence, the chairman of the Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

(f) A practitioner shall not be entitled to the procedural rights afforded in Articles VII and VIII of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless based on a determination of clinical incompetence or unprofessional conduct.

Section 3. Emergency Privileges

In the case of emergency, any physician, dentist or podiatrist member of the Medical Staff or any member of the Allied Health Practitioner Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician, dentist or podiatrist must request the privileges necessary to continue to treat the patient.

In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 4. Disaster Privileges

During disasters only when the emergency operations plan has been activated and the Hospital is unable to meet immediate patient care needs, the organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners. Emergency privileges shall be granted only: (i) after the volunteer Practitioner has completed a disaster privileges form and signed a statement attesting that the information provided on such form is accurate; (ii) the information available reasonably supports a favorable determination regarding the volunteer Practitioner’s qualifications (including licensure or certification in the Commonwealth of Pennsylvania), ability and judgment to exercise the privileges requested; and (iii) the volunteer Practitioner has acknowledged in writing that s/he has received, or been given access to the Medical Staff bylaws, Rules and Regulations and that the Practitioner agrees to be bound by the terms thereof and the Hospital Bylaws, Rules and Regulations, and policies.

(a) Licensed Independent Practitioners known to the Hospital Chief Executive Officer, the President of the Medical Staff or their designees may be granted disaster privileges without further documentation. Licensed Independent Practitioners not known to the President, Hospital CEO or their designees may be granted disaster privileges upon demonstration of a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following: (i) a current hospital photo identification card that
(b) Practitioners granted disaster privileges shall be identified with a hospital identification tag.

(c) The professional performance of those Practitioners who have been granted disaster privileges shall be supervised by a member of the Medical Staff by direct observation, retrospective chart review or mentoring.

(d) As soon as the emergency/disaster situation is under control, the Medical Staff Office shall verify the credentials, including primary source verification of licensure, of those volunteer Practitioners who are not members of the Medical Staff who have been granted disaster privileges. Such verification shall be completed within seventy-two (72) hours from when the volunteer Licensed Independent Practitioner presents to the organization. The President, the Hospital CEO or their designees shall make a decision, based on the information obtained regarding the professional practice of the volunteer Licensed Independent Practitioner, within seventy-two (72) hours from when the volunteer Licensed Independent Practitioner presents to the Division, related to the continuation of the disaster privileges initially granted.

(e) When the emergency management plan has been deactivated and patients placed under the care of a member of the Medical Staff, disaster privileges will automatically terminate or on the discovery of any information or the occurrence of any event of a nature which raises question about a volunteer Practitioner's professional qualifications or competence to exercise any or all of the emergency privileges granted, the President or the CEO may terminate any or all of such volunteer Practitioner's emergency privileges, provided that, where the life or well being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected forthwith by any person entitled to impose summary suspensions under these bylaws. In the event of any such termination, the volunteer Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the departmental chair responsible for supervision. Otherwise, any grant of emergency privileges shall terminate when an emergency situation no longer exists.

(f) A Practitioner who is refused emergency privileges shall not be entitled to any of the procedural rights afforded under these bylaws.

Section 5. Expedited Privileges

Once an application has been recommended for approval by the department chair, the Credentialing Committee, and the Medical Executive Committee, expedited privileges may be granted by an appointed committee consisting of two or more voting members of the governing body. In exercising such privileges, the applicant shall act under the supervision of the chairperson of the department to which he/she is assigned.
An applicant for appointment or reappointment is ineligible for the expedited process if any of the following has occurred:

(a) The applicant submits an incomplete application;

(b) There is a current challenge or a previously successful challenge to licensure or registration;

(c) The applicant has received an involuntary termination of medical staff membership at another organization;

(d) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;

(e) The department chair determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant;

(f) The applicant is suspended or debarred from participation in federal health care programs such as Medicare or Medicaid;

(g) The applicant’s DEA, if applicable, is suspended or revoked or otherwise limited; or

(h) The MEC’s recommendation to the governing body is negative in any way.

Section 6. Ongoing Professional Practice Evaluation

Each member of the Medical Staff shall be subject to ongoing professional practice evaluation in accordance with the policies adopted by the Medical Executive Committee and approved by the Board of Directors.

Focused Professional Practice Evaluation: A period of focused professional practice evaluation shall be implemented in accordance with the policy adopted by the Medical Executive Committee and approved by the Board of Directors for all initially requested Clinical Privileges, where the Practitioner has requested a new Clinical Privilege where there is no documented evidence of the Practitioner having performed competently the Clinical Privilege at the Hospital, and for evaluating the performance of Practitioners when issues affecting the provision of safe, high quality patient care are identified.

Article VII: CORRECTIVE ACTION

Section 1. Procedure

(a) Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the hospital or to transgress moral and ethical standards, or to be found wanting in the Medical Staff peer review/quality assessment process, or to be detrimental to patient safety, or reasonably probable of being in violation of the Medical Staff bylaws or hospital policies, or inconsistent with the efficient delivery of health care at the recognized professional level or where the practitioner shows signs of physical or mental impairment that
affects his or her ability to perform the essential functions of his or her position and/or clinical privileges, corrective action against such practitioner may be requested by:

(1) any officer of the Medical Staff;
(2) the chairperson of any clinical department;
(3) the chairperson of any standing committee of the Medical Staff;
(4) the Chief Executive Officer;
(5) the Board of Directors.

All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

Professional review actions are taken in the reasonable belief that the action is in the furtherance of quality health care. Action will be taken after a reasonable effort to obtain facts and with fairness for the Medical Staff member through adequate notice and hearing or other procedures. Any action taken is warranted by the facts after a reasonable effort to obtain the facts and after fair procedures have been followed.

(b) Within 45 days following the receipt of a request for corrective action involving reduction or suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Executive Committee.

(c) The action of the Medical Executive Committee on a request for corrective action may be to affirm, reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff membership be suspended, revoked or denied, or other action as deemed appropriate by the Medical Executive Committee, such as fines, community service, etc., or to recommend no action.

(d) Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff entitle the affected practitioner to the procedural rights provided in Article VIII of these Bylaws, except as otherwise provided for in these Bylaws.

(e) The chairman of the Medical Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article V, Section 2, and in Article VIII if applicable, of these Bylaws.
Section 2. Summary Suspension

(a) Whenever action must be taken immediately to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the mental health or safety and well-being of any patient, employee, or other person present in the hospital, a practitioner may have some or all of his/her clinical privileges suspended summarily, which suspension shall become effective immediately upon imposition and the Chief Executive Officer of the hospital shall promptly give notice of the suspension to the practitioner. Summary suspension may be requested by any one of the following:

(1) The Chairperson of the Practitioner's Department;
(2) The Chairperson of the Medical Executive Committee;
(3) The Chief Executive Officer; or
(4) A member of the Board of Directors

The agreement of two Officers of the Medical Staff, one of which must be the President or in his/her absence, the President-Elect, must be obtained before the summary suspension may be imposed.

(b) A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a hearing in accordance with Article VIII of these Bylaws.

(c) After receipt of the report of the Hearing Committee, the Medical Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension. If the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall, also in accordance with Article VIII, be entitled to request an appellate review by the governing body, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the governing body.

(d) Immediately upon the imposition of a summary suspension, the chairman of the Medical Executive Committee or responsible departmental chairperson shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

Section 3. Automatic Suspension

(a) Action by the State Board of Medical Examiners revoking or suspending a practitioner's license, revocation of a practitioner's DEA, or any lapse or termination of the practitioner's medical/professional liability insurance shall automatically suspend all of his/her hospital privileges.

(b) It shall be the duty of the president of the Medical Staff to cooperate with the Chief Executive Officer in enforcing all automatic suspensions.

(c) The Practitioner shall be notified of the basis of any automatic suspension by certified and regular mail as promptly as possible after the automatic suspension.
(d) The Practitioner shall be provided with thirty (30) days to produce clear and convincing evidence that the facts relied upon by the Hospital in imposing an automatic suspension are not correct.

(e) If the Hospital does not receive such evidence within thirty (30) days, the Practitioner’s Membership and Clinical Privileges shall automatically terminate unless the time is extended by the President of the Medical Staff in consultation with the Chief Executive Officer and the individual shall not be entitled to a hearing as set forth elsewhere in these Bylaws.

(f) In the event the Practitioner does produce evidence with thirty (30) days which disputes the facts relied upon by the Hospital in automatically suspending the Practitioner, the Practitioner shall be entitled to a Fair Hearing and Appellate Review unless the automatic suspension is terminated and the Practitioner is reinstated.

(g) If any action is taken which does not entitle a Practitioner to a hearing, the Practitioner shall be offered the opportunity to submit a written statement or any information which the Practitioner wishes to be included in the Practitioner’s peer review records along with documentation regarding the action taken.

Article VIII: HEARING & APPELLATE REVIEW PROCEDURE

Section 1. Right to Hearing and to Appellate Review

(a) When any Medical Staff member or Allied Health Profession Staff member receives notice of a recommendation of the Medical Executive Committee that, if ratified by decision of the governing body, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an Ad Hoc Committee of the Medical Staff. The notice of proposed professional review action shall state in concise language the acts or omissions with which the Medical Staff member is charged, a list of specific or representative charts being questioned, and/or other reasons or subject matter that was considered in making the adverse recommendation or decision and a list of witnesses that may be called by the hospital and any time limits required to request a hearing and a summary of hearing rights. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected Medical Staff member, he/she shall be entitled to an appellate review by the governing body before the governing body makes a final decision on the matter.

(b) The Medical Staff member shall have thirty (30) days after receipt of notice of proposed adverse action to request a hearing. The request shall be in writing to the Chief Executive Officer. When any Medical Staff member receives notice of a decision by the governing body that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a committee appointed by the governing body, and if such hearing does not result in a favorable recommendation, to an appellate review by the governing body, before the governing body makes a final decision on the matter.

(c) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VIII to assure that the affected Medical Staff member is
accorded all rights to which he/she is entitled. It is intended that the hearing and review procedures of this article shall be carried out in full compliance with the provisions of Section 11112 of the Health Care Quality Improvement Act of 1986, 42 U.S.C. 1101, et. seq. (HCQIA). To the extent that any provisions of this Article are inconsistent with the provisions of Section 11112 of HCQIA, the provisions of the HCQIA shall govern.

(d) The Medical Staff member shall have not less than 30 days following the date of receipt of such notice within which to request a hearing or an appellate review.

(e) A practitioner is not entitled to a hearing/appellate review for the following adverse actions:

(1) A practitioner who fails to pay Medical Staff dues and is terminated therefore is not entitled to the procedural rights afforded under this section.

(2) A practitioner who fails to fulfill the meeting attendance requirement is not entitled to the procedural rights afforded under this section.

(3) The denial of a request for temporary or emergency privileges does not entitle the practitioner to the procedural rights afforded under this section.

(4) A practitioner whose membership/privileges end as a result of Article VII, Section 3, Automatic Suspension is not be entitled to the procedural rights afforded under this section.

(5) Failure to return the completed reappointment application.

Section 2. Request for Hearing

(a) The Chief Executive Officer shall be responsible for giving prompt written notice by certified mail, return-receipt or by courier with receipt, an adverse recommendation or decision to any affected Medical Staff member who is entitled to a hearing or to an appellate review.

(b) The failure of a Medical Staff member to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter. The failure of a Medical Staff member to request an appellate review to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review on the matter.

(c) When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee of the Medical Staff or of a Hearing Committee appointed by the governing body, the recommendation shall thereupon become and remain effective against the Medical Staff member pending the governing body's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the governing body, the recommendation shall thereupon become and remain effective against the Medical Staff member in the same manner as a final decision of the governing body provided for in Section 7 of this Article VIII. In either of such events, the Chief Executive Officer shall promptly notify the affected Medical Staff member in writing of his/her status.
Section 3. Notice of Hearing

(a) Within 30 days after receipt of a request for hearing from a Medical Staff member entitled to the same, the Medical Executive Committee or the governing body, whichever is appropriate, shall schedule/and arrange for such a hearing and shall, through the Chief Executive Officer, notify the Medical Staff member in writing of the time, place and date so scheduled. The hearing date shall be not less than 30 days, nor more than 60 days from the date of the request for hearing; provided, however, that a hearing for a Medical Staff member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than 90 days from the date of receipt of such Medical Staff member's request for hearing.

(b) The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff member is charged, a list of specific or representative charts being questioned, and/or other reasons or subject matter that was considered in making the adverse recommendation or decision and a list of witnesses that may be called by the Hospital.

Section 4. Composition of Hearing Committee

(a) When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an Ad Hoc Committee of not less than five members of the Medical Staff appointed by the president of the Medical Staff in consultation with the Executive Committee, and one of the members so appointed shall be designated as chairman. No staff member who has actively participated in the consideration of the adverse recommendation or who is in direct economic competition with the Medical Staff member involved shall be appointed a member of this Hearing Committee. Mere knowledge of the proceedings shall not, however, preclude a staff member from serving on the Hearing Committee.

(b) When a hearing relates to an adverse decision of the governing body that is contrary to the recommendation of the Executive Committee, the governing body shall appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this committee as chairman. At least two representatives from the Medical Staff shall be included on this committee. No staff member who has actively participated in the consideration of the adverse recommendation or who is in direct economic competition with the Medical Staff member involved shall be appointed a member of this Hearing Committee. Mere knowledge of the proceedings shall not, however, preclude a staff member from serving on the Hearing Committee.

Section 5. Conduct of Hearing

(a) There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.

(b) An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. The practitioner shall have the right to have a record made of the hearing. The practitioner has a right to have copies of the record upon payment of reasonable charges for that record. After the hearing, the practitioner has the right to the written recommendation of the decision-maker, including a statement for the basis of the recommendation.
(c) The personal presence of the Medical Staff member from whom the hearing has been scheduled shall be required. A Medical Staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2 of this Article VIII and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in said Section 2. Good cause will be determined in the sole and absolute discretion of the Hearing Committee.

(d) Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponements shall only be for good cause shown and is the sole discretion of the Hearing Committee.

(e) The affected Medical Staff member shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or other person of the Medical Staff member’s choice in lieu of an attorney. At least seven days prior to the hearing, the affected Medical Staff member will supply a written list of witnesses to be called on his/her behalf, and the name of the person selected to represent him.

(f) The chairman of the Hearing Committee or his/her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

(g) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matters 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 Medical Staff member for whom the hearing is being held shall, prior to, during the hearing and at close of the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing.

(h) In making a recommendation, official notice may be taken by the Hearing Committee, either before or after submission of the matter for a recommendation, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The Medical Staff member for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information which can be considered in connection with applications for appointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

(i) The Executive Committee, when its action has prompted the hearing, shall appoint one or more of its members and/or a designee to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse
recommendation, but the affected Medical Staff member shall thereafter be responsible for supporting his/her challenge to the adverse recommendation by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

(j) The Medical Staff member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the Medical Staff member does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

(k) The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. However, the affected Medical Staff member, the Medical Executive Committee of the Medical Staff, the governing body, and/or the Hearing Committee may be represented at any phase of the hearing procedure by an attorney-at-law, if so desired.

(l) The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Medical Staff member for whom the hearing was convened.

(m) Within 30 days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation. Thereafter, the Hearing Committee shall promptly forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the governing body, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the governing body. Thereafter, the procedure to be followed shall be as provided in Section 2 of Article V of these Bylaws.

Section 6. Appeal to the Governing Body

(a) Within 30 days after receipt of a notice by an affected Medical Staff member of an adverse recommendation or decision made or adhered to after a hearing as above provided, he/she may, by written notice to the governing body delivered through the Chief Executive Officer by certified mail, return receipt requested, request an appellate review by the governing body. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Medical Staff member's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

(b) If such appellate review is not requested within 30 days, the affected Medical Staff member shall be deemed to have waived his/her rights to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article VIII.

(c) Within 30 days after receipt of such notice of request for appellate review, the governing body shall schedule a date for such review, including a time and place for oral
argument if such has been requested, and shall, through the Chief Executive Officer, by written notice, by certified mail, return-receipt or by courier with receipt, notify the affected Medical Staff member of the same. The date of the appellate review shall not be less than 30 days, nor more than 60 days, from the date of receipt of the notice of request for appellate review, except that when the Medical Staff member requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than 60 days from the date of receipt of such notice.

(d) The appellate review shall be conducted by the governing body or by a duly appointed appellate review committee of the governing body of not less than five members.

(e) The affected Medical Staff member shall have access to the report and record (and transcription, if any) of the Ad Hoc Hearing Committee and all other material that was considered in making the adverse recommendation against him. He/she shall submit a written statement in his/her own behalf, in which he states the reasons for the appeal, those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified.

This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the governing body through the Chief Executive Officer by certified mail, return receipt requested, at least 15 days prior to the date of such appellate review by certified mail, return receipt requested. Failure of the affected Medical Staff member to submit a written statement within the time and in the manner herein provided, shall be deemed a waiver of his/her right to the appellate review.

(f) The governing body or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph e. of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Medical Staff member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Medical Staff member shall be present at such appellate review body.

A member(s)/designee(s) of the Medical Executive Committee or the governing body, whichever is appropriate, shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him by any member of the appellate review body.

(g) New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the governing body or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

(h) If the appellate review is conducted by the governing body, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Medical Executive Committee of the Medical Staff for further review and recommendation within 60 days.

(i) If the appellate review is conducted by a committee of the governing body, such committee shall, within 30 days after the scheduled or adjourned date of the appellate review,
either make a written report recommending that the governing body affirm, modify or reverse its prior decision, or refer the matter back to the Medical Executive Committee for further review and recommendation within 60 days.

(j) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the hospital Bylaws, all action required of the governing body may be taken by a committee of the governing body duly authorized to act.

Section 7. Final Decision by Governing Body

(a) Within 60 days after the conclusion of the appellate review, the governing body shall make its final decision in the matter and shall send written notice by certified mail, return-receipt, or by courier with receipt, thereof to the Executive Committee, and through the Chief Executive Officer, to the affected Medical Staff member. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall not be subject to further hearing or appellate review.

If this decision is contrary to the Executive Committee's last recommendation, the governing body shall make its final decision with like effect and notice as first above provided in this Section 7.

(b) Notwithstanding another provision of these Bylaws, no Medical Staff member 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 action by the Medical Executive Committee of the Medical Staff, or by the governing body, or by a duly authorized committee of the governing body, or by both.

Article IX: OFFICERS

Section 1. Officers of the Medical Staff

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

Section 2. Qualifications of Officers

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

Section 3. Election of Officers

(a) Officers shall be elected at the annual meeting of the Medical Staff. Only members of the active Medical Staff, except as otherwise stated in the Bylaws, shall be eligible to vote. Active staff members may request an absentee ballot from the Medical Staff Office no later than five days prior to the scheduled meeting. The completed ballot must be returned to the Medical Staff Office prior to the scheduled meeting in order to be counted.

(b) The situation where there are three or more candidates and no candidate receives a majority shall be covered by a provision for successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority vote is obtained by one candidate.
Nominations:

(1) By the Nominating Committee: Nominations will be made by the Nominating Committee pursuant to Article XI.

(2) By petition: Nominations also may be made by petition signed by 20 members of the active staff and filed with the Medical Staff Office at least 20 (twenty) days prior to the annual meeting of the staff. As soon as reasonably possible, the names of these additional nominees shall be reported to the staff in writing.

(3) By other means: If before the election, all of the individuals nominated for an office pursuant to Section 3c 1) and 2) shall refuse, be disqualified from, or otherwise be unable to accept nomination then the Nominating Committee may submit one or more substitute nominees at the annual meeting. There will be no nominations from the floor.

Section 4. Term of Office

All officers shall serve a two-year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.

The President-Elect will become President of the Medical Staff after his/her two-year term as President-Elect without further voting. All other officers shall serve a two-year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.

Section 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the President and President-Elect, shall be filled by the Medical Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term. When a vacancy is created in the office of the President-Elect, then the Nominating Committee of the staff shall meet and submit candidate(s) for election at the next scheduled meeting of the staff. Additional candidates may be nominated from the floor at that time and then an election shall take place for the office.

Section 6. Duties of Officers

(a) President: the President shall serve as the chief administrative officer of the Medical Staff to:

(1) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the hospital.

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

(3) Serve as chairman of the Executive Committee.

(4) Serve as ex-officio member of all other Medical Staff committees without vote.

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(5) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

(6) Appoint committee chairs and members to all standing, special and multidisciplinary Medical Staff committees except the Executive Committee.

(7) Represent the views, policies, needs and grievances of the Medical Staff to the governing body and to the Chief Executive Officer.

(8) Receive, and interpret the policies of the governing body to the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

(9) Be responsible for the educational activities of the Medical Staff.

(10) Be the spokesman for the Medical Staff in its external professional and public relations.

(b) President-Elect: in the absence of the President, he/she shall assume all the duties and have the authority of the President. He/she shall be a member of the Medical Executive Committee of the Medical Staff and shall chair the Credentials Committee. He/she shall automatically succeed the President when the latter fails to serve for any reason.

(c) Immediate Past-President: the duties of the immediate past-President are advisory in nature. He/she is a member of the Medical Executive Committee of the Medical Staff.

(d) Secretary: He/she shall be a member of the Medical Executive Committee of the Medical Staff. The secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. He/she shall be the secretary of the Ad Hoc Bylaws Committee whenever it convenes.

(e) Treasurer: He/she shall be a member of the Medical Executive Committee of the Medical Staff. He/she shall keep a record of the financial status of the Medical Staff and shall make a financial report at each regular meeting of the active staff.

Section 7. Removal of Officers

Whenever the conduct or actions of an officer of the Medical Staff are thought to be detrimental to the performance of his/her duties, a member of the Executive Committee, or the President, may ask that he/she be considered for removal from his/her office. Such a request must be provided in writing to the Vice President of Medical Affairs.

A quorum of the Medical Executive Committee shall serve as an ad hoc hearing body to consider the complaint. A two-thirds vote (excluding the officer under consideration), with the approval of the Governing Board, shall determine whether the officer shall retain or lose his/her position.

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As long as removal from office does not alter the practitioner's staff appointment or clinical privileges, he may not invoke the Hearing and Appellate Review Procedure of Article IX.

Article X. CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments & Services

Each department shall be organized as a separate part of the Medical Staff and shall have a chairperson who shall be responsible for the overall supervision of the clinical work within his/her department.

Section 2. Qualifications, Selection & Tenure of Department Chairpersons

(a) Each chairperson shall be the member of the active staff in good standing best qualified by training, experience and demonstrated ability for the position and shall be board certified in his/her specialty. The directors of Medicine, Surgery, Pediatrics, Obstetrics, Family Practice and Emergency Medicine may not hold a similar position on another hospital staff.

(b) Each department chairperson shall be nominated in person by an active staff member of their department at a department meeting at least 60 days prior to the end of the current department chairperson's term. All members eligible to vote will be notified in writing prior to the nominations being held.

The election will be conducted at the following meeting. No nominations from the floor will be accepted at this meeting. Each department's Rules and Regulations should address the method by which the election is to be conducted. The results of the election shall be ratified by the Medical Executive Committee and appointed by the governing board for a two year term.

In the event of a tie which cannot be resolved within the department, the Medical Executive Committee will determine the outcome.

(c) Removal of a chairperson during his/her term of office may be initiated by a two-thirds majority vote of all active staff members of the department or by a two-thirds vote of the Executive Committee, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and by the governing board.

(d) Chairpersons of the clinical departments of Medicine, Surgery, Obstetrics and Gynecology, Family Practice and Pediatrics shall not serve more than two successive terms in office.

(e) A vacancy in the office of a department chairperson is filled by appointment of an acting chairman by the Medical Executive Committee, after considering the recommendations of the members of the department involved and subject to approval by the Board. The acting chairperson serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in this Section or provided, however, that the Medical Executive Committee may determine not to call a special election, if a regular election for the office is to be held within 180 days, in which case the acting officer serves only until the election results are final and the individual then elected assumes office immediately. The newly elected chairperson will serve a two year term, beginning on the day the results are final.
Section 3. Functions of Department Chairpersons

Each chairperson shall:

(a) Be accountable for all professional, clinically related activities and administrative activities within his/her department, including the coordination and integration of interdepartmental and intradepartmental services.

(b) Be a member of the Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care.

(c) Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report, at least annually, thereon to the Executive Committee.

(d) Appoint a department audit committee to conduct the initial phase of patient care review required by these Bylaws.

(e) Be responsible for enforcement of the hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her department; be responsible to establish Rules and Regulations within his/her department.

(f) Be responsible for implementation within his/her department of actions taken by the Medical Executive Committee of the Medical Staff and to report back to the Medical Executive Committee the action taken.

(g) Transmit to the Credentialing Committee his/her department’s recommendation concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his/her department, based on evidence of relevant training and experience; current competence (including any available relevant results of ongoing appraisals of clinical performance and practice); and effects of health status on the privileges to be recommended; and, if the level or scope of privileges was previously increased, evidence of satisfactory performance in accordance with those privileges and determine the data necessary for the ongoing professional practice evaluations of the department’s Practitioners.

(h) Be responsible for the teaching, education and research program in his/her department.

(i) Participate in every phase of administration of his/her department through cooperation with the nursing service and the hospital administration in matters affecting patient care, as related to personnel, supplies, special regulations, standing orders and techniques, and assessment and recommendation of off-site sources of services not provided by the department or organization.

(j) Be responsible for the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Chief Executive Officer or the governing body.
(k) Be responsible for assignment and revision of Emergency Room On-Call Schedule, in conjunction with the Departmental Rules & Regulations.

Section 4. Functions & Departments

(a) Each clinical department shall establish its own Rules and Regulations, consistent with the policies of the Medical Staff and of the governing board, for the granting of clinical privileges and for the holding of office in the department. These Rules and Regulations shall be reviewed regularly and be submitted to the Medical Executive Committee for approval.

(b) Each department shall establish a planned, systematic and ongoing mechanism to monitor and evaluate the quality of care/services provided and clinical performance of individuals with delineated clinical privileges. This activity shall be conducted in accordance with the current JCAHO, state and other regulatory and accrediting requirements.

Opportunities to improve care/service, shall be identified through evaluation of the results of department specific monitoring, evaluation activity, and the following Medical Staff monitoring functions: Surgical and Invasive procedures evaluation, Drug Usage Evaluation, Medical Record Review, Blood Usage Review, Pharmacy and Therapeutics function, Risk Management activities, related to clinical aspects of patient care, hospital-wide review functions (Utilization Review, Infection Control, Internal/External disaster and hospital safety).

Members of the department shall participate in the identification of important aspects of care relevant to the department/service, identification of indicators used to monitor the quality of the important aspects of care and the intra or interdepartmental/service evaluation of the quality of care/service to which they contribute.

(c) Each department shall meet at specified frequency as defined in their respective rules and regulations consistent with the requirements of regulatory agencies to periodically review care/service to draw conclusion, formulate recommendations, initiate actions and communicate to appropriate members of the department/service the findings, conclusions, recommendations and actions taken. Specific consideration shall be given to violation of the ethical and religious directives for Catholic health facilities.

A written report shall be submitted to the Executive Committee, detailing results of service/departmental monitoring evaluation of patient care/services.

Relevant results from the quality assessment activities are used to improve processes that affect patient care outcomes and when relevant to the performance of individual practitioners are used in the evaluation of the practitioners clinical and/or technical skills during reappraisal for reappointment to the Medical Staff or renewal/revision of clinical privileges.

(d) A report shall be submitted in writing on a quarterly basis to the Medical Executive Committee detailing such departmental analysis of patient care.

Section 5. Assignment to Departments

The Medical Executive Committee shall, after consideration of the recommendation of the clinical departments as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and for all other approved practitioners with clinical privileges.

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Section 6. Family Practice

Family physicians shall have clinical privileges in one or more departments in accordance with their education, training, experience and demonstrated competence. They shall be subject to all of the rules of such departments and to the jurisdiction of each departmental chairperson involved.

Section 7. Trauma Service

(a) The Trauma Service will be supervised by a qualified trauma surgeon responsible to the Medical Staff Executive Committee.

(b) The members of the Trauma Service will be required to attend 50 percent of the meetings of the Service.

(c) Trauma Service will conduct regular multi-disciplinary conferences, patient care conferences and establish their own quality assurance program.

Article XI: COMMITTEES

Section 1. Medical Executive Committee

(a) Composition: The Medical Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the chairperson of each clinical department including Anesthesiology, Emergency Medicine, Pathology and Radiology. It shall also consist of two members-at-large to be elected for a two-year period with the election to be held in the same year that the department chairpersons are elected. The members-at-large shall represent the medical and surgical subspecialties unless the chairperson of the respective department is a subspecialist. In that case, the member-at-large may be a general internist or general surgeon as appropriate. Members of the Medical Executive Committee are prohibited from serving concurrently on the Medical Executive Committee or in a similar capacity at another institution.

Vacancies in these positions will be filled by the Medical Executive Committee until a replacement is elected at the next general staff meeting, the Medical Staff having received two weeks' notice of the election, unless vacancy occurs less than two weeks before the next general staff meeting. The immediate past president of the Medical Staff will be a voting member of the Medical Executive Committee for the first year following his/her completed term of office and will be on an ex-officio, non-voting status for the second year following his/her term of office. Medical Executive Committee members may be removed from the Medical Executive Committee for failure to maintain his or her status in good standing and otherwise subject to removal in the same manner as Officers of the Medical Staff.

(b) The president of the staff automatically becomes the chairman.

(c) The Chief Executive Officer and the Vice President of Medical Affairs are ex-officio members without vote and should sit with the committee. Past presidents of the Medical Staff, excluding the current past president, who are still members of the Medical Staff, are invited to attend meetings as ex-officio members without vote.

(d) Duties: the duties of the Medical Executive Committee shall be:

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(1) To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

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

(3) Review and act on reports of Medical Staff or hospital committees, departments and other assigned activity groups.

(4) To implement policies of the Medical Staff not otherwise the responsibility of the departments.

(5) To provide liaison between Medical Staff and the Chief Executive Officer on matters of a medico-administrative nature.

(6) To recommend action to the Chief Executive Officer on matters of a medico-administrative nature.

(7) To make recommendations on hospital management matters (for example, long-range planning) to the governing body through the Chief Executive Officer.

(8) To fulfill the Medical Staff's accountability to the governing body for the medical care rendered to patients in the hospital.

(9) To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital.

(10) To provide for the preparation of all meeting programs either directly or through delegation to a program committee or other suitable agent.

(11) To review the credentials of all applicants and to make recommendations for the staff membership, assignments to department and delineation of clinical privileges.

(12) To review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal or change in clinical privileges.

(13) To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff to take corrective or review measures when warranted.

(14) To report at each general staff meeting.

(15) Organizing the Medical Staff's quality assessment and improvement activities and establishing a mechanism to conduct, evaluate and revise such activities.
(16) To provide medical staff review and approval of all patient related contracted services for quality.

(17) To represent the Medical Staff between meetings of the Organized Medical Staff within the scope of its responsibilities as defined in these Bylaws.

(e) Meetings: the Medical Executive Committee shall meet at least ten times per year and maintain a permanent record of its proceedings and actions.

Section 2. Credentials Committee

(a) Composition: the Credentials Committee shall consist of at least ten members of the active staff appointed by the President and representing the major clinical specialties, the hospital-based specialties and two Medical Staff at-large representing the medical and surgical subspecialties.

Duties: the duties of the Credentials Committee shall be:

(1) To review the credentials of all applicants and to make recommendation for membership and delineation of clinical privileges in compliance with Articles V and VI of these Bylaws.

(2) To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendation from the departments in which such applicant requests privileges.

(3) To review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles V and VI of these Bylaws.

(4) To investigate any breach of ethics that is reported to it.

(5) To review reports that are referred by the Executive Committee, Health Information Management Committee, medical care evaluation, and by the President of the staff.

(b) Meetings: the Credentials Committee shall meet at least ten times per year and shall maintain a permanent record of its proceedings and actions and report in writing to the Executive Committee.

Section 3. Pharmacy & Therapeutics Committee

(a) Composition: Membership shall consist of at least five representatives of the Medical Staff and one each from the pharmacy service, the nursing service and from hospital management. The hospital pharmacist shall be a member of and act as secretary for the committee.

(b) Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the
formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and other matters relating to drugs in the hospital. It shall also perform the following specific functions:

(1) Drug utilization functions:

(i) Develop and implement a systematic and ongoing criteria based mechanism to evaluate and continuously improve the appropriate and effective use of drugs. This is carried out in cooperation with nursing management, pharmacy and other services as appropriate. This process shall measure prescription or ordering of medications, preparation and dispensing, administration, and monitoring the medications' effects on patients.

(ii) Select drugs for evaluation based on the frequency of use, risk involved, known or suspected problems, drugs used for specific diagnosis, condition or procedure.

(iii) Recommend to the Medical Executive Committee and appropriate clinical departments mechanisms to evaluate drugs and the criteria for evaluation and monitoring of drugs.

(iv) Recommend actions and report individual and/or aggregate results of monitoring and evaluation activity to the Medical Executive Committee, clinical departments and Administrative departments as appropriate to be considered during privileging and performance appraisals.

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

(3) Develop and review periodically a formulary or drug list for use in the hospital.

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

(5) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

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

(c) Meetings: this committee should meet at least six times a year, shall maintain a record of its proceedings and activities, and shall report in writing to the Medical Executive Committee.

Section 4. Infection Control Committee

(a) Composition: This committee shall consist of at least one representative from each clinical department and at least one each from Nursing Services, pathology services, hospital administration and the person(s) directly responsible for management of the surveillance,
prevention and control program. Representation from remaining hospital department/services is available on a consultative basis.

(b) Authority: The Infection Control Committee or its designee has the authority to institute any surveillance, prevention and control measure or study when there is reason to believe that any patient or personnel may be in danger of acquiring an infection.

(c) Duties: The Infection Control Committee shall be responsible for the type and scope of surveillance activities, review and analysis of actual infections, promotion of preventative and corrective programs designed to minimized infection hazard and supervision of infection control in all phases of the hospital's activities including:

(1) Inpatient care areas;
(2) Outpatient services;
(3) Diagnostic or specialized care areas including surgical anesthesia services;
(4) Support services

(d) Meetings: The committee shall meet no less than six times yearly, shall maintain a record of its proceedings and activities, forward written reports of its meetings to the Medical Executive Committee, Chief Executive Officer, Nurse Executive, and persons responsible for hospital-wide quality assessment and improvement activities.

Section 5. Invasive Procedure Review Committee

The Invasive Procedure Review Committee is delegated by the Medical Staff to conduct and oversee review of:

(a) Surgical and other invasive procedures to improve the selection and performance of surgical and other invasive procedures.

(b) Improve the appropriateness and effectiveness with which blood and blood components are used.

(c) Composition: Committee membership consists of at least one physician from each clinical department, a physician from the department of Pathology, Administrative Representative and representative from the Quality Management Services Department.

(d) The Chairperson is appointed by the President of the Medical Staff who will be responsible for directing the committee activities and acting upon committee recommendations.

Duties: The committee function includes, but is not limited to:

(1) Developing and implementing an ongoing, systematic program for evaluating the appropriateness and effectiveness of performing surgical and other invasive procedures. This includes review of specimens removed during a surgical or
other invasive procedure, the agreement or disagreement of preoperative and pathologic
diagnosis and infractions of the directives for Catholic hospitals.

(2) Developing and implementing an ongoing systematic review process for
blood, blood components and autologous transfusion in order to improve the
appropriateness and effectiveness of its use. The processes measured include:

(i) ordering practices;

(ii) distributing, handling and dispensing blood and blood products;

(iii) administration of blood and blood products;

(iv) monitoring the blood and blood components’ effects on patients;

(3) Develop and recommending screening criteria or indications to identify
single cases or patterns of cases requiring more intensive evaluation.

(4) The Committee shall meet monthly and report results of these activities
to appropriate clinical departments and the Medical Executive Committee.
Departments/services are to review these results in accordance with the Ethical and
Religious Directives for Catholic Health Facilities.

Section 6. Cancer Committee
Composition: The Cancer Committee is an interdisciplinary standing committee consisting of
board certified physicians from all medical specialties involved in the care of patients with
cancer. Members shall include, but not be limited to, representatives from surgery, internal
medicine, dermatology, gynecology, medical oncology, pediatrics, diagnostic and therapeutic
radiology, pathology and family practice. The committee must also include members from
administration, nursing, quality management, social service, rehabilitation, pharmacy, dietary and
medical records, including cancer registry.

The Cancer Committee is responsible for planning, initiating, stimulating and assessing cancer
related activities in the hospital.

Duties: Required duties are to:

(a) Develop and evaluate the annual goals and objectives for the clinical,
educational, and programmatic activities related to cancer.

(b) Ensure that educational and consultative cancer conferences cover all major sites
and related issues.

(c) Monitor quality management and improvement through completion of quality
management studies that focus on quality, access to care, and outcomes.

(d) Promote clinical research.

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(e) Supervise cancer registry and ensure accurate and timely abstracting staging, and follow-up reporting

(f) Perform quality control of registry data.

(g) Encourage data usage and regular reporting.

(h) Ensure that the content of the annual report meets mandated requirements.

(i) Publish the annual report.

(j) Uphold medical and ethical standards.

(k) Report its proceedings and actions to the Medical Executive Committee.

Section 7. Patient Care Committee
Composition: The Patient Care Committee consists of physicians appointed by the President of the Medical Staff, nurses and representatives of administration. They shall meet six times per year. The function of the committee is to provide a forum to promote quality of patient care through inter-professional interaction. They shall make a report of their meetings to the Medical Executive Committee.

Section 8. Continuing Medical Education Committee
Composition: The Continuing Medical Education Committee shall consist of a panel of physicians appointed by the President of the Medical Staff representing different clinical departments and hospital personnel representing ancillary departments at St. Mary Medical Center whose duties support the maintenance of the library and education programs of the hospital. It shall meet at least quarterly. The purpose of the committee is to assess the education needs, formalize and conduct the CME activities (conferences, seminars, etc.); to maintain a budget to upgrade and adequately stock library facilities to be readily available for use by the Medical Staff. To provide the Medical Staff an opportunity to learn and be informed of the newest techniques and latest information related to their practice, to improve the quality of care rendered to their patients, and to obtain medical education credits.

Section 9. Medical Staff Bylaws Committee
Composition: The Bylaws Committee of the Medical Staff shall consist of members appointed by the President of the Medical Staff.

They shall meet as often as needed to process recommended changes to the Bylaws and Rules and Regulations of the Medical Staff. The Bylaws Committee shall also review the Medical Staff Bylaws, Rules and Regulations and policies, the Bylaws of the Board of Directors and hospital policies periodically to ensure compatibility with each other and compliance with law and regulation. Amendments shall be processed as described in Article XVI. They shall review the Bylaws at least annually. A report of the Bylaws Committee's activities shall go to the Medical Executive Committee.
Section 10. Nominating Committee

Composition: The Nominating Committee shall consist of at least seven members of the active staff; the President of the staff as Chairman, the most recent Past President of the staff if available, the President-Elect, and at least four active members of the staff appointed by the President of the staff. Members of the Nominating Committee may not be nominated for Medical Staff office while serving on the Committee.

Duties: The Nominating Committee shall:

(a) Announce to the staff at least 75 days prior to elections that the Committee is considering nominations. The Staff is invited to submit names at this time.

(b) Submit to the Medical Staff Office the names of one or more qualified nominees for each office to be filled by election, as well as for vacancies to the Executive Committee.

(c) Obtain an appropriate commitment from the candidate in writing.

(d) Report such nominees to the staff in writing at least forty-five (45) days prior to the annual meeting.

(e) Also be prepared to submit substitute nominees should all the candidates be unable to accept the nomination pursuant to Article IX, Section 3c.
Article XII. **MEDICAL STAFF MEETINGS**

**Section 1. General Staff Meetings**

The agenda of the General Staff Meeting shall include reports of review and evaluation of the work done in the clinical departments and the performance of the required Medical Staff functions. The Medical Staff shall conduct regular meetings at least once a year.

**Section 2. Special Meetings**

The President or the Medical Executive Committee may call a special meeting of the Medical Staff at any time. The President shall call a special meeting by sending a mailed notice within 30 days before the date of such meetings, by or at the direction of the President (or other persons authorized to call the meeting). The notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meetings. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

**Section 3. Quorum**

The presence of fifty percent of the total membership of the active Medical Staff at any regular or special meeting shall constitute a quorum for purposes of amendment of these Bylaws, Rules and Regulations, and the presence of twenty-five percent of such membership a quorum for all other actions.

**Section 4. Attendance Requirements**

Each member of the active and provisional Medical Staff shall be required to attend a minimum of 5 meetings per year. The meeting attendance requirement of Associate Medical Staff Members is 50% of the General Medical Staff meetings during the two-year reappointment period, except Associate Staff Family Practitioners who have NO meeting attendance requirement.

Failure of an active, associate or provisional member of the Medical Staff to satisfy the meeting attendance requirement will result in a fine equal to twice the then current Medical Staff dues, a one year probational period without voting privileges and without the right to hold office. *(Note: failure to meet the requirement during the probational year results in an additional probational year with a fine equal to twice the then current Medical Staff dues, no voting privileges, and no right to hold office.)*

If the fine is not paid within three months of the start of the probational year, the member may resign or will be removed from the Medical Staff. If the member resigns or is removed, the member is not eligible to reapply for staff privileges for six months. In the event that Medical Staff Membership terminates for failure to meet the meeting and/or encounter requirements, the procedures set forth in Articles VII and VIII do not apply.

Committee assignments will be offered on a voluntary basis to all Active, Provisional and Associate members. If the minimum number for each committee is not attained, assignment will
be done on a rotational basis from those Medical Staff members who have had no committee assignment for the previous year. Credit will be given to all members serving on a committee. This credit can be applied toward their meeting attendance requirement, except for Provisional members.

A practitioner whose patient's clinical course is scheduled for discussion at a regular departmental meeting or clinico-pathological conference shall be so notified and shall be expected to attend such meeting.

**Section 5. Agenda**

(a) The agenda at any regular Medical Staff meeting shall be:

Administrative

1. Call to order.
2. Acceptance of the minutes of the last regular and of all special meetings.
5. Reports from the Chief Executive Officer of the hospital.
6. Reports of departments.
7. Reports of committees.
8. New business (including elections where appropriate).

Professional

1. Review and analysis of the clinical work of the hospital.
2. Reports of medical committees.
3. Discussion and recommendations for improvement of the professional work of the hospital.
4. Adjournment

(b) The agenda at special meetings shall be:

1. Reading of the notice calling the meeting.
2. Transaction of business for which the meeting was called.
3. Adjournment

**Article XIII: COMMITTEE & DEPARTMENT MEETINGS**

**Section 1. Regular Meetings**

Each department shall meet at the frequency specified in their respective rules and regulations but not less than monthly to review and evaluate the clinical work of practitioners with privileges in the department. Committees may, in resolution, provide the time for holding regular meetings without notice other than such resolution.

**Section 2. Special Meetings**

A special meeting of any committee or department may be called by or at the request of the chairman or director thereof, by the President of the Medical Staff or by one-third of the group's then members, but not less than two members.
Section 3. Notice of Meetings
Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than seven days before the time such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum
One third of the active Medical Staff members of a committee or department, but not less than two members, shall constitute a quorum at any meeting.

Section 5. Manner of Action
The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereat. All voting members of the active Medical Staff are entitled to one (1) vote on matters to be voted on by the members.

Section 6. Rights of Ex-Officio Members
Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

Section 7. Minutes
Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting. The minutes should document the actual discussion of patients evaluated and treated, including any conclusions or resultant recommendations.

Section 8. Clinicopathological Conferences
At least two (2) clinicopathological conferences under the direction of the hospital pathologist must be held each year.

Article XIV: THE ALLIED HEALTH PROFESSIONAL STAFF
Allied Health Professionals (AHPs) are Certified Registered Nurse Practitioners (CRNPs) are individuals who require collaboration with a physician as set forth in a collaborative agreement and within the CRNP specialty and as defined in the Rules and Regulations of the State Board of Nursing.

(a) AHPs currently include; Registered Nurse Anesthetists, Certified Registered Nurse Anesthetists, Physician Assistants, Certified Nurse Midwives, Certified Registered Nurse Practitioners, Psychologists. Registered Nurse First Assistant (RNFA) and Registered Dietician.

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(b) AHPs shall complete an application form and provide evidence of their credentials to the Credentials Committee of the Medical Staff. While these individuals are not Medical Staff members, their application shall be processed in the same manner.

(c) Prerogatives of Allied Health Professionals

(1) The prerogatives of a physician-directed AHP are to provide such specifically designated patient care services as are granted to him/her under the degree of supervision or direction of a Medical Staff member consistent with any limitations stated in the Medical Staff Bylaws, the State Rules and Regulations and Medical Staff or hospital policies governing the AHPs practice in the hospital.

(2) Serve on committees when so appointed.

(3) Attend and participate in, when invited, clinical, scientific and educational meetings of the staff or a department when appropriate to his/her discipline. Exercise such other prerogatives as the Medical Executive Committee may accord AHPs in general or a specific category of AHPs.

(4) Prerogatives of AHPs are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff authorization or to an AHP's association with the staff.

(d) Obligations of Allied Health Professionals - Each AHP shall:

(1) Abide by the Hospital and Medical Staff Bylaws and Rules and Regulations in addition to the rules and regulations of their respective governing body.

(2) Participate, when requested, in quality review program activities and in discharging such other functions as may be required from time to time.

(3) When requested, attend clinical and education meetings of the staff and of the department with which he/she is affiliated.

(4) Refrain from any conduct or acts that are or could be reasonably interpreted as being beyond, or an attempt to exceed, the scope of practice authorized within the hospital.

(e) Terms and Conditions of Affiliation - An allied health professional shall be individually assigned to the clinical unit appropriate to his/her professional training and is subject to an initial probationary period, formal periodic reviews and disciplinary procedures as determined for his/her category. An AHP is entitled to the same procedural due process rights as provided in the Hearing Appellate Review for Medical Staff members and applicants.

The quality and efficiency of the care provided by AHPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or hospital quality review/risk management or utilization management mechanisms.
(f) Definition of Scope of Practice – Written guidelines for the performance of specified services by each category of AHPs shall be developed and described in the delegated privileges. These guidelines shall include:

(1) Specific categories of patients that may be seen.

(2) A description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the medical record.

(3) Definition of the degree of assistance that may be provided to a practitioner in the care of patients on hospital premises and any limitations thereon, including the degree of practitioner supervision required.

(g) Procedure for Recredentialing - An evaluation of the AHPs performance shall be sent to the Credentials Committee at the end of the provisional year and at each re-evaluation period (one or two years) thereafter.

Article XV: IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this hospital:

First, that 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 maintaining quality patient care in this or any other health facility, shall be privileged to the fullest extent permitted by law.

Second, that such privileges shall extend to members of the hospital's Medical Staff and of its governing body, its other practitioners, its Chief Executive Officer and his/her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIV, the term “third parties” mean both individuals and organizations from which information has been requested by an authorized representative of the governing body or of the Medical Staff.

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

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews and (7) other hospital, departmental, service or community activities related to quality patient care and inter-professional conduct.
Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article XIV, may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the hospital execute releases in accordance with the tenor and import of this Article XIV in favor of the individuals and organizations specified in the third paragraph of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness as may be applicable under the laws of this State.

Seventh, that the consents, authorizations, releases, rights, privileges and immunities provided by Section 1 and 2 of Article V of these Bylaws for the protection of this hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

Article XVI: RULES & REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Any proposed Rule or Regulation being considered by the Medical Executive Committee shall be distributed to the members of the Medical Staff for review and comment, in accordance with such procedures as are approved by the Medical Executive Committee before the proposed Rule or Regulation is adopted and sent to the Board for approval. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting on notice, by a two-thirds vote of those present of the active Medical Staff. Amendments to the Rules and Regulations may also be proposed directly to the Board of Directors upon a petition of a voting member of the Medical Staff. Any proposed amendments made by petition shall also be submitted to the Medical Executive Committee for review and comment. Thereafter, the procedures contained in Article XVII shall govern. Such changes shall become effective when approved by the governing body.

Article XVII: AMENDMENTS TO MEDICAL STAFF BYLAWS

These Bylaws shall be reviewed at least annually and may be amended or changed in the following manner:

(a) Proposed amendments or changes may originate from the Executive Committee, any other standing committee of the Medical Staff, administration, or from any Active Staff Meeting and then be referred to the Bylaws Committee for discussion.

(b) Amendments to these Bylaws may also be proposed directly to the Board of Directors upon a Petition of a voting member of the Medical Staff. Any proposed Bylaws amendments made by petition shall also be submitted to the Medical Executive Committee and Bylaws Committee for review and comment. Thereafter, the procedures contained in these bylaws shall govern.

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(c) After review and formulation by the Bylaws Committee, these amendments shall be reviewed by the Medical Executive Committee and then presented to the next regular or special meeting of the Medical Staff.

(d) Prior notice of such proposed amendments shall be given to the Medical Staff no later than fifteen days prior to the staff meeting at which approval will be sought.

(e) To be adopted, an amendment shall require a two-thirds vote of the Active Medical Staff present.

(f) Amendments so made shall be effective when approved by the governing body.
Article XVIII: CONFLICT MANAGEMENT

Section 1. Conflicts within the Medical Staff

In the event of a dispute between leaders or segments of the medical staff that cannot be resolved by the Medical Executive Committee, the matter in dispute shall be referred to an ad hoc Conflict Resolution Committee.

(a) The ad hoc Conflict Resolution Committee shall consist of up to five (5) members consisting of an equal number of representatives of the opposing viewpoints and an impartial chair. These members shall be active members of the medical staff appointed by the Medical Staff President.

(b) Additional non-voting members may be invited to participate by the Conflict Resolution Committee chair. These additional members may include relevant department chairs, administrators, or neutral representatives of the Medical Staff.

(c) The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting patient safety and quality of care.

(d) The Conflict Resolution Committee decision will be reported to the Medical Executive Committee for approval. If not approved, the matter is returned to the Conflict Resolution Committee for further review. The Medical Executive Committee approval/disapproval will be reported to the Board of Directors for final disposition.

Section 2. Conflicts with the Board of Directors

In the event of a dispute between the Board of Directors and either the Organized Medical Staff or Medical Executive Committee, the matter in dispute shall be referred to a Joint Conference Committee.

(a) The Joint Conference Committee shall consist of an equal number of active members of the Medical Staff appointed by the Medical Staff President and members of the Board of Directors appointed by the Chair of the Board. An impartial chair for the Joint Conference Committee shall be selected collaboratively by the Medical Staff President and Chair of the Board of Directors.

(b) Either the President of the Medical Staff or Chair of the Board of Directors may request the convening of a Joint Conference Committee to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

(c) A decision of the Joint Conference Committee is then presented to the Medical Executive Committee for approval. If not approved by the Medical Executive Committee, the matter is returned to the Joint Conference Committee for further review.

(d) After approval/disapproval by the Medical Executive Committee, the decision is submitted to the Board of Directors for final disposition.
Section 3. Resolution Techniques

If deemed appropriate by the President of the Medical Staff, Chair of the Board of Directors, and the Chief Executive Officer an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.
Article XIX: INTERNS AND RESIDENTS

Interns and residents, who are assigned to complete clinical rotations at St. Mary Medical Center, shall not hold appointments to membership in the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall perform only those clinical activities, commensurate with their training and experience, permitted by the curriculum of the graduate medical education program and under the supervision of qualified and licensed Practitioners who are members of the Medical Staff with appropriate clinical privileges, in accordance with Medical Staff Rules and Regulations or Policies and Procedures governing such supervision.

Section 1. Graduate Medical Education Committee

(a) Composition

The Graduate Medical Education Committee shall consist of the director of each graduate medical education (“GME”) program at the Hospital, a resident from each program who is nominated by his peers (minimum of two), a quality improvement/safety representative, and the Designated Institutional Official (DIO) who shall chair the Committee. The Committee may also include members from clinical and administrative departments or services that interface with the GME programs.

Additional GMEC members and subcommittees: In order to carry out portions of the GMEC’s responsibilities, additional GMEC membership may include others as determined by the GMEC.

(b) Duties

The Graduate Medical Education Committee shall:

(1) Oversee all GME programs sponsored by or affiliated with the Hospital, including evaluating, monitoring, and advising on all aspects of GME at the Hospital including accreditation.

(2) Review and approve Hospital GME policies and procedures including those regarding the quality of education and the work environment for residents in all programs at the Hospital, in compliance with all Accreditation Council for Graduate Medical Education (“ACGME”) standards.

(3) Be accountable to, and report at least annually to, the MEC and the Board regarding resident performance, resident participation in patient safety and quality of care education, and the accreditation status of the GME programs.

(4) Work with the MEC to assure that all Members who supervise residents possess Clinical Privileges commensurate with the supervising activities and comply with all applicable ACGME and Hospital policies.

(c) Meetings

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The GMEC shall meet in at least quarterly. At least one resident or fellow Committee member shall attend each meeting.
Article XX: ADOPTION

These Bylaws with the appending Rules and Regulations, shall be adopted at any regular or special meeting of the active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the governing body of the hospital. Copies of the revisions will then be distributed to members of the medical staff. Approved by the Board of Directors on September 17, 1976. Original approved, December 15, 1972.

RULES & REGULATIONS

Section 1.  GENERAL

1.  The Rules and Regulations approved by the Medical Staff and the governing body are binding on all members of the Medical Staff.

2.  Hospital and Medical Staff services are available to all persons without regard to race, creed, color, sexual preference, handicap or national origin.

3.  All members of the Medical Staff are obliged to conform to the established ethics of their profession.

4.  All members of the Medical Staff are obliged to practice medicine in this hospital in strict adherence to the Ethical & Religious Directives for Catholic Health Care Facilities.

5.  All members of the Medical Staff are obliged to participate in an ongoing program of continuing education consistent with guidelines set forth by the American Medical Association or respective national or local organizations.

6.  Members of the Active Medical Staff are obligated to serve on the Emergency Room on-call roster as scheduled by the Department Chair and in conjunction with the Departmental Rules & Regulations.

Section 2.  ADMISSION & DISCHARGE OF PATIENTS

1.  A patient may be admitted to the hospital only by a member of the Medical Staff.  All practitioners shall be governed by the official admitting policy of the hospital.

2.  A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient.  Whenever these responsibilities are transferred to another staff member, the original attending physician shall obtain the commitment of the new attending physician to accept the case, and a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3.  Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated.  In the case of an emergency, such statement shall be recorded as soon as possible.

4.  In any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

5.  Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the hospital that the said emergency admission was a bona fide emergency.  The history and physical examination must clearly justify
the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

6. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend to him/her. Where no such selection is made, a member of the active or associate staff on duty in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairperson of each department shall provide a schedule for such assignments.

7. Each member of the staff shall arrange for proper professional care of his/her patients at all times.

8. The chief admitting clerk will admit patients on the basis of the following order of priorities:

   a) Emergency Admission: Within 24 hours following an emergency admission, the attending physician shall sufficiently document in writing the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee for appropriate action.

   b) Urgent Admissions: This category includes those so designated by the attending practitioner and shall be reviewed as necessary to determine priority when all such admissions for a special day are not possible.

   c) Pre-operative Admissions: This includes all patients already scheduled for surgery.

   d) Routine Admissions: This will include elective admissions involving all services.

9. Patient transfers: Transfer priorities shall be as follows:

   a) Emergency room to appropriate patient bed.

   b) From obstetric patient care area (unit) to general care area, when medically indicated.

   c) From intensive care unit to general care area.

   d) From cardiac care unit to general care area.

   e) From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

   No patient will be transferred without such transfer being approved by the responsible physician.

10. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

11. For the protection of patients, the medical and nursing staffs and the hospital, certain principles are to be met in the care of the potentially suicidal patient:
a) Any patient known or suspected to be suicidal in intent shall be admitted to medical-surgical nursing unit until the patient can be transferred to another institution where suitable facilities shall be attended at all time.

b) Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff.

12. Admissions to intensive and cardiac care units: if any questions as to the validity of admission or to discharge from the intensive care unit or the coronary care unit should arise, that decision is to be made through consultation with the chairman of the Special Care Committee or his/her designee.

13. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay and approved by the particular clinical department and the Medical Executive Committee of the Medical Staff. The documentation must contain:

   a) An adequate written record of the reason for continued hospitalization.

   b) The estimated period of time the patient will need to remain in the hospital.

   c) Plans for post-hospital care.

Upon request of the Quality Management Services, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

14. Patients shall be discharged only on the order of the attending practitioner or by the Nurse Practitioner (NP) or Physician Assistant (PA) with the supervision of the attending.

15. It shall be the responsibility of the attending practitioner to write discharge diagnosis on patients on the day prior to discharge whenever possible. Patients should be checked out with the cashier and leave the hospital by 11:30 a.m. whenever possible.

16. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. When possible, he/she shall notify the family and sign the death certificate. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or his/her designee. Policies with respect to release of dead bodies shall conform to local law.

17. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. Autopsy at St. Mary Medical Center is encouraged when death occurs under the following circumstances:

   a) Deaths in which autopsy may assist to explain unknown and unanticipated medical complications.

   b) Deaths in which cause of death is not known with certainty on clinical grounds.

   c) Cases in which autopsy may help to allay concerns and provide reassurance to the family and/or the public regarding the death.

   d) Deaths of patients who have participated in clinical trials approved by Institutional Review Boards.

   e) Obstetric deaths

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f) Neonatal and pediatric deaths

g) Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

h) When jurisdiction has been waived by a coroner:

1) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.

2) Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.

3) Natural deaths subject to, but waived by, a forensic medical jurisdiction, such as deaths occurring within 24 hours of hospital admission, and deaths which the patient sustained or apparently sustained an injury while hospitalized.

4) Deaths known or suspected to have resulted from environmental or occupational hazards.

5) Deaths within 48 hours of a surgical or invasive procedure, including radiology.

An autopsy may be performed only with a written consent, signed in accordance with state law. The autopsy permit must indicate if a head autopsy is authorized. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within 48 hours and the complete protocol should be made a part of the record within 2 months.

Section 3. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body.

If a complete history has been recorded and a physical examination performed prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff within thirty days prior to the patient's admission to the hospital. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

3. Patients undergoing both inpatient and outpatient emergent and non-emergent operative and/or other invasive procedures shall have, prior to the procedure, a plan of care formulated and documented that includes an assessment of the patient relative to the acuity needs, plan for the operative or other invasive procedure, and a plan for the level of post-procedure care.

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When the history and physical examination are not recorded before an operation or invasive procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient and has documented a brief note which includes the pre-op diagnosis and planned procedure.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problems.

5. Operative/invasive procedure reports should be dictated or written in the medical record immediately after surgery and should contain a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the names of the primary surgeon and any assistants.

The completed operative/invasive procedure report should be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When there is a transcription and/or filing delay, a comprehensive operative progress note should be entered in the medical record immediately after surgery in order to provide pertinent information for use by any practitioner who is required to attend the patient.

6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the reason for the consult, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

7. Consultations shall be completed and recorded in the patient's record, preferably in 24 hours, but no later than within 36 hours of the request.

8. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

9. All clinical entries in the patient's medical record shall be accurately dated and authenticated.

10. Final diagnosis shall be recorded in full and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

11. A discharge summary shall be dictated or written on the day of discharge on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by a responsible practitioner. If the practitioner is not the attending physician, he/she must be authorized by the attending physician and must be knowledgeable about the patient’s condition.

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12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

13. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In care of readmission of a patient, all previous records shall be available for the use of the attending practitioner. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

14. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is retired incomplete in accordance with the Medical Records Department Policy and Procedure which addresses the issue.

16. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

17. Medical records of patient discharge shall be completed within 30 (thirty) days following discharge.

Section 4. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any specific treatment of surgical procedure must be obtained.

2. Medication or treatment shall be administered only upon written and signed orders of a physician, dentist, podiatrist, physician's assistant, nurse practitioner, nurse anesthetist, psychologist and midwife acting within the scope of his/her license, granted privileges and protocols, and qualified according to Medical Staff Bylaws. Telephone orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for such orders to be given in written manner by the responsible practitioner.

Telephone orders shall be taken only by a practitioner, professional nurse, physical therapist, respiratory therapist or a pharmacist who may transcribe oral orders pertaining to drugs, approved in accordance with hospital policy, who shall transcribe the orders in the proper place in the medical record of the patient. The order shall include the date, time and full signature of the person taking the order and shall be countersigned by a prescribing practitioner within 24 hours. If the practitioner
is not the attending physician, he/she must be authorized by the attending physician and must be knowledgeable about the patient’s condition.

Verbal orders for treatment and medication dictated by a practitioner authorized according to Medical Staff Bylaws to personnel qualified according to Medical Staff Bylaws and in the same room as the practitioner shall be accepted in accordance with Medical Staff rules. The person entering verbal orders into a medical record shall sign and date the entry. The practitioner shall authenticate the order within 24 hours. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

3. The practitioner’s orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat" and "continue orders" are not acceptable.

4. All previous orders are canceled when patients go to surgery.

5. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigation may be exceptions. These shall be used in full accordance with the statement of principles involved in the use of investigation drugs in hospitals and all regulations of the Federal Drug Administration.

Narcotics that are ordered without time limitation of dosage shall be automatically discontinued after 7 (seven) days. Orders for anticoagulant drugs will be reviewed for continuance after a period of three days. Orders for all other drugs will be reviewed for continuance after a period of 14 days.

The use of oxytoxics for induction or stimulation of labor requires the specific orders, including dosage and rate of administration, as well as the presence of a physician. All orders for oxytoxic drugs are automatically discontinued after 24 hours.

Drugs brought into the hospital by patients must be collected, stored and returned to the patient on discharge and on the advice of the attending physician.

6. Any qualified member of the active staff with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

7. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency.

8. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her supervisor who in turn may refer the matter to the director of nursing service. If warranted, the director of nursing may bring the matter to the attention of the chairperson of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chairperson of the department may himself request a consultation.

9. Compulsory consultations are not required for primary Cesarean Sections, but are required before any operations which would result in sterilization in either sex. Consultations with an active

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member of the obstetrical/gynecological staff is required before any D & E procedure is performed which may interfere with possible viable pregnancy where there have been conflicting reports on pregnancy tests. A D & E may be performed without consultation on an inevitable abortion when the patient is hemorrhaging or when products of conception have been passed and documented. No abortions or procedures for the purpose of sterilization are permitted.

10. Plans for the care of mass casualties and for the evacuation of patients and personnel from the hospital in case of fire or other emergency must be current and practiced at least twice yearly.

Section 5. MEDICAL STAFF MEETINGS

A meeting of the Medical Staff shall take place in December. Notice regarding time and place shall be mailed to each member of the staff at least one week in advance.

Section 6. GRIEVANCE PROCEDURE

1. If, in the opinion of any member of the Medical Staff, the Medical Staff Bylaws, his/her Departmental Rules & Regulations, and/or policies and procedures are not being appropriately followed, the Member may submit his/her complaint in writing to the Chairperson of his/her department. The written complaint shall specifically state the issue and the reasons why, in the member’s opinion, the Bylaws, Rules & Regulations, and/or policies and procedures are not being followed.

2. Within 10 working days of receiving such a letter, the Chairperson of the Department shall respond in writing to the Medical Staff Member regarding his/her decision.

3. If the Medical Staff Member is not satisfied with the response of the Department Chairperson, he/she may request in writing a review of the complaint and response by the President of the Medical Staff. Within 10 working days of receiving such a letter, the President of the Medical Staff shall review the complaint and responses and respond in writing to the Medical Staff Member regarding his/her decision.

4. If the Medical Staff Member isn’t satisfied with the response of the President of the Medical Staff, he/she may request in writing a review of the complaint and responses by the Medical Executive Committee. Within 30 working days of receiving such a letter, the Medical Executive Committee will review the responses and respond in writing to the Medical Staff Member regarding their decision. The Medical Staff Member may be invited to the Medical Executive Committee meeting to provide information regarding his/her complaint.

5. If the Medical Staff Member is not satisfied with the response of the Medical Executive Committee, he/she may request in writing a review of the complaint and responses by the Board of Directors. Within 30 working days of receiving such a letter, the Board of Directors shall respond in writing to the Medical Staff Member regarding their decision. The Medical Staff Member may be invited to the Board of Directors’ meeting to provide information regarding his/her complaint. The decision of the Board of Directors will be final.

6. Complaints filed and the responses to those complaints will be reviewed by the Medical Executive Committee and the Board of Directors for approval.

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Section 7. PEER REVIEW

1. Peers are defined as physicians and allied health professionals with similar specialties (i.e., Medicine, Surgery, Radiology, etc.)
2. Those circumstances requiring peer review are defined in each department’s Rules and Regulations.
3. Participants in the peer review process are appointed by the department chairperson. Provision is made for participation in the review process by the individual whose performance is being reviewed.
4. Department peer review activities are conducted on a regular basis as defined by the department.
5. For specific circumstances, peer review panels with appropriate specialty/subspecialty representation are appointed by department chairpersons.
6. External peer review with appropriate specialty/subspecialty representation is arranged by the Vice President of Medical Affairs:
   a) If a specialty/subspecialty peer is not available internally;
   b) If the only specialty/subspecialty peer available could be perceived to have a conflict of interest;
   c) At the request of the department chairperson.
7. Peer review is conducted within two months from the time the department chairperson becomes aware that a circumstance requiring peer review has occurred.
8. Opportunities for improvement identified through the peer review process result in:
   a) On the department level: sharing of aggregate data with members at the department meeting. When appropriate, speakers are invited to educate on issues identified through the peer review process.
   b) On the individual level: results of peer review activities are documented in the Physician Profile and are considered for the maintenance of privileges and for the recredentialing process. Corrective actions are in accordance with the Medical Staff Bylaws.
9. Peer review files can only be accessed by persons involved in the decision process for credentialing and recredentialing as defined in the Medical Staff Bylaws. Physicians can access their own files through their department chairman.

Section 8. PHYSICIAN CONTRACTS

1. Medical Staff may authorize the MEC to engage an attorney to advise physician leaders, managers and clinical on-call service providers in their negotiation with the Administration to achieve fair and timely contracts.