MS Bylaws - Section 01 - Medical Staff Purpose and Authority CH

MS Bylaws - Section 02 - Medical Staff Membership CH

MS Bylaws - Section 03 - Categories of the Medical Staff CH

MS Bylaws - Section 04 - Officers and At-Large Members of the Medical Staff CH

MS Bylaws - Section 05 - Medical Staff Organization CH

MS Bylaws - Section 06 - Committees CH

MS Bylaws - Section 07 - Medical Staff Meetings CH

MS Bylaws - Section 08 - Conflict Resolution CH

MS Bylaws - Section 09 - Review, Revision, Adoption and Amendment to Bylaws, Rules and Regulations CH

MS Bylaws - Section 10 - Informal, Educational, and/or Informal Proceedings CH

MS Bylaws - Section 11 - Corrective Action CH

MS Bylaws - Section 12 - Automatic Suspension and Revocation CH

MS Bylaws - Section 13 - Summary Suspension CH

MS Bylaws - Section 14 - Fair Hearing Plan CH

MS Bylaws - Section 14 - Fair Hearing Plan CH

MS Bylaws - Section 15 - Reinstatement CH

MS Bylaws - Section 16 - Medical Staff Credentials Committee CH

MS Bylaws - Section 17 - Qualifications for Credentialing and Privileging CH

MS Bylaws - Section 18 - Initial Appointment Procedure CH

MS Bylaws - Section 19 - Reappointment Procedure CH

MS Bylaws - Section 20 - Clinical Privileges CH

MS Bylaws - Section 21 - Clinical Competency Evaluation CH

MS Bylaws - Section 21 - Clinical Competency Evaluation CH

MS Bylaws - Section 22 - Medical Administrative Officers CH

MS Bylaws - Section 23 - Leave of Absence CH
SECTION 1. MEDICAL STAFF PURPOSE AND AUTHORITY

1.1 PURPOSE

The purpose of these Bylaws is to organize the activities of physicians and other clinical practitioners who practice on the Medical Staffs of Chambersburg and Waynesboro Hospitals. Both Medical Staffs will utilize these Bylaws to coordinate their activities wherever possible for the benefit of their respective Hospitals and the Summit Health hospital system. Each Medical Staff will carry out, in conformity with these Bylaws and applicable Pennsylvania and federal health facility regulations, the functions delegated to the Medical Staff by the respective board of directors of Chambersburg and Waynesboro Hospitals, and will cooperate together wherever possible and as legally permitted, to improve the quality and efficiency of patient care across the entire hospital system. Recognizing that the role of cooperative medical staffs is evolving, as hospital systems continue to merge and consolidate, this medical staff model may be modified from time to time to address new or changing operational and legal requirements.

Specifically, the intent of these Bylaws is to maximize and facilitate the opportunities for Medical Staff cooperation; to implement “best” practices across member Hospitals; to more efficiently share knowledge and innovations among Medical Staff members; to facilitate the adoption of system-wide accountable care organizations and other modern patient care delivery systems; to more efficiently coordinate and utilize hospital system resources; and to otherwise improve the quality of the care for all hospital system patients.

While this cooperative medical staff model will be undertaken under the direction of Summit Health pursuant to Summit Health’s legal authority to direct the corporate affairs of its wholly-owned hospital subsidiaries, this process is not intended to contradict or exceed any Pennsylvania or federal requirements pertaining to the legal responsibilities of each entity’s governing body, or the separate licensing requirements of each participating Hospital. In certain medical staff matters that materially impact the hospital system as a whole, or where inconsistency or disagreement exists between the member Hospitals, Summit Health’s Board of Directors may direct or approve the actions taken by each Hospital Board. However, nothing in these Bylaws is intended to replace the legal responsibility of each entity’s governing body to approve, adopt or ratify corporate or organizational decisions, including medical staff decisions, to the extent required by law. Accordingly, these Bylaws shall be interpreted and applied strictly in accordance with applicable federal and Pennsylvania legal/regulatory requirements.

1.2 AUTHORITY
Subject to the authority and approval of the Chambersburg and Waynesboro Hospital boards, and subject to final review and approval by the Summit Health Board as the governing body of the sole member of each of Hospital, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies. Henceforth, unless the context or applicable law requires otherwise, the term “Hospital” refers to both Chambersburg Hospital and Waynesboro Hospital, each utilizing these Bylaws for its own Medical Staff. Whenever the term “Medical Staff” is used, it shall mean the Medical Staff of Chambersburg Hospital and Waynesboro Hospital respectively, whether individually or cooperating jointly as part of the Summit Health hospital system; and whenever the term “the Summit Board” is used, it shall mean the Summit Health Board of Directors, with final review and approval authority over all medical staff-related and other actions taken by its member Hospitals. Whenever the term “President of the Hospital” is used, it shall mean the President or Chief Executive Officer of Summit Health acting in the capacity of President of each Hospital. The term President includes a duly appointed acting officer or administrator serving when the President is unavailable, as authorized by the corporate bylaws of the Hospitals and Summit Health.
SECTION 2. MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated rules, regulations, policies and procedures of the Medical Staff and the Hospital.

2.2 QUALIFICATIONS FOR MEMBERSHIP

Part III of these Bylaws (Credentials Procedures Manual) delineates the qualifications for Medical Staff membership. Qualified applicants for appointment and reappointment to the Medical Staff shall be considered for and granted privileges in accordance with these Bylaws only to the Hospital or Hospitals to which the applicant applies in writing in accordance with Medical Staff procedures in Part III of these Bylaws.

2.3 NONDISCRIMINATION

The Hospital will not discriminate in granting staff appointment and/or clinical privileges based on national origin, race, gender, religion, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law.

2.4 CONDITIONS AND DURATION OF APPOINTMENT

The respective Hospital Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) of Chambersburg Hospital and/or Waynesboro Hospital, as applicable, in accordance with the processes outlined in Part III of these Bylaws, except for emergency and disaster privileges. Henceforth, unless the context requires otherwise, whenever the term “MEC” is used, it shall mean the MEC of Chambersburg Hospital and the MEC of Waynesboro Hospital cooperating jointly with respect to those clinical matters or other areas of MEC responsibility where legally permitted to do so. Nevertheless, while the MEC may meet as a whole on these matters where cooperation is legally permitted or necessary, each Hospital shall maintain a separate MEC responsible for making recommendations to the respective Hospital Board concerning those practitioners with privileges at each Hospital, or any other Hospital-specific medical staff matters, consistent with Section 6.2. Appointment and reappointment to the Medical Staff shall be for no more than two (2) years.

2.5 MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

The Medical Staff will process requests for Medical Staff membership and/or clinical privileges on a Hospital-by-Hospital basis only when the potential applicant meets the current qualifying criteria.
approved by the respective Hospital. The respective Hospital Board will grant and authorize membership and/or privileges as delineated in Part III (Credentials Procedures Manual) of these Bylaws. In the event that the Hospital Board reaches inconsistent or contradictory decisions on any matter pertaining to the governing criteria for Medical Staff membership or clinical privileges, including failure to reach consensus or to resolve differences pursuant to Section 2.9.1, such matter shall be referred to the Summit Board for resolution and further direction to each Hospital as applicable consistent with these Bylaws.

2.6 MEDICAL STAFF MEMBERS RESPONSIBILITIES

2.6.1 Each Medical Staff member must provide for appropriate, timely and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances, and as consistent with his/her clinical privileges.

2.6.2 Each Medical Staff member and practitioner must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Each Medical Staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department of the Hospital in which the Medical Staff member has clinical privileges or in other Hospital coverage programs as determined by the applicable MEC and the respective Hospital Board, and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, as necessary to meet the patient care needs of the Hospital and community.

2.6.4 Each Medical Staff member and other practitioner must submit to any pertinent type of health evaluation as requested by the officers of the Medical Staff, President of the Hospital and/or applicable Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the applicable MEC or Credentials Committee as part of an evaluation of the member’s or practitioner’s ability to provide medical care safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician health or impairment.

2.6.5 Each Medical Staff member and practitioner must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures and standards of the Medical Staff and Hospital.

2.6.6 Each Medical Staff member and practitioner must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or other amount established by the Hospital or applicable law, whichever is higher. In addition, members and practitioners shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each member and practitioner shall promptly notify the President of the Hospital or designee immediately of any malpractice claims filed in any court of law against the individual.

2.6.7 Each applicant, Medical Staff member and practitioner agrees to release from any liability, to the fullest extent permitted by law, all persons or entities for all activities or conduct, undertaken without malice, in connection with investigating and/or evaluating, or regarding any other actions or statements concerning, the quality of care or professional conduct provided by the individual and his/her qualifications, privileges or credentials.
2.6.8 Per Medical Staff and Hospital policies, each Medical Staff member and practitioner shall prepare and complete in timely fashion, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, clinical services or departments.

A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. A physician, oral and maxillofacial surgeon, dentist, or other qualified licensed individual must complete and document the medical history and physical examination in accordance with state law and Hospital policy.

An updated examination of the patient, including any changes in the patient’s condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. A physician, oral and maxillofacial surgeon, dentist, or other qualified licensed individual must complete and document an updated examination of the patient, including any changes in the patient’s condition, in accordance with state law and Hospital policy.

The rules and regulations delineate the content of complete and focused history and physical examinations.

2.6.9 Each Medical Staff member and practitioner will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information includes patient information, peer review information, employment information, the Hospital’s business information and any other non-public information.

2.6.10 Each Medical Staff member and practitioner must participate in any type of competency evaluation when determined necessary by the MEC, with approval of the respective Hospital Board, to properly assess the individual’s qualifications or privileges, as applicable.

2.6.11 Each Medical Staff member shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital when serving as officers or department chairs or on Medical Staff committees, or in conducting other Medical Staff activities. Medical Staff leadership will address and resolve conflict of interest issues per the Medical Staff Conflict of Interest Policy.

2.7 MEDICAL STAFF MEMBER RIGHTS

2.7.1 Each Medical Staff member in the Active category has the right to a meeting with the respective MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her department chair or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the President of the Medical Staff at least two (2) weeks in advance of a regular MEC meeting, meet with the MEC to discuss the issue.
2.7.2 Each Medical Staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these Bylaws, regarding an officer’s removal or resignation from office.

2.7.3 Each Medical Staff member in the Active category may initiate a call for a meeting of the Medical Staff to discuss a matter relevant to the Medical Staff (whether relevant to one or both Hospitals) by presenting a petition signed by five percent (5%) of the members of the Active category at the respective Hospital or Hospitals. Upon presentation of such a petition to the MEC of the respective Hospital, the MEC shall schedule a Medical Staff meeting for the specific purposes addressed by the petitioners. They will not transact any other business than that detailed in the petition, unless the petitioners agree to include the matter for discussion/action at the next regularly scheduled Medical Staff meeting.

2.7.4 Each Medical Staff member in the Active category may challenge, or propose changes to, any rule, regulation or policy established by the MEC or Medical Staff. If a Medical Staff member believes that a rule, regulation or policy is inappropriate, any Medical Staff member may submit a petition to the MEC of the respective Hospital, signed by five percent (5%) of the members of the Active category of the Hospital. Upon presentation of such a petition, the members will follow the adoption procedure outlined in Section 9.3.

2.7.5 Each Medical Staff member in the Active category may call for a department meeting by presenting a petition signed by five percent (5%) of the members of the department. Upon presentation of such a petition, the department chair will schedule a department meeting for this purpose, unless the petitioners agree to include the matter for discussion at the next regularly scheduled meeting.

2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges or any other matter relating to Medical Staff membership or privileges. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any practitioner eligible for Medical Staff appointment and clinical privileges has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff’s Hearing and Appeal Plan (as contained in Part II of these Bylaws).

2.8 STAFF DUES

The MEC of each Hospital shall determine the annual dues for Medical Staff members and shall allocate dues in accordance with program needs and applicable legal requirements. The Medical Staff shall consider as a practitioner’s voluntary resignation from the Medical Staff, his/her failure to pay dues pursuant to Section 12.1.8. The MEC may pass policies from time to time that exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 GENERAL MEDICAL STAFF CONSIDERATIONS

2.9.1 Special Definitions

For the purposes of this Section 2.9, the following definitions shall apply:
The term “Information” means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, dates and other disclosures, whether in written, electronic or oral form, relating to any of the subject matters specified in this Section.

The term “Malice” means the deliberate dissemination of known false information with intent to harm.

The term “Medical Staff Inter-Hospital Committee” or “Inter-Hospital Committee” means the committee comprised of representatives of both Hospital boards that serves as a forum for the discussion and resolution of Medical Staff-related matters when the Hospital boards reach inconsistent decisions, require joint consultation or otherwise are unable to resolve conflicts between the boards with respect to Medical Staff appointments, bylaws, or other matters requiring cooperation or approval by both Hospital boards. When circumstances require joint medical staff determinations or decisions, or the Hospital Boards have reached inconsistent or contradictory decisions, the Hospital Boards shall appoint two (2) or more members of each board (excepting ex-officio members) to serve on the Inter-Hospital Committee as representatives of the respective Hospitals, with authority to consider, and make recommendations to the Summit Board. The Committee appointees must be disinterested parties in any medical staff decision, as defined under these Bylaws. Except as explicitly provided in these Bylaws to the contrary, any action of the Inter-Hospital Committee requires an affirmative vote of at least three members of the Inter-Hospital Committee. All Inter-Hospital Committee medical staff recommendations must be approved by the Summit Board, and thereafter adopted or ratified by the respective Hospital boards, to constitute legally binding actions of the Hospitals. The Inter-Hospital Committee appointees shall not have the authority to make medical staff decisions on behalf of the Hospitals or hospital system without such approvals, and shall be subject to these Bylaws and applicable legal requirements.

The term “Practitioner” means a Medical Staff member, an applicant for Medical Staff appointment or reappointment, or, as and applicable, an allied health professional.

The term “Representative” means a Hospital board member, Summit Board member, or any member of the committee thereof, the Hospital President and any officer, vice president or authorized administrator, the Medical Staff and any member, officer, department or committee thereof, and any individual or entity (including affiliates or third parties) authorized by any of the foregoing to perform specific Medical Staff functions, including peer review evaluation, administration and any information gathering, organizing and disseminating functions.

The term “Third Parties” means both individuals, entities and other organizations performing any functions for, or providing information to, any representative, as defined above.

2.9.2 Authorizations and Conditions

By applying for, or exercising, clinical privileges within the Hospital, a Practitioner:

Authorizes Representatives of the Hospital to solicit, provide and act upon Information bearing upon his/her professional ability, conduct and qualifications;

Agrees to be bound by the provisions of the Medical Staff Bylaws and to waive all legal claims against any Representative who acts in accordance with the provisions of the Medical Staff Bylaws, rules, regulations or policies;
Acknowledges that the provisions of this Section are express conditions to the Practitioner’s application for, or acceptance of, Medical Staff membership, or his/her exercise of clinical privileges at one or both Hospitals; and,

Acknowledges that this Section shall serve as a general release of liability and a waiver of legal rights as to the activities and individuals covered thereby, and that this release and waiver is a binding condition without which the Hospital Board would not consider or grant Medical Staff membership or clinical privileges.

The Practitioner’s authorizations and release of liability extends to all Information and activities shared by and between the Hospitals and throughout the hospital system regardless of whether the Practitioner’s privileges are limited to only one Hospital.

2.9.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any Representative of this or any other healthcare facility or organization or medical staff for achieving and maintaining quality patient care, shall, to the fullest extent permitted or required by law, be confidential and shall not be disseminated to anyone other than a Medical Staff Representative, or used in any way except as set forth herein, provided however that inadvertent disclosure shall not waive confidentiality. Such confidentiality shall also extend to Information that may be provided by or to Third Parties. This information shall not become part of any patient’s file or of the general Hospital records, except as normally included or required for operational or legal purposes.

This information may be released to the Hospitals or Third Parties/facilities where the Practitioner holds privileges, or is an applicant for Medical Staff membership or privileges, subject to Section 2.9.7.

2.9.4 Immunity from Liability

2.9.4.1 For Action Taken

To the fullest extent permitted by law, no Representative or Medical Staff member shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative, if such representative acts without Malice.

2.9.4.2 For Providing Information

To the fullest extent permitted by law, no Representative or Medical Staff member, and no Third Party, shall be liable in any judicial proceeding for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, to a Representative or Medical Staff member, or to any other hospital, organization of healthcare professionals, or other health-related or educational institution or organization concerning a Practitioner who is or has been an applicant to, or member of, the Medical Staff or who did or does exercise clinical privileges at the Hospital, provided that such Representative or Third Party acts without malice.

2.9.5 Activities and Information Covered
The confidentiality and immunity provided by this Section shall cover, to the fullest extent permitted by law, all communications, reports and records which may be disclosed in the furtherance of credentialing/peer review, quality improvement and related activities, and only in accordance with these Bylaws and applicable legal requirements. Confidentiality extends to: 1) the records and minutes of all Medical Staff committees, 2) the records of all Medical Staff credentialing/peer review files concerning individual practitioners and 3) the discussions and deliberations which take place pursuant to the credentialing/peer review process or any related Medical Staff activities including but not limited to:

Applications for appointment and clinical privileges;
Periodic reappraisals for reappointment and clinical privileges;
Corrective action;
Hearings and appellate reviews;
Patient care or safety reports, reviews, evaluations or audits;
Utilization reviews; and,

Other hospital, department, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

2.9.6 Information

The communications, reports, records, recommendations, disclosures and other Information referred to in this Section 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 safety, or the efficient functioning of an institution or organization.

2.9.7 Releases

Each Practitioner shall execute, upon request of the Hospital, general and specific authorizations and releases in accordance with Medical Staff or Hospital policy, as consistent with these Bylaws. Practitioners holding privileges at both Hospitals shall authorize the exchange of Information between the Hospitals relating in any way to the credentialing/peer review activities at either Hospital for purposes of corrective action, fair hearings and/or the granting or termination of clinical privileges by the Hospital(s), subject to review and approval by the respective Hospital Board, consistent with these Bylaws. The execution of such releases shall not be deemed a prerequisite to the effectiveness of this Section or any provisions of the Medical Staff Bylaws.

2.9.8 Cumulative Effect

Provisions in these Bylaws and in application or release forms relating to authorizations, confidentiality of Information and immunities from liability, shall be in addition to other protections provided by law and not in limitation thereof.
SECTION 3. CATEGORIES OF THE MEDICAL STAFF

3.1 THE ACTIVE CATEGORY

3.1.1 Qualifications

Initial Appointment - Members of this category must have served on the Medical Staff for at least six (6) months and be involved in either:

Reappointment – Members of this category must have served on the Medical Staff for at least two (2) years and be involved in either:

a. Twelve (12) or more patient contacts every year (i.e., a patient contact is defined as an inpatient admission or outpatient observation, preoperative history and physical examinations, consultation, an inpatient or outpatient surgical procedure or shifts of work for those providing hospital-based services at the hospital, or,

b. Twelve (12) or more Medical Staff or Hospital meetings during the medical staff year.

If a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all Bylaws, rules, regulations and policies of the Medical Staff and Hospital, the member may be appointed to another Medical Staff category if he/she meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category must:

a. Attend Medical Staff, department, section, and committee meetings of which he/she is a member and any Medical Staff or Hospital education programs;

b. Vote on all matters presented by the Medical Staff department, section, and committee(s) to which the member is assigned; and

c. Hold office and sit on, or be the chair of, any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws, rules, regulations or policies.

d. Satisfactorily complete his or her monitoring requirements and

e. Be a member in good standing of the Associate staff for at least six (6) months. However, practitioners may remain on the Associate staff when the Board imposes a monitoring period for change in appointment status or privileges.

3.1.3 Responsibilities
Members of this category shall:

Contribute to the organizational and administrative affairs of the Medical Staff;

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

Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

3.2 THE ASSOCIATE CATEGORY

3.2.1 Qualifications

The Medical Staff reserves the Associate category for Medical Staff members who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives

Members of this category may:

Attend Medical Staff, department and division meetings of which he/she is a member, and any Medical Staff or Hospital education programs;

Not vote on matters presented by the entire Medical Staff or department or be an officer of the Medical Staff; and,

Serve on Medical Staff committees, other than the MEC, and may vote on recommendations or matters that come before such committees.

3.2.3 Responsibilities

Except as otherwise specified herein, members of this category shall have the same Medical Staff responsibilities as Active category members.

3.3 HONORARY RECOGNITION

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the respective Hospital Board. This recognition is entirely discretionary and may be rescinded at any time. Those honored with Honorary Recognition shall consist of those members who have retired from active Hospital practice, who are of outstanding reputation, and have provided distinguished service to the Hospital. They may attend Medical Staff, department and division meetings, continuing medical education activities, and the Medical Staff President may appoint them to committees. They shall not hold clinical privileges, hold office or be eligible to vote at the department or general Medical Staff level.

3.4 SENIOR CATEGORY

Any practitioner who is sixty-five (65) years of age or older or who has been on the staff for twenty-five (25) years may request placement on the Senior Staff. Practitioners in this category shall retain all the
prerogatives, and be subject to all the rules covering the Medical Staff, except they may elect to be excused from participation on any staff committees, other Medical Staff service (including unassigned emergency department call) and payment of dues; provided, however, such practitioners would be required to participate in quality assessment and improvement activities commensurate with the clinical privileges. The Medical Staff honors physicians who have served on the Medical Staff for twenty-five (25) years by inducting them into the Quarter Century Club.
SECTION 4. OFFICERS AND AT-LARGE MEMBERS OF THE MEDICAL STAFF

The Active category of Medical Staff of the Hospital shall elect the following officers, consistent with the requirements of Section 6.2, who shall serve as Medical Staff officers on behalf of the Hospital. To qualify for nomination for such offices, a candidate must be a member of the Active Category of Medical Staff of the Hospital. To be elected, each candidate for office must receive a majority of the affirmative votes cast by the Active category of Medical Staff of the Hospital. OFFICERS OF THE MEDICAL STAFF:

4.1.1 President of the Medical Staff

4.1.2 Vice President of the Medical Staff

4.1.3 Secretary/Treasurer

4.1.4 Two (2) At-Large Members, selected in accordance with Section 4.2.

4.2 QUALIFICATIONS OF OFFICERS AND AT-LARGE MEMBERS

4.2.1 Officers and At-Large Members concurrently must be members in good standing of the Active category of the Hospital and be actively involved in patient care, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership education and/or be willing to participate in such education during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the Hospital, and have excellent administrative and communication skills. (Medical Staff members in good standing at the Hospital are encouraged to apply for privileges at both Hospitals and otherwise take a leadership role in improving the quality and efficiency of patient care throughout the hospital system). Qualifications for the positions of President of the Medical Staff also include the degree of MD, DO, DDS, DMD or DPM. The Medical Staff Nominating Committee (as described in Section 4.3 below), subject to approval by the respective MECs, will have discretion to determine if an Active category member wishing to run for office meets the qualifying criteria, as well as all other applicable requirements of these Bylaws (e.g. Section 6.2.2).

4.2.2 Officers and At-Large Members may not simultaneously hold a leadership position (by serving on the MEC or board) on another hospital’s medical staff or in a healthcare facility or entity not affiliated with the Hospitals or hospital system. Noncompliance with this requirement will result in removal of the officer from office in accordance with Section 4.7.2.

4.3 ELECTION OF OFFICERS
4.3.1 Whenever possible, the Nominating Committee of each Hospital shall meet together as a joint Nominating Committee and shall offer at least two (2) nominees for each available position, if qualified and willing to serve and subject to MEC approval and elections in accordance with these Bylaws. The Medical Staff must announce all nominations, and the names of the nominees distributed to all members of the Active medical staff, at least thirty (30) days prior to the election, which is prior to their taking office in July.

4.3.2 A petition signed by at least five percent (5%) of the members of the Active staff of Chambersburg Hospital or at least five percent (5%) of all members of the Active category of the Medical Staff of Waynesboro Hospital respectively, may add nominations to the ballot. The Medical Staff must submit such a petition to the President of the Medical Staff at least twenty-one (21) days prior to the election of the Medical Staff to place the nominee(s) on the ballot. The Nominating Committee must determine if the candidate meets the qualifications in Section 4.2 above, subject to MEC approval, before the Medical Staff can place him/her on the ballot.

4.3.3 The Medical Staff shall elect officers prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote. The joint MECs, acting together for each Hospital pursuant to Section 6.2, shall determine the mechanisms by which Active members may cast votes. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member’s voting choices. No proxy voting will be permissible. Each Medical Staff will elect the nominee(s) who receive a majority vote of the Active category members of the Hospital. In the event of no candidates achieving a majority vote of the Active category of the Hospital, the MEC will arrange for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a majority of votes.

4.4 ELECTION OF AT-LARGE MEMBERS

4.4.1 The nominating committee shall offer nominations to fill two (2) At-Large positions for the MEC of each Hospital. The Medical Staff shall elect At-Large Members prior to the expiration of the term of the current At-Large Members.

4.4.2 The active Medical Staff will vote for At-Large members during the Medical Staff meeting following the annual meeting that elects the Officers consistent with the requirements of this Section 4 and these Bylaws. The two-year term of the At-Large members will run from September to August.

4.5 TERM OF OFFICE

All officers and At-Large Members serve a term of two (2) years. They shall take office in the month of July. The Medical Staff may re-elect an individual for two successive terms, and may run for the same position after an absence of two years (2). Each officer shall serve in office until the end of his/her term of office, until a successor is appointed/elected, or unless s/he resigns sooner or the Medical Staff removes him/her from office.

4.6 VACANCIES OF OFFICE
The MEC shall fill vacancies of office that occur during the term, excepting the office of the President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term.

4.7 DUTIES OF OFFICERS

4.7.1 President of the Medical Staff: the president of the Medical Staff shall represent the interests of the Medical Staff before MEC and the respective Hospital Board. The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff’s advocate and representative in its relationship to, and regular consultation with, the Hospital Boards and the Summit Board and the administration of the hospital system, consistent with the corporate bylaws of each entity. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services of the hospital system and each Hospital, and all other functions of the Medical Staff as outlined in the Medical Staff Bylaws, rules, regulations and policies. Specific responsibilities and authority allow the Medical Staff President to:

Call and preside at all general and special meetings of the Medical Staff;

Serve as chair of MEC and as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the President of the Hospital, or as required by the corporate bylaws, to serve as ex officio director on the board of the Hospital Board, Summit Board, or on board committees as applicable;

Enforce Medical Staff Bylaws, rules, regulations and Medical Staff/Hospital policies;

Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with Hospital administration, recommend Medical Staff members to appropriate Hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; in consultation with the chairs of the Hospital Boards and chair of the Summit Board, appoint the Medical Staff members to appropriate board committees when those are not designated by position or by specific direction or the respective Hospital Board or the Summit Board or the Hospital’s or Summit’s corporate bylaws, or otherwise prohibited by state law;

Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

Report to the respective Hospital Board and the Summit Board, as applicable, regarding the MECs’ recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital;

Continuously evaluate and periodically report to the Hospital, MEC, the Hospital Boards and the Summit Board regarding the effectiveness of the credentialing and privileging processes;

Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Hospital Board, the Summit
Board, Hospital management, other professional and support staff, and the community the Hospital serves;

Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, the respective Hospital Board, and the Summit Board;

Attend Hospital Board and Summit Board meetings and board committee meetings as invited by the respective Hospital Board or the Summit Board, or as required by the Hospital’s corporate bylaws;

Ensure that the decisions of the Hospital Board, and Summit Board as applicable, are communicated and carried out within the Medical Staff; and,

Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

4.7.2 Vice President of the Medical Staff: In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. He/she shall serve as a member of the Credentials Committee and perform such further duties to assist the President of the Medical Staff as the President may request from time to time.

4.7.3 Secretary/Treasurer: This officer will collaborate with the Medical Staff and Hospital leadership, assure maintenance of meeting minutes and records of both Hospitals, attend to official notices and correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. He/she shall perform such further duties to assist the President of the Medical Staff as the President may request from time to time.

4.7.4 At-Large Members: These two (2) At-Large Members, each elected by a majority of the affirmative votes cast by the Active category of Medical Staff of Chambersburg Hospital and a majority of the affirmative votes cast by the Active category of the Medical Staff of Waynesboro Hospital, will advise and support the Medical Staff officers and are responsible for representing the needs/interests of the Medical Staff before the MEC, not simply representing the preferences of their own clinical specialty.

4.8 REMOVAL AND RESIGNATION FROM OFFICE

4.8.1 Removal by vote: The Hospital Board, subject to provision of notice to the Summit Board, may remove a Medical Staff officer or At-Large Member for failure to perform their duties or a violation of the Medical Staff Bylaws or rules, regulations or policies. In the event that the Hospital Boards reach inconsistent or contradictory conclusions regarding any such removal, such matter shall be referred to the Inter-Hospital Committee for consideration. The determination of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1. Further, a petition of five percent (5%) of the members of the Active category of the Medical Staff of either Hospital may initiate a process to call a meeting to vote for removal. In such a case, the Medical Staff will accomplish removal by a two-thirds (2/3rds) vote of all Active category members of the Medical Staff of both Hospitals, subject to Hospital Board approval.
4.8.2 Mandatory removal: The Hospital Board, subject to provision of notice to the Summit Board, shall vote to remove any officer or At-Large Member for failure to meet the qualifications for office. In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding any officer removal, such matter shall be referred to the Inter-Hospital Committee for consideration. The determination of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1. If an investigation is warranted, such investigation shall be conducted by the MEC, and the recommendations of the MEC shall be submitted to the respective Hospital Board.

4.8.3 Resignation: Any elected officer or At-Large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or when the Medical Staff elects a successor, or any time specified by the MEC or Medical Staff President as warranted by the circumstances.
SECTION 5. MEDICAL STAFF ORGANIZATION

5.1 ORGANIZATION OF THE MEDICAL STAFF

5.1.1 Subject to, and consistent with, these Bylaws, each Medical Staff shall organize into departments. Each department shall address applicable clinical practices for the respective Hospital, where circumstances require Hospital-specific departmental decisions, or shall collaborate jointly whenever possible, subject to Hospital Board review or approval as necessary. Further, any department may create divisions within the department in order to facilitate Hospital-specific Medical Staff activities, consistent with Section 5.1.2. The Rules and Regulations contain a list of departments organized by the Medical Staff and formally recognized by each MEC.

5.1.2 The MECs, acting separately or jointly, with Hospital Board approval, may designate new Medical Staff departments or clinical sections or dissolve current departments or clinical sections as it determines will best promote Medical Staff needs or interests, including promoting performance improvement, patient safety, and effective credentialing and privileging. In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding establishment or dissolution of departments or clinical sections, such matter shall be referred to the Inter-Hospital Committee for consideration. The recommendations of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1.

5.2 QUALIFICATIONS, SELECTION, TERM, AND REMOVAL OF DEPARTMENT CHAIR

5.2.1 Each Hospital department chair shall serve a term of two (2) years commencing on July 1, and the Medical Staff may elect the chair to serve up to three successive terms. Further successive terms will require an exemption by the MEC and the Hospital Board. Absent exception granted by the respective Hospital Board, all chairs must be members of the Active category of the Medical Staff at both Hospitals, be in good standing, have unrestricted clinical privileges and an appropriate specialty board certification, or have affirmatively established comparable competence through the credentialing process.

5.2.2 The Medical Staff shall elect department chairs by majority vote of the Active category members of the department of each Hospital by confidential ballot. If the post of chair of a department is vacant, the vice chair will assume the position through the remainder of the term. The MEC and respective Hospital Board must approve each department chair elected by the Active category department members, before he/she may assume the position. Once approved, the department chair will be deemed to serve as chair of each Hospital department respectively, unless removed pursuant to Section 5.2.4 below.

5.2.3 The department chair appoints the department vice chair who serves at the department chair’s discretion. The MEC and respective Hospital Board must approve each department vice chair appointed by the respective department chairs, before he/she may assume the position on behalf of each Hospital.

5.2.4 Removal and Resignation from department leadership positions
Removal of department chair by vote: The Hospital Boards, or either of them, may remove a department chair for failure to perform his/her duties or a violation of the Medical Staff Bylaws, or rules, regulations or policies. In addition, a petition of twenty percent (20%) of the Active category Medical Staff in the Hospital department may call a meeting to vote for removal. A vote of two-thirds (2/3rds) of the Active category members of the department at each Hospital shall be necessary for accomplishing removal.

Removal of department vice chair: The department chair may remove a department vice chair at any time, except whenever the process for removal of the department chair has been initiated or is ongoing.

Mandatory removal of department chair or vice chair: The MEC shall remove a department chair or vice chair for failure to meet the qualifications for office, subject to approval of the respective Hospital Board.

5.2.5 In the absence of both the chair and the vice chair of a department, the Medical Staff President shall appoint an interim chair until a new election for the department chair occurs, as scheduled by the MEC and conducted in accordance with Section 5.2.2.

5.2.6 In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding any exemptions to term limits for department chairs, approval of an election of any department chair, appointment of a vice chair, or removal of a department chair, or any matter arising under Section 5.2, such matter shall be referred to the Inter-Hospital Committee for consideration. The determination of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1.

5.3 THE RESPONSIBILITIES OF DEPARTMENT CHAIRS ARE:

To oversee all clinically-related activities of the department;

To oversee all administratively-related activities of the department, unless otherwise provided by the Hospital;

To provide ongoing surveillance of the performance of all individuals in the Medical Staff department who have been granted clinical privileges;

To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff department;

To recommend clinical privileges for each member of the department and other licensed independent practitioners practicing with privileges within the scope of the department;

To assess and recommend to the MEC and Hospital administration off-site sources for needed patient care services not provided by the Medical Staff department or the Hospital;

To integrate the department into the primary functions of the Hospital;

To coordinate and integrate interdepartmental and intradepartmental services and communication;

To develop and implement Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to
reflect required changes consistent with current practice, problem resolution, and standards changes, and unique circumstances and differences in patient populations and services offered at each Hospital;

To recommend to the Hospital sufficient numbers of qualified and competent persons to provide patient care and service;

To provide input to the Hospital regarding the qualifications and competence of department or service personnel who are not licensed independent practitioners (LIPs) but provide patient care, treatment and services;

To continually assess and improve of the quality of care, treatment and services;

To maintain quality control programs as appropriate;

To orient and continuously educate all persons in the department; and,

To make recommendations to each MEC and Hospital administration for space and other resources needed by the Medical Staff to provide patient care services.

5.4 ASSIGNMENT TO DEPARTMENT

The MEC will recommend department assignments for all members in accordance with their qualifications, and after consideration of the recommendations of the chair of the appropriate department. The MEC will assign each member to one primary department. Clinical privileges are independent of department assignments.

5.5 TELEMEDICINE PRIVILEGES

Requests for telemedicine privileges at the Hospital that includes patient care, treatment, and services will be processed by using credentialing information from the distant site if the distant site is a Joint Commission accredited telemedicine entity.

5.6 DISASTER PRIVILEGES

5.6.1 If the institution’s Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the President of the Hospital and other individuals as identified in the institution’s Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present 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:

a. A current picture hospital ID card that clearly identifies professional designation;

b. A current license to practice;

c. Primary source verification of the license;
d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

f. Identification by a current Hospital or Medical Staff Member who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

5.6.2 The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

5.6.3 The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.6.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

5.6.5 Once the immediate situation has passed and such determination has been made consistent with the institution’s Disaster Plan, the practitioner’s disaster privileges will terminate immediately.

5.6.6 Any individual identified in the institution’s Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to a right to a fair hearing or an appeal.
SECTION 6. COMMITTEES

6.1 DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee (MEC) of Chambersburg Hospital and an MEC of Waynesboro Hospital, as provided in Section 2.4 hereof, and such other standing and ad hoc committees as established by the MECs, acting cooperatively together, consistent with the Medical Staff Bylaws, rules and regulations. Meetings of these committees will be either regular or special. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

6.2.1 Composition: The MEC of each Hospital shall meet as a standing committee consisting of the following voting members: the department chairs and the officers of the Medical Staff, as well as the alternative members with the stated preference that such individuals be Active category members of both Medical Staffs, provided however that MEC representation for Waynesboro Hospital should include, to the extent possible, practitioners who allocate most of their clinical activities to that Hospital, subject to the eligibility requirements of Section 4.2.1. Further, the President of the Medical Staff shall serve as the chair of the MEC. In addition, ex-officio non-voting MEC members are the Hospital President, Vice President Medical Affairs, Chief Nursing Officer, and Vice President for Administration, Director of Provider Resources, and the Advanced Practice Professional (APP) chair of the APP Committee. The MECs shall meet separately as committees of each Hospital Medical Staff respectively. In addition, the MECs shall collaborate together and meet jointly wherever possible to discuss or resolve system-wide issues, provided however that each MEC separately meet and deliberate upon the Hospital-specific impact of these issues or recommendations, as well as to address any other Hospital issues or business. Each Hospital MEC shall maintain separate minutes that clearly delineate the deliberations, decisions and recommendations pertaining to each Hospital, as endorsed, voted upon and approved by a majority of the MEC members of each Hospital.

Removal from MEC: An officer or department chair who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC. When the officer, or a department chair resigns, or is removed from these positions, his/her replacement will serve on the MEC.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

Serve as the decision-making body of each Medical Staff, subject to review and approval of the respective Hospital Board, in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions. In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding
approval of any MEC action or decision, such matters shall be referred to the Inter-Hospital Committee for consideration, subject to final review and approval by the Summit Board pursuant to Section 2.9.1.

Coordinate the implementation of policies adopted by the respective Hospital Board, as reviewed and approved by the Summit Board as applicable;

Submit recommendations to the respective Hospital Board concerning all matters relating to appointment, reappointment, staff category, department assignments, clinical privileges and corrective action;

Report to the respective Hospital Board and, as required, to the Summit Board, through the President of the Medical Staff, and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;

Make recommendations to the respective Hospital Board and, as required, to the Summit Board on medical administrative and management matters;

Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

Review and act on reports from Medical Staff committees, departments, and other assigned activity groups;

Formulate and recommend to the Hospital Board, Medical Staff rules, policies, and procedures for approval;

Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner’s ability to perform privileges requested or currently granted;

Make recommendations to the Hospital Board for approval concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures, subject to final review and approval by the Summit Board as applicable;

Consult with administration on the quality, timeliness and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;

Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

Hold Medical Staff leaders, committees and departments accountable for fulfilling their duties and responsibilities;

Make recommendations to the Medical Staff and the Hospital Boards for changes or amendments to the Medical Staff Bylaws, subject to final review and approval by the Summit Board as applicable; and,
Each MEC is empowered to act for the Hospital Medical Staff between meetings of the Medical Staff, as necessary based upon the circumstances.

6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. The Medical Staff shall maintain permanent records of its proceedings and actions. The Medical Staff expects MEC voting members to attend each meeting. If unable to attend the MEC, a voting member may choose to designate a member of their department to attend the meeting in his/her absence, subject to approval by Medical Staff President and without a vote.
SECTION 7. MEDICAL STAFF MEETINGS

7.1 MEDICAL STAFF MEETINGS

7.1.1 The Medical Staff shall hold an annual meeting and three (3) other general meetings of the Medical Staff at such times as the President of the Medical Staff determines, in consultation with the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.

7.1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group, subject to the Quorum requirements of Section 7.4. The Medical Staff may act without a meeting of the Medical Staff by presentation of the proposed action/question to each member eligible to vote in person, via telephone, online and/or by mail or e-mail or any other secure and legal method, and their vote recorded in accordance with procedures specified and approved by the MEC for such action/question. Such vote shall be binding, subject to Hospital Board approval, and final review and approval by the Summit Board as applicable, so long as the question that the Medical Staff votes on receives the majority of the votes cast, and subject to the Quorum requirements of Section 7.4.

7.1.3 For Bylaws amendments, the provisions of Section 9.2.1 of these Bylaws shall prevail.

7.1.4 Special Meetings of the Medical Staff:

The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

Written or electronic notice stating the time, place and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Active Category member of the Medical Staff at least three (3) working days before the date of such meeting. The Medical Staff shall not transact any business at any special meeting, except that stated in the notice of such meeting.

7.2 REGULAR MEETINGS OF MEDICAL STAFF COMMITTEES AND DEPARTMENTS

By resolution, committees and departments may provide the time for holding regular meetings without notice other than such resolution.

7.3 SPECIAL MEETINGS OF COMMITTEES AND DEPARTMENTS

A committee chair or chair of the department may call a special meeting of any committee or department respectively, and the President of the Medical Staff may call a special meeting of any committee or department.
7.4 QUORUM

7.4.1 Medical Staff Meetings: For proposed actions/questions at any Medical Staff meeting, the action/question will pass only when it receives a majority vote by the members of the Active category of the Medical Staff at the Hospital, when at least thirty percent (30%) of the members of the Active category of the Medical Staff of the Hospital are present at the meeting.

7.4.2 MEC: A quorum will exist when forty percent (40%) of the voting MEC members for each Hospital are present.

7.4.3 Credentials Committee and Peer Review Committee: Each Hospital shall have a Credentials Committee and a Peer Review Committee, responsible for credentialing and quality assurance/performance improvement, respectively, at their respective Hospital. Notwithstanding the preceding sentence and unless the context requires otherwise, whenever the term “Credentials Committee” is used, it shall mean the Credentials Committee of Chambersburg Hospital and the Credentials Committee of Waynesboro Hospital functioning jointly and cooperatively. Similarly, unless the context requires otherwise, whenever the term “Peer Review Committee” is used, it shall mean the Peer Review Committee of Chambersburg Hospital and the Peer Review Committee of Waynesboro Hospital functioning jointly and cooperatively. Any actions taken jointly or cooperatively by these committees, or meetings thereof, shall be limited to circumstances where a practitioner holds, or is applying for, clinical privileges at both Hospitals, and are subject to applicable peer review of other legal/regulatory requirements.

7.4.4 Department meetings or Medical Staff committees other than those listed in 7.4.2 and 7.4.3 above: Those present and eligible to vote, but not less than two (2).

7.5 ATTENDANCE REQUIREMENTS

7.5.1 Members of the Active Category must attend at least fifty percent (50%) of the quarterly Medical Staff meetings and at least fifty percent (50%) of all committee meetings of which they are a voting member except as required by section 7.5.3. Failure to meet these attendance requirements will result in sanctions or corrective action per Medical Staff Bylaws and policy.

7.5.2 Members of the Associate Medical Staff are encouraged to attend meetings

7.5.3 MEC, Credentials, Peer Review, and Utilization Committee members: Members of these committees are expected to attend at least two-thirds (2/3rds) of the meetings held. Failure to meet these attendance requirements may result in removal from the committee by the Medical Staff President, consistent with these Bylaws.

7.5.4 Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or Hospital policies, or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable department chair or Medical Staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Medical Staff will give the practitioner special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner’s appearance is mandatory. Failure of the practitioner to appear at
any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic suspension of the practitioner's membership and privileges, in accordance with Section 12.1.3. Such suspension would not give rise to a fair hearing, but the suspension will be automatically rescinded if the practitioner participates in the previously referenced meeting within thirty (30) days of notice. If the practitioner fails to appear within thirty (30) days of notice, the practitioner will have their membership and privileges automatically revoked, consistent with the provisions of Section 12.1.3 of Part II of these Bylaws.

7.5.5 Nothing in the foregoing Section shall preclude the initiation of summary suspension of clinical privileges or other corrective action as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 PARTICIPATION BY THE PRESIDENT OF THE HOSPITAL

The President of the Hospital or his/her designee may attend any general, committee or department meetings of the Medical Staff as an ex-officio member without vote. The members of such committees or departments may go in to executive session, with Active Category Medical Staff members only, when desired, as determined by the committee or department chair.

7.7 ROBERT'S RULES OF ORDER

Medical Staff and committee meetings shall run in a manner the meeting chair determines. If the chair or a majority vote of those attending a meeting determines that they need parliamentary procedure, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.8 NOTICE OF MEETINGS

Written or electronic notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the department or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 ACTION OF COMMITTEE OR DEPARTMENT

The recommendation of the majority of its members present at a meeting at which a quorum is present shall be the recommended action of a committee or department. The members will forward such recommendation to the MEC for action, or further recommendation to the respective Hospital Board. In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding approval of any committee or departmental action, such matter shall be referred to the Inter-Hospital Committee for consideration. The recommendations of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1.

7.10 RIGHTS OF EX OFFICIO MEMBERS
Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee have all rights and privileges of regular members, except that they cannot vote, cannot make motions, and will not be counted in determining the existence of a quorum.

7.11 MINUTES

Minutes of each regular and special meeting of each Medical Staff, or respective committee or department thereof, shall be prepared and shall include, at a minimum, a record of the attendance of members and the vote taken on each matter. The presiding committee chair or department chair shall authenticate the minutes, and the committee or department shall submit copies thereof to the MEC or another designated committee. The Medical Staff shall maintain a permanent file of the minutes of such meeting(s).
SECTION 8. CONFLICT RESOLUTION

8.1 In the event the respective Hospital Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety (excepting professional review actions decided in accordance with Part II of the Medical Staff Bylaws), the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the three (3) officers of the Medical Staff and an equal number of members of the respective Hospital Board, for review and discussion. The committee will submit its recommendation to the Hospital Boards within thirty (30) days or sooner of the initiation of the request for the Joint Conference Committee meeting, to be considered by the respective Hospital Boards at their next scheduled meetings, or sooner, as may be warranted by the circumstances.

8.2 To promote timely and effective communication and to foster collaboration between the Hospital Boards and the Summit Board, Hospital management and Medical Staff, the chair of either Hospital Board, the chair of the Summit Board, President of the Hospital, or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue or relay information directly.

8.3 Any conflict between the Hospital Boards, concerning any recommendations arising under this section may be submitted to the Inter-Hospital Committee for review and recommendations for resolving such conflict. The Inter-Hospital Committee may meet with Medical Staff and MEC representatives and/or consider any input requested or submitted. The recommendations of the Inter-Hospital Committee shall be sent back to MEC and the Hospital boards for approval, subject to final review and approval by the Summit Board pursuant to Section 2.9.1.
SECTION 9. REVIEW, REVISION, ADOPTION AND AMENDMENT TO BYLAWS, RULES AND REGULATIONS

9.1 MEDICAL STAFF RESPONSIBILITY

9.1.1 The Medical Staff shall have the responsibility to formulate, review as required, and recommend to the respective Hospital Board, any Medical Staff Bylaws, or amendments thereof, as determined necessary or warranted. Amendments to the Medical Staff Bylaws, shall be effective only when approved by both Hospital Boards and the Summit Board. In the event that the Hospital Boards reach inconsistent or contradictory decisions regarding approval of any such Medical Staff bylaw or amendment thereto, such matter shall be referred to the Inter-Hospital Committee for consideration. The recommendations of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board pursuant to Section 2.9.1. The Medical Staff can exercise this responsibility through its Medical Staff President or other elected and appointed leaders, or through direct vote of its membership, or otherwise in accordance with these Bylaws.

9.1.2 The Medical Staff shall exercise such responsibility in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption and amendment of the related rules, regulations and policies and protocols developed to implement the various sections of these Bylaws.

9.2 METHODS OF ADOPTION AND AMENDMENT OF BYLAWS

9.2.1 Either MEC, or a petition signed by ten percent (10%) of the members of the Active category members of either Hospital, may originate proposed amendments to these Bylaws, including opting out of the cooperative Medical Staff model described in Section 1.1 of the Bylaws.

Each Active member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active category members of the Medical Staff shall receive at least fifteen (15) days advance notice of the proposed changes. The amendment shall be considered approved by the Medical Staff if the amendment receives a majority of the votes cast by the Active category members of each Hospital eligible to vote.

Amendments so adopted shall be effective only when approved by the respective Hospital Board, subject to final review and approval by the Summit Board pursuant to Section 2.9.1 as applicable.

9.3 METHODS OF ADOPTION AND AMENDMENT TO ANY MEDICAL STAFF RULES AND REGULATIONS.

9.3.1 The Medical Staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws.
9.3.2 Upon receiving a petition from Medical Staff members pursuant to Section 2.7.4, or upon its own motion, the joint MECs shall vote on any proposed changes to Medical Staff rules, regulations or policies which do not constitute changes to these Bylaws at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, the Medical Staff may adopt, amend or repeal any rules or regulations or policies, in whole or in part, and such changes shall be effective without Hospital board and Summit Board approval, except that any changes which serve to modify or amend these Bylaws, as determined by either Hospital Board or the Summit Board upon request or upon its own motion, shall require approval by both Hospital Boards, subject to final review and approval by the Summit Board, to be or remain effective.

9.3.3 In addition to the process described in 9.3.2 above, the Medical Staff itself may, petition to change any Medical Staff rule, regulation or policy by first submitting a petition, signed by ten percent (10%) of the members of the Active category of the Medical Staff of Chambersburg Hospital or ten percent (10%) the members of the Active category of the Medical Staff of Waynesboro Hospital, to the MECs. Upon presentation of such petition, the joint MECs will follow an adoption process similar to the process outlined in 9.2.1. The MECs may adopt such amendments to Medical Staff rules, regulations and policies that are, in the Committee’s judgment, technical modifications or clarifications. Such modifications may include reorganization, renumbering, punctuation, spelling or other errors of grammar or expression. The respective Hospital Boards and the Summit Board need not approve such changes, subject to Section 9.3.2 above.
INFORMAL, EDUCATIONAL, AND/OR INFORMAL PROCEEDINGS

10.1 CRITERIA FOR INITIATION

These Bylaws encourage Medical Staff leaders and Hospital management to use progressive steps, beginning with informal education efforts, to address questions relating to an individual’s clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that another may raise. The respective Hospital will consider confidential all informal intervention efforts by Medical Staff leaders and Hospital management as part of the Hospital’s performance improvement, self-evaluation and professional and peer review activities. Informal intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. When any observations arise, suggesting opportunities for a practitioner to improve, the Medical Staff should refer the matter for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and Hospital. Informal intervention efforts may include but are not limited to the following:

Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation and letters of guidance; and,

Sharing summary comparative quality, utilization and other relevant information to assist individuals to conform their practices to appropriate norms.

Notwithstanding any informal intervention efforts if taken, if it appears that the practitioner’s performance places patients in danger or compromises the quality of care, or in cases where it appears that any other professional review action is necessary while informal interventions are being undertaken, the respective MEC (or the joint MECs when a practitioner holds privileges at both Hospitals) will consider whether it should be recommended to the respective Hospital Boards, to restrict or revoke the practitioner’s membership and/or privileges in accordance with this Part II of the Medical Staff Bylaws. Before issuing such a recommendation, either MEC may, in its discretion, authorize an investigation of any matters in question. Nothing in these Bylaws shall restrict either MEC from making any recommendations to its respective Hospital Board, or taking any other action consistent with these Bylaws.
SECTION 11. CORRECTIVE ACTION

11.1 Initiation

Whenever the activities or professional conduct of any Medical Staff member are at risk of being:

Inconsistent with the effective delivery of patient care at the generally recognized professional level of quality;

in violation of these Medical Staff Bylaws, staff rules and regulations, departmental rules or Hospital policies, procedures, rules or regulations;

a failure in meeting professional conduct, judgment or performance expectations, standards or responsibilities;

a violation of policy or standards prohibiting discrimination,

an abuse of clinical or other Hospital privileges; or,

an exhibition of potential physical or mental impairment; then,

an investigation may be requested by any officer of the Medical Staff, by the chair of any department, by the Hospital President or his designee, by the respective Hospital Board, or by the respective or joint MECs; provided, however, any individual may ask any of the aforementioned individuals or committees to request an investigation. Initiation of an investigation pursuant to this Section 11 does not preclude imposition of summary suspension as provided for in Section 13, nor does it require the prior imposition of such a suspension.

All requests for an investigation, other than those requested by the MEC, shall be in writing, submitted to the respective or joint MECs, and supported by reference to the specific conduct or activities that constitute the grounds for the request. The Medical Staff President shall promptly notify the Hospital President in writing of all requests for an investigation received by the MEC.

11.2 INVESTIGATION

After consideration of a request for an investigation, the respective or joint MECs, as appropriate when the practitioner holds privileges at both Hospitals, shall either: (i) reject the request and report its conclusions to the Hospital Board; or (ii) forward the request either to the chair of the department in which the questioned activities or conduct occurred or to the chair of the department in which the practitioner is a member for investigation, or (iii) appoint an ad hoc committee to investigate in accordance with the requirements of Section 11.3 hereof. The practitioner who is under investigation shall be invited to discuss his/her alleged conduct with the department chair or the investigating committee. A practitioner’s failure to appear or to cooperate with the investigation may be considered by
the MEC in evaluating the investigating committee’s findings and in recommending corrective action. Any such appearance by the practitioner shall be informal in nature and shall not constitute a hearing, and none of the procedural rules provided in the Fair Hearing Plan in Section 14 hereof with respect to hearings shall apply. Within twenty (20) working days after the receipt of the request, the department chair or the investigating committee shall forward a written report of its investigation to the MEC. The Medical Staff President shall promptly forward a copy of the report to the respective Hospital Board, the Hospital President, the department chair if applicable, and the practitioner, within three (3) working days.

11.3 OPTION OF THE BOARD

When the MEC has rejected a request for an investigation pursuant to Section 11 hereof and have reported these conclusions to the respective Hospital Board as set forth in Section 11, either Hospital Board as applicable may direct the Medical Staff President to appoint an ad hoc investigating committee composed of disinterested members of the Medical Staff, at least one of which is on the Medical Staff at the Hospital where the conduct under investigation allegedly took place, to investigate the activities or conduct on which the request for an investigation was based. The practitioner who is under investigation shall be invited to discuss his/her alleged conduct with the investigating committee consistent with Section 11.2. Any such appearance shall be informal in nature and shall not constitute a hearing, and none of the procedural rules provided in the Fair Hearing Plan in Section 14 hereof with respect to hearings shall apply. Within twenty (20) working days after the acceptance by the investigating committee of their appointment, the investigating committee shall forward a written report of its investigation to the respective or joint MECs for action in accordance with Section 11.4. The Medical Staff President shall promptly forward a copy of the report to the Hospital Board, the Hospital President, the department chair and the practitioner, within three (3) working days.

11.4 MEC ACTION

Within ten (10) working days following receipt of the report of an investigation, the respective or joint MECs shall meet to consider the report. At the meeting for this purpose, the practitioner will be invited to meet at least once with the MEC and provide a written statement or other documentation in support of his/her position. A practitioner’s failure to appear or to cooperate with the investigation may be considered by the MEC in evaluating the investigating committee’s findings and in recommending corrective action. Such appearance by the practitioner and/or written submission to the MEC shall also be informal in nature and not constitute a hearing pursuant to the Fair Hearing Plan in Section 14. Since the investigation process conducted by the MEC is informal for purposes of the Committee’s determinations and recommendation, the practitioner shall not be permitted to make any discovery or document requests or other demands except for the opportunity to appear or submit a written statement as provided herein. Following the conclusion of the MEC investigation process, including the practitioner’s written submission and/or appearance, and consideration of the investigating committee’s report, actions of the MEC may include, without limitation, recommending:

(a) Rejecting the request for corrective action;

(b) Issuing a warning, a letter of admonition or a letter of reprimand;
(c) Temporary terms of probation or requirements for consultation or monitoring that do not include an actual limitation on, or reduction of, the staff member's clinical privileges;

(d) a course of training or education;

(e) reduction, suspension or revocation of clinical privileges;

(f) reduction of staff category or limitation of any staff prerogatives directly related to patient care; and,

(g) suspension or revocation of staff appointment.

The MEC shall promptly report in writing any action taken or recommended pursuant to this Section 11.4 to the practitioner, the Hospital President, the Hospital Board, and the department chair within three (3) working days.

11.5 BOARD ACTION

Following receipt of an MEC recommendations pursuant to Section 11.4, the respective Hospital Board shall review the MEC's recommendations at the next regular meeting or at a special meeting called for such purposes, if earlier, and shall affirm, reverse or modify the actions recommended by the MEC at such meeting. In the event that the Hospital Boards reach inconsistent or contradictory conclusions following their review of the MEC's investigation and recommendations, such matter shall be referred to the Inter-Hospital Committee for consideration. The decision of the Inter-Hospital Committee shall be subject to Summit Board review and approval pursuant to Section 2.9.1 as applicable. The Hospital President shall promptly notify the practitioner and the MEC of such action within three (3) working days. If the action is an action described in Section 11.4 (e), (f) or (g), the practitioner shall be entitled to procedural rights as provided in Section 14 hereof. If the action is favorable to the practitioner, or is an action described in Section 11.4 (a), (b), (c) or (d) of these Bylaws, the investigation shall be considered closed and resolved in accordance with such action. No corrective action recommended by the MEC shall be reported to the practitioner's state licensing board or to the National Practitioner Data Bank until such action is made final by Hospital Board action, consistent with Section 2.9.1 as applicable.
SECTION 12. AUTOMATIC SUSPENSION AND REVOCATION

12.1 License

If a practitioner's license to practice his/her profession in the Commonwealth of Pennsylvania is revoked or suspended by a licensing or certifying authority, the practitioner’s Medical Staff appointment and clinical privileges of such practitioner shall immediately and automatically be revoked.

Whenever a licensing or certifying authority imposes probation, limitations or restrictions on a practitioner's license or certification other than revocation or suspension of his/her license, the respective or joint MECs shall review the licensing or certifying authority’s action and the grounds therefore. The MEC shall determine whether either the grounds for the authority’s action or the effect of that action should result in a suspension, revocation, limitation or modification of the affected practitioner’s Medical Staff appointment and/or clinical privileges in order to ensure that the practitioner is practicing within the scope of his or her license or certification, is acting within the standards and requirements of these Bylaws, and patient safety and quality of care is not compromised. The MEC shall promptly take appropriate action consistent with such findings, and consistent with these Bylaws. The MEC action shall be effective immediately upon imposition by the MEC, and shall be communicated promptly to the respective Hospital Board consistent with Section 11.4.

When the action of the licensing agency has been to revoke or suspend the practitioner’s license or certification, any subsequent request for the opportunity to practice at the Hospital after the practitioner has regained his/her license or certification shall only be by application for appointment to the Medical Staff as a new applicant.

12.2 Drug Enforcement Administration (DEA) Number

A practitioner, whose DEA number is revoked, suspended or voluntarily relinquished after the commencement of an investigation by a law enforcement agency, shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. The MEC shall treat the matter as a request for corrective action, and the procedures in Section 11.1 and in the succeeding sections shall be followed.

12.3 Failure to Satisfy Special Appearance Requirement

A practitioner who fails to satisfy the requirements of Section 7.5.4 shall automatically be suspended from exercising his/her clinical privileges as may be determined in accordance with the provisions of said Section 7.5.4. The suspension shall continue until removed by the MEC, or until the practitioner’s privileges are automatically revoked in accordance with Section 7.5.4.

12.4 Felony Conviction
Upon exhaustion of appeals after conviction of a felony of a practitioner in any court of the United States, either federal or state, his practitioner's staff appointment and clinical privileges shall automatically be revoked. Revocation pursuant to this section of the Bylaws does not preclude the practitioner from subsequently applying for Medical Staff appointment in accordance with the Bylaws, and provided that the nature and circumstances of the felony conviction shall be fully considered in assessing eligibility for Medical Staff membership and clinical privileges.

12.5 Medical Records and Health Information Management.

The medical records committee is authorized by these Bylaws to establish specific time limits in which Hospital charts must be completed and to establish fines or regulations on Hospital privileges, including suspension of privileges upon due notice, for failure to complete medical records within the time limits. Privileges lost by temporary suspension for reasons outlined in this section may be reinstated without application to the Medical Staff when the records are deemed complete by the Chair of the Medical Records Committee in consultation with the Director of Health Information Management, provided however that the practitioner's failure to complete medical records before the expiration of a thirty (30) day suspension shall constitute an automatic revocation of Medical Staff membership and privileges. This does not preclude imposition of summary suspension or any other corrective action taken under these Bylaws for the practitioner's failure, or repeated failure, to meet Medical Staff standards or requirements.

12.6 Medicare, Medicaid, Tricare or other federal programs.

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General’s List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

12.7 Failure to participate in an evaluation.

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall, after written notice and warning, have all privileges automatically suspended. Failure to comply within thirty (30) days will be considered a voluntary resignation from the Medical Staff and automatic revocation of clinical privileges.

12.8 Failure to pay Medical Staff dues.

A practitioner who fails to timely pay Medical Staff dues shall, after written notice and warning, have all privileges automatically suspended. Continued failure to comply after thirty (30) days thereafter will be considered a voluntary resignation from the Medical Staff and automatic revocation of clinical privileges.

12.9 Failure to become board certified.

The Medical Staff will deem a practitioner who fails to become board certified in compliance with these Bylaws, or the rules, regulations or policies of his/her department, to have relinquished immediately and
voluntarily his or her Medical Staff appointment and clinical privileges unless upon recommendation from the MEC, the respective Hospital Board grants an exception, for a good cause. Any disagreement between the Hospital boards shall be resolved by the Inter-Hospital Committee, pursuant to Section 2.9.1.

12.10 Failure to Return a Complete Reappointment Application.

Failure to return or complete a reappointment application at least ninety (90) days prior to expiration of privileges, will result in institution of the “Failure to Return Reappointment Application” with automatic suspension of membership and privileges by written notice to practitioner.

12.11 Failure to Execute Release and/or Provide Documents.

A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff, President of the Hospital or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall, after written notice and warning, have all privileges automatically suspended. If the practitioner executes the release and/or provides the documents within thirty (30) days of notice of the automatic suspension, the MEC may reinstate the practitioner’s clinical privileges, subject to approval by the respective Hospital Board. Thereafter, the practitioner shall be deemed to have resigned voluntarily from the Medical Staff, and the practitioner must reapply for staff membership and privileges.

12.12 Procedural Rights

A practitioner whose appointment or privileges have been automatically suspended or revoked, or another action has been taken, by operation of this Section 12 may, within thirty (30) days of the date of such action, appeal directly to the respective Hospital Board by providing written documentation or evidence solely for purposes of establishing that the automatic suspension, revocation or other action was imposed in error in that the event giving rise to the action did not occur or has been rescinded. The hearing and any subsequent proceedings shall not be conducted in accordance with the provisions of Section 14, but shall be conducted and decided solely within the discretion of the respective Hospital Board. Any disagreement between the Hospital Boards in deciding the matter shall be resolved by the Inter-Hospital Committee, pursuant to Section 2.9.1. Further, the imposition of an automatic suspension, revocation, or other action does not preclude initiation of correction action pursuant to Section 11.

12.13 MEC Deliberation

Following any action taken or warranted as described in Section 12 above, MEC may, but is not required to, review and consider the facts, and may recommend to the respective Hospital Board such further corrective action, or the reinstatement of clinical privileges under appropriate circumstances, to be considered and either approved or rejected by the respective Hospital Board. Any disagreement between the Hospital Boards in deciding the matter shall be resolved by the Inter-Hospital Committee, subject to final review and approval by the Summit Board pursuant to Section 2.9.1.
SECTION 12. CORRECTIVE ACTION

12.1 AUTOMATIC SUSPENSION AND REVOCATION

12.1.1 License

If a practitioner's license to practice his/her profession in the Commonwealth of Pennsylvania is revoked or suspended by a licensing or certifying authority, the practitioner's Medical Staff appointment and clinical privileges of such practitioner shall immediately and automatically be revoked.

Whenever a licensing or certifying authority imposes probation, limitations or restrictions on a practitioner's license or certification other than revocation or suspension of his/her license, the respective or joint MECs shall review the licensing or certifying authority's action and the grounds therefore. The MEC shall determine whether either the grounds for the authority's action or the effect of that action should result in a suspension, revocation, limitation or modification of the affected practitioner's Medical Staff appointment and/or clinical privileges in order to ensure that the practitioner is practicing within the scope of his or her license or certification, is acting within the standards and requirements of these Bylaws, and patient safety and quality of care is not compromised. The MEC shall promptly take appropriate action consistent with such findings, and consistent with these Bylaws. The MEC action shall be effective immediately upon imposition by the MEC, and shall be communicated promptly to the respective Hospital Board consistent with Section 11.4.

When the action of the licensing agency has been to revoke or suspend the practitioner's license or certification, any subsequent request for the opportunity to practice at the Hospital after the practitioner has regained his/her license or certification shall only be by application for appointment to the Medical Staff as a new applicant.

12.1.2 Drug Enforcement Administration (DEA) Number

A practitioner, whose DEA number is revoked, suspended or voluntarily relinquished after the commencement of an investigation by a law enforcement agency, shall immediately and automatically be divested of his/her right to prescribe medications covered by such number. The MEC shall treat the matter as a request for corrective action, and the procedures in Section 11.1 and in the succeeding sections shall be followed.

12.1.3 Failure to Satisfy Special Appearance Requirement

A practitioner who fails to satisfy the requirements of Section 7.5.4 shall automatically be suspended from exercising his/her clinical privileges as may be determined in accordance with the provisions of said Section 7.5.4. The suspension shall continue until removed by the MEC, or until the practitioner's privileges are automatically revoked in accordance with Section 7.5.4.
12.1.4 Felony Conviction

Upon exhaustion of appeals after conviction of a felony of a practitioner in any court of the United States, either federal or state, the practitioner's staff appointment and clinical privileges shall automatically be revoked. Revocation pursuant to this section of the Bylaws does not preclude the practitioner from subsequently applying for Medical Staff appointment in accordance with the Bylaws, and provided that the nature and circumstances of the felony conviction shall be fully considered in assessing eligibility for Medical Staff membership and clinical privileges.

12.1.5 Medical Records and Health Information Management.

The medical records committee is authorized by these Bylaws to establish specific time limits in which Hospital charts must be completed and to establish fines or regulations on Hospital privileges, including suspension of privileges upon due notice, for failure to complete medical records within the time limits. Privileges lost by temporary suspension for reasons outlined in this section may be reinstated without application to the Medical Staff when the records are deemed complete by the Chair of the Medical Records Committee in consultation with the Director of Health Information Management, provided however that the practitioner's failure to complete medical records before the expiration of a thirty (30) day suspension shall constitute an automatic revocation of Medical Staff membership and privileges. This does not preclude imposition of summary suspension or any other corrective action taken under these Bylaws for the practitioner's failure, or repeated failure, to meet Medical Staff standards or requirements.

12.1.6 Medicare, Medicaid, Tricare or other federal programs.

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

12.1.7 Failure to participate in an evaluation.

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall, after written notice and warning, have all privileges automatically suspended. Failure to comply within thirty (30) days will be considered a voluntary resignation from the Medical Staff and automatic revocation of clinical privileges.

12.1.8 Failure to pay Medical Staff dues.

A practitioner who fails to timely pay Medical Staff dues shall, after written notice and warning, have all privileges automatically suspended. Continued failure to comply after thirty (30) days thereafter will be considered a voluntary resignation from the Medical Staff and automatic revocation of clinical privileges.

12.1.9 Failure to become board certified.
The Medical Staff will deem a practitioner who fails to become board certified in compliance with these Bylaws, or the rules, regulations or policies of his/her department, to have relinquished immediately and voluntarily his or her Medical Staff appointment and clinical privileges unless upon recommendation from the MEC, the respective Hospital Board grants an exception, for a good cause. Any disagreement between the Hospital boards shall be resolved by the Inter-Hospital Committee, pursuant to Section 2.9.1.

12.1.10 Failure to Return a Complete Reappointment Application.

Failure to return or complete a reappointment application at least ninety (90) days prior to expiration of privileges, will result in institution of the “Failure to Return Reappointment Application” with automatic suspension of membership and privileges by written notice to practitioner.

12.1.11 Failure to Execute Release and/or Provide Documents.

A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff, President of the Hospital or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall, after written notice and warning, have all privileges automatically suspended. If the practitioner executes the release and/or provides the documents within thirty (30) days of notice of the automatic suspension, the MEC may reinstate the practitioner’s clinical privileges, subject to approval by the respective Hospital Board. Thereafter, the practitioner shall be deemed to have resigned voluntarily from the Medical Staff, and the practitioner must reapply for staff membership and privileges.

12.1.12 Procedural Rights

A practitioner whose appointment or privileges have been automatically suspended or revoked, or another action has been taken, by operation of this Section 12 may, within thirty (30) days of the date of such action, appeal directly to the respective Hospital Board by providing written documentation or evidence solely for purposes of establishing that the automatic suspension, revocation or other action was imposed in error in that the event giving rise to the action did not occur or has been rescinded. The hearing and any subsequent proceedings shall not be conducted in accordance with the provisions of Section 14, but shall be conducted and decided solely within the discretion of the respective Hospital Board. Any disagreement between the Hospital Boards in deciding the matter shall be resolved by the Inter-Hospital Committee, pursuant to Section 2.9.1. Further, the imposition of an automatic suspension, revocation, or other action does not preclude initiation of correction action pursuant to Section 11.

12.1.13 MEC Deliberation

Following any action taken or warranted as described in Section 12 above, MEC may, but is not required to, review and consider the facts, and may recommend to the respective Hospital Board such further corrective action, or the reinstatement of clinical privileges under appropriate circumstances, to be considered and either approved or rejected by the respective Hospital Board. Any disagreement between the Hospital Boards in deciding the matter shall be resolved by the Inter-Hospital Committee, subject to final review and approval by the Summit Board pursuant to Section 2.9.1.
SECTION 14. FAIR HEARING PLAN

14.1 INITIATION OF HEARING

The following recommendations or actions shall, if deemed adverse pursuant to Section 14.1 – 14.2 entitle the practitioner affected thereby to a hearing:

Denial of initial staff appointment,
Denial of reappointment,
Suspension of staff appointment (other than pursuant to Section 12.1 hereof),
Revocation of staff appointment (other than pursuant to Section 12.1 hereof),
Denial of requested modification of staff category,
Reduction in staff category,
Limitation of admitting prerogatives,
Denial of requested department assignment,
Denial of requested clinical privileges,
Reduction in or limitation of clinical privileges,
Suspension of clinical privileges (other than pursuant to Section 12.1 hereof), and
Revocation of clinical privileges (other than pursuant to Section 12.1 hereof)

14.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 14.1 shall be deemed adverse action only when it has been:

Recommended by the MEC of the Hospital or Hospitals at which the practitioner has privileges and approved by the respective Hospital Board, or if applicable, following Inter-Hospital Committee consideration pursuant to Section 11.5; or,

Taken by the respective Hospital Board without prior action by the MEC, consistent with Section 11.5.

14.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A practitioner against whom adverse action has been taken pursuant to Section 14.2 shall be given, within three (3) working days, written notice of such action by the President of the Medical Staff, or sooner notice as he/she determines necessary under the circumstances. The notice shall state:
That an adverse action has been taken or is proposed to be taken against the practitioner;

The reasons for the adverse action;

That the practitioner has no more than thirty (30) days from the date of furnishing the notice to request a hearing; and,

A summary of the hearing procedures and rights of the practitioner, which can consist of furnishing the practitioner a copy of this Fair Hearing Plan with the notice.

14.4 REQUEST FOR HEARING

A practitioner shall have no more than thirty (30) days following his/her receipt of a notice pursuant to Section 14.3 to file a written request for a Hearing. Such request shall be deemed to have been made when delivered in written form to the Medical Staff President. The Medical Staff President shall immediately notify the Hospital President of receipt of any such notice. Any time limits set forth in this or any other provision of the Fair Hearing Plan as set forth in Section 14 may be extended or shortened by mutual agreement of the practitioner and the Medical Staff President.

14.5 WAIVER BY FAILURE TO REQUEST A HEARING

The practitioner’s failure to request a Hearing within the time specified in Section 14.4 shall be an unconditional waiver of all rights to contest the action taken and at such time the action shall be deemed final and binding on the practitioner.

14.6 NOTICE OF HEARING AND STATEMENT OF REASONS

Upon receipt of the practitioner’s timely request for a Hearing, the President of the Medical Staff shall commence the convening of the Hearing Panel and Hearing Officer (pursuant to Section 14.8.3) and tentatively schedule the Hearing, giving written notice to the practitioner who requested the Hearing. The notice shall include:

The proposed time, place and date of the Hearing;

A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the Medical Staff at the Hearing;

The names of the Hearing Panel members and Hearing Officer, if known; and,

A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the Hearing so long as the additional material is relevant to the adverse recommendation or action concerning the individual requesting the Hearing, and that the individual and the individual’s counsel have reasonable time to review this additional information and rebut it.

A statement that failure to appear at the Hearing shall constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending.
14.7 SUPPORTING DOCUMENTS/WITNESS LIST

At least fifteen (15) calendar days before the Hearing, each party shall furnish to the other a written list of the names of the witnesses they intend to call. Either party may request that the other party provide either a list of, or copies of, all documents that he/she will offer as pertinent information or witnesses at the Hearing, and which are pertinent to the basis for which the corrective action was proposed or contested. The witness list of either party may, in the discretion of the Hearing Officer, be supplemented or amended at any time during the Hearing, if determined to be relevant by the Hearing Officer and if adequate notice of the change is given to the other party. The Hearing Officer shall have the authority to limit the number of witnesses or documents submitted as he/she determines necessary to ensure a prompt and fair process that does not unduly inconvenience the participants.

14.8 HEARING PREREQUISITES

14.8.1 Scheduling the Hearing

The Hearing Officer shall notify the parties in writing of the time, place and date of the Hearing based upon the scheduling requests and requirements of all participants. The Hearing Officer shall schedule the hearing date not less than thirty (30) days, or more than forty-five (45) days, from the date of the notice of the Hearing, unless the time period is modified by mutual agreement of the parties, and after considering the scheduling needs of all participants by the Hearing Officer.

14.8.2 Statement of Charges

The final notice of Hearing, which shall be provided in advance of the Hearing in accordance with Section 14.7, shall contain a concise statement of the basis of the adverse recommendation or action, a list by number of the specific or representative patient records in question or other relevant documents, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the Hearing, and a list of witnesses, if any, expected to testify on behalf of the Medical Staff.

14.8.3 Appointment of Hearing Panel and Hearing Officer

Method of Appointment

A Hearing requested pursuant to Section 14.4 shall be conducted by a Hearing Panel selected and appointed by the Hospital President and comprised of three (3) disinterested members of the Active category Medical Staff in good standing, at least one of which is on the Active Medical Staff at the Hospital where the conduct which is the subject of the Hearing took place. The Hospital President may in his/her sole discretion seek recommendations for Hearing Panel members from the Medical Staff President. All members of the Medical Staff appointed to the Hearing Panel shall be subject to the requirements of this Section 14.8.3. The Hearing Panel shall designate one of the members so appointed as a chairperson.

Service on Hearing Panel
All members of a Hearing Panel shall be required to consider and decide the matter impartially. No member of a Hearing Panel shall be a practitioner in direct economic competition with the practitioner who is the subject of the Hearing, or a practitioner who either has requested, or has served on, a body that has recommended the adverse action, unless the affected practitioner has waived all objections to such practitioner.

Hearing Officer

The Hospital President shall appoint or approve a Hearing Officer after consultation with the Medical Staff President. The Hearing Officer may be an attorney at law, but any member or employee of a firm utilized by the Hospital, including the Medical Staff, for legal advice regarding its affairs and activities shall not be eligible to serve as the Hearing Officer. The Hearing Officer must not be in direct economic competition with the practitioner and shall not have actively participated in the consideration of the adverse recommendation or action. The Hearing Officer will preside at the Hearing to assure that all parties and participants in the Hearing have an opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall determine the order of, or procedure for, presenting evidence and arguments during the Hearing, and shall have the authority and discretion to make all rulings on questions that pertain to matters of law and procedure, and the evidence (or relevance thereof) presented.

14.9 HEARING PROCEDURE

14.9.1 Personal Presence

The personal presence at the Hearing of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing, or who fails to cooperate with the hearing scheduling, conduct or process, as determined by the Hearing Panel (in consultation with the Hearing Officer) shall be deemed to have waived all rights to further review in the same manner and with the same consequence as provided in Section 14.5.

14.9.2 Representation

The practitioner who requested the Hearing shall be entitled to be accompanied and represented at the Hearing and throughout the proceedings by an impartial member of the Medical Staff or his/her professional society, or by legal counsel. The Hospital President shall appoint legal counsel at the Hearing to present the recommendation or action on behalf of the Medical Staff. In addition, the MEC, the respective Hospital Board, and the Summit Board shall be entitled to have one or more representatives at the Hearing, including counsel, provided however that only counsel appointed for the Hospital President for the purposes of the Hearing may actively participate in the Hearing.

14.9.3 Rights of Parties

At a Hearing, the parties, through their representatives, shall have the right:

To have a record made of the proceedings, copies of which shall be made available to the parties;
To call, examine, cross-examine and impeach witnesses, including in the case of the Medical Staff, to call the practitioner as if under cross-examination;

To present evidence determined to be relevant by the Hearing Officer, regardless of its admissibility in a court of law;

To make opening and closing statements at the Hearing; and,

To submit a brief memorandum summarizing the evidence presented at the Hearing (as contained exclusively within the Hearing record), as well as any legal or other issues bearing upon each party's burden of proof in Section 14.9.6.

14.9.4 Procedure and Evidence

The Hearing shall not be conducted strictly per rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if, in the judgment of the Hearing Officer, it is the sort of evidence upon which responsible persons customarily rely in the conduct of a hearing, regardless of the admissibility of such evidence in a court of law.

Each party shall be entitled to submit, prior to, during, or after the Hearing, memoranda concerning any issue of law or fact for consideration by the Hearing Panel. The Hearing Panel also may require one or both parties to prepare and submit to the Hearing Panel, written statements of their position on the issues, prior to, during, or after the Hearing.

Oral testimony shall be taken only on oath or affirmation.

14.9.5 Evidentiary Notice

In reaching a decision, the Hearing Panel and/or Hearing Officer may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts or administrative agencies of the Commonwealth of Pennsylvania. Parties present at the Hearing shall be informed of the matters to be noticed and those matters shall be recited in the Hearing record. Any party shall be given opportunity, on timely request, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Officer. The Hearing Panel shall be entitled to review and consider any relevant materials otherwise available to the Medical Staff with respect to the affected practitioner. Generally, documents, evidence or other materials or information pertaining to other practitioners, or any corrective action or lack thereof with respect to other practitioners, does not constitute relevant or admissible evidence with respect to an individual practitioner's adverse Medical Staff recommendations or action.

14.9.6 Burden of Proof

The body whose adverse recommendation or action occasioned the Hearing shall have the initial obligation to present evidence in support thereof and has the burden to show, by a preponderance of the
evidence, that the action was justified by the facts. The practitioner shall have, thereafter, the burden of persuasion to disprove, by a preponderance of the evidence, that justification.

14.9.7 Record of Hearing

A stenographic transcript or its equivalent shall be made. Videotape and electronic recording of the Hearing shall be equivalent, so long as an accurate transcribed record can be made from them.

14.9.8 Postponement

Requests for postponement of a Hearing shall be granted by the Hearing Officer only upon a showing of good cause, and after considering the scheduling needs of all participants.

14.9.9 Recesses, Adjournment and Deliberations

The Hearing Panel may recess the Hearing and reconvene the same without additional notice for the convenience of the participants or for obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the Hearing shall be closed. The Hearing Panel shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties and reach a decision. Upon the conclusion of its deliberations, the Hearing shall be declared finally adjourned.

14.9.10 Objections

Any objection to the appointment of a Hearing Panel member or Hearing Officer must be made prior to the start of the Hearing and state the reasons therefore. Objections to the introduction of evidence or any other objection must be made at the time of the Hearing, or prior to the Hearing. Failure to object as and when required by this Section 14.9.10 shall be a waiver of any future right to raise such objection.

14.10 HEARING PANEL REPORT AND FURTHER ACTION

14.10.1 Hearing Committee Report

Within ten (10) working days after final adjournment of the Hearing, the Hearing Panel shall reach a decision and make a written report of its findings and recommendations in the matter. The Hearing Officer may, at the request of the Hearing Panel, assist in the drafting of the findings and recommendations and shall advise the Hearing Panel as to the form and structure of such report. A copy of the report shall be furnished to the Hospital Board, the Hospital President, the MEC, appropriate department chairs, and the practitioner promptly following adoption by the Hearing Panel. The practitioner will also be notified, at the time of the furnishing of the report, that he or she has the right to request an appellate review meeting with the respective Hospital Board or the Inter-Hospital Committee if both Hospitals have an interest in the matter, pursuant to Section 14.11 hereof.

14.10.2 Action on Hearing Panel Report
The practitioner shall have ten (10) working days after receipt of the Hearing Panel’s report in which to request appellate review by the respective Hospital Board or the Inter-Hospital Committee in accordance with Section 14.11. Such a request must be in written form and delivered to the Medical Staff President. If a meeting with the respective Hospital Board or the Inter-Hospital Committee is requested pursuant to this Section, then the meeting will be held within twenty (20) working days of receipt of the request or at a later time as schedules allow, and if agreeable to practitioner. The practitioner will be notified in writing of the date and time of the meeting as soon as practicable. The practitioner shall be entitled to be represented by counsel or any other person who represented him/her at the Hearing. In addition, the practitioner will be entitled to provide such documents or evidence as solely contained in the Hearing Record, or summary thereof, as he or she deems appropriate and germane to the Hearing Panel’s decision to be considered by the respective Hospital Board or Inter-Hospital Committee, if applicable.

Within twenty (20) working days after a meeting with the respective Hospital Board or the Inter-Hospital Committee, or if no such meeting was requested by the practitioner, within twenty (20) working days after expiration of the time period to request a meeting, the respective Hospital Board or Inter-Hospital Committee, shall consider the report of the Hearing Panel (and the evidence and arguments presented by practitioner at that meeting if applicable) and affirm, modify or reverse the Hearing Panel’s recommendation in the matter. In the event that the appellate review is conducted by the Inter-Hospital Committee, the decision of the Inter-Hospital Committee may be subject to review and approval by the Summit Board pursuant to Section 2.9.1 as applicable. The final decision of the Hospital Board, shall be transmitted to the practitioner, Medical Staff President, appropriate department chairs, MEC and Hospital President, as applicable.

14.10.3 Notice and Effect of Determination

Notice

The Medical Staff President shall promptly send a copy of the final decision to the practitioner within three (3) working days.

Effect of the Determination

The decision of the respective Hospital Board, or the Inter-Hospital Committee as reviewed and approved by the Summit Board pursuant to Section 2.9.1 as applicable, and as thereafter adopted or ratified by the Hospital Board, shall become the final decision of the Hospital(s) and the Medical Staff, and the matter shall be considered closed.

14.11 APPELLATE REVIEW PROCESS AND PROCEDURES

14.11.1 Request for Appellate Review to the Board

Pursuant to Section 14.10.2 above, a practitioner shall have ten (10) days following his/her receipt of the Hearing Panel report to file a written request for an appellate review by the respective Hospital Board. If both Hospitals are included in the request for appellate review, the appellate review shall be conducted by the Inter-Hospital Committee. Such request shall be deemed to have been made when delivered to the
President of the Medical Staff, and may include a memorandum or summary of the transcript and record of the Hearing Panel, that was considered in adopting the adverse recommendation or action. Counsel on behalf of the Medical Staff may submit its response to the practitioner’s memorandum and/or its comments to the Hearing Panel Report based upon the Hearing Record.

14.11.2 Waiver by Failure to Request Appellate Review

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 14.11.1 waives any right to such review.

14.11.3 Scope of Appellate Review

Appellate review shall be limited to the following categories:

There was a substantial noncompliance with the procedures required by these Bylaws or applicable law that has resulted in demonstrable prejudice to the practitioner; or,

The decision was not supported by substantial evidence based upon the Hearing Record and information, documentation and arguments presented to the Hearing Panel; or,

The Hearing Panel’s decision was arbitrary and capricious.

14.11.4 Content of Request

The written request for appellate review must identify specifically the grounds for appeal and include a clear and concise statement of the basis or facts in the Hearing Record supporting the appeal.

14.11.5 Board Action With respect to an Appeal

Pursuant to Section 14.10.2, the respective Hospital Board or the Inter-Hospital Committee shall consider the appeal. Decisions resulting from the appellate review conducted by the Inter-Hospital Committee shall be subject to review and approval by the Summit Board as applicable in accordance with Section 2.9.1. Pursuant to Section 14.10.2, the practitioner shall be given the opportunity to request an appellate hearing and make a presentation to the respective Hospital Board or the Inter-Hospital Committee, as applicable, and respond to questions posed at that meeting. The respective Hospital Board or the Inter-Hospital Committee shall act on the appeal in a timely manner, provided that a decision is made in accordance with Section 14.10.2. Whether or not the practitioner requests a meeting with the respective Hospital Board or the Inter-Hospital Committee, the respective Hospital Board or the Inter-Hospital Committee shall have the right to question members of the Hearing Panel in connection with such appellate review. If the appeal is denied, then the decision shall be final in accordance with Section 14.10.3. If the appeal is sustained, the respective Hospital Board or the Inter-Hospital Committee (subject to review and approval of the Summit Board pursuant to Section 2.9.1 as applicable) may:

Remand the matter to the MEC for recommendations;

Grant or reinstate the clinical privileges in question;

Remand the matter to the Hearing Panel with appropriate instructions; or,
Modify the previous decision as warranted by the record.

The Medical Staff President shall give prompt written notice of the decision to the practitioner, which notice shall include the reasons for the action taken.

14.12 Waiver

If at any time after receipt of notice pursuant to Sections 11.5 of an adverse action described in Section 11.4 (e), (f) or (g) giving rise to practitioner’s procedural rights as provided in this Section 14 (whether such notice follows a decision of the respective Hospital Board or the Inter-Hospital Committee, or is otherwise deemed adverse to the practitioner pursuant to Sections 11.5, 13.1, 14.2, 18.4.6 or 18.4.7 of these Bylaws), a practitioner fails to make a required request or appearance or otherwise fails to exercise his/her rights pursuant to this Section 14 or comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or determination, and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

14.13 Number of Reviews

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no practitioner shall be entitled as a right to more than one evidentiary Hearing and appellate review with respect to an adverse recommendation or action. Moreover, a final action by the respective Hospital Board or the Inter-Hospital Committee, as reviewed and approved by the Summit Board pursuant to Section 2.9.1 as applicable, with respect to which a practitioner has either waived or exhausted his/her rights to a Hearing or appellate review regarding such practitioner’s Medical Staff membership or privileges, shall not allow the practitioner any further rights to a fair hearing or appellate review pursuant to these Bylaws.

14.14 Extensions

Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in Section 14 may be extended upon the agreement of the parties and only with the approval of the Hearing Officer or the applicable appellate body, after consideration of the scheduling needs of participants and affected individuals.

14.15 Releases

By requesting a Hearing or Appellate Review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of Section 14 of the Medical Staff Bylaws in all matters relating thereto.
SECTION 15. REINSTATEMENT

15.1 Re-Appointment

Any practitioner who has had his/her Medical Staff membership or clinical privileges revoked by final action of the respective Hospital Board or Inter-Hospital Committee, as reviewed and approved by the Summit Board as applicable pursuant to Section 2.9.1, shall not be entitled to apply for or request reappointment to the Medical Staff or return of clinical privileges for a period of three (3) years following the final action. Any practitioner seeking reinstatement to the Medical Staff after revocation must apply as an initial applicant for Medical Staff appointment and must meet all existing criteria for Medical Staff membership and clinical privileges in existence at that time.
SECTION 16. MEDICAL STAFF CREDENTIALS COMMITTEE

16.1 Confidentiality

16.1.1 This committee shall function in accordance with Section 7.4.3 hereof as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

16.1.2 The credentials file is the property of the respective Hospital(s), and the Medical Staff will maintain it with the strictest confidence and security. A designated agent of the Hospital will maintain the files in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Authorized staff may show the file to accreditation and licensure agency representatives with permission of the President of the Hospital(s) or their designee.

Individual practitioners may review their credentials file under the following circumstances: Only upon written request approved by the President of the Medical Staff, credentials chair or Vice President of Medical Affairs (VPMA). The individual practitioner may review such file in the presence of the medical services professional, Medical Staff representative, or a designee of Hospital administration. The practitioner cannot review confidential letters of reference, and the designated agent will sequester them in a separate file and remove them from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file other than information supplied by the practitioner or addressed to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.
SECTION 17. QUALIFICATIONS FOR CREDENTIALING AND PRIVILEGING

17.1.1 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the respective MEC and the respective Hospital Board;

17.2 Exceptions

17.2.1 All practitioners who are current Medical Staff members and/or hold privileges as of the effective date of these Bylaws and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements unless specified by department rules and regulations, until such practitioners otherwise are due for reappointment pursuant to Section 19 of these Bylaws.
SECTION 18. INITIAL APPOINTMENT PROCEDURE

18.1 General Procedure

The Medical Staff, acting individually or jointly whenever a practitioner applies for privileges at both Hospitals, and with the assistance of administration, through its designated departments, committees and officers, shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of membership status and shall adopt and transmit recommendations thereof to the respective Hospital Board.

18.2 APPLICATION FOR INITIAL APPOINTMENT

18.2.1 Application Form

Each application for appointment to the Medical Staff shall be in writing, on the form prescribed by the Hospital Board, and signed by the applicant. The Hospital President or his/her designee(s), or designated Medical Staff representative, shall promptly file all written requests for application forms from persons claiming to be practitioners, and furnish a copy of the Medical Staff Bylaws, rules and regulations to each such person.

18.2.2 Content

The application form shall include such provisions as are necessary to secure information useful for evaluation of the applicant, to include a history of all liability claims; any reports submitted to the National Practitioner Data Bank; limitations imposed upon insurance coverage previously completed or currently pending, or the voluntary relinquishment of any licensure or registration; voluntary or involuntary termination of Medical Staff membership, and voluntary or involuntary limitation, reduction, loss or denial of clinical privileges at another hospital. In addition, the form shall include a statement that the applicant has been furnished a copy of the Bylaws, rules and regulations of the Medical Staff, and that he/she agrees to be bound by the terms thereof during the time the application is under consideration and, if staff appointment is granted, while a member of the Medical Staff. All initial applications will include the applicant’s consent for the Hospital or Medical Staff representative to conduct a criminal background check. If the applicant is already a member in good standing of the Medical Staff of another entity of Summit Health Credentials Verification Organization (SHCVO), the Medical Staff will recognize his/her SHCVO application and credentials file as the initial application.

18.3 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

Signifies his/her willingness to appear for interviews concerning his/her application;
Authors Medical Staff representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;

Consents to the inspection by Medical Staff Representatives of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

Releases from any liability all Medical Staff representatives for their conduct and activities performed without actual malice in connection with evaluating the applicant and his/her credentials;

Unconditionally releases from all liability, consistent with Sections 2.9.2, 2.9.4 and 2.9.7 of the Bylaws, all persons, entities and organizations (including affiliates and third parties) that provide information, including otherwise privileged or confidential information, to Medical Staff Representatives concerning the applicant’s ability, professional ethics, character, evidence of current ability and competence, and other qualifications for staff appointment and clinical privileges.

For purposes of this Section, the term "Medical Staff Representative" as defined in Section 2.9.1, includes all persons entities and third parties described therein.

18.4 PROCESSING THE APPLICATION

18.4.1 Applicant’s Burden

The burden is on the applicant to provide all required information. It is the applicant’s responsibility to ensure that the Medical Staff receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required by the Medical Staff (subject to respective Hospital Board approval) that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional or clarifying information is required, the Medical Staff will send a letter requesting such information to the applicant. If the applicant does not return the requested information to the Medical Staff within ninety (90) days of the receipt of the request letter, the Medical Staff shall deem the applicant to have voluntarily withdrawn his/her application. The Hospital Board will not deem such withdrawal as an adverse appointment decision, and the applicant shall not be entitled to any procedural rights.

18.4.2 Transmittal for Evaluation

The applicant shall submit his/her application form to the Hospital President or his/her designee(s), or designated Medical Staff representative, who after conducting an initial review for completeness, shall notify the department chair of the application and shall collect or verify the references, licensure and DEA status and other qualification documentation or evidence submitted to support the application. The Medical Staff shall promptly notify the applicant of any failures in such collection or verification efforts. The Medical Staff, through its authorized representative(s), shall secure all required information from the National Practitioner Data Bank.

When the application is complete, the Medical Staff President will then contact the chair of each department in which the applicant seeks privileges.
The Medical Staff shall also post the name of the applicant in the Doctors' Lounge, along with a notice requesting any staff member with information pertinent to evaluation of the applicant to provide such information orally or in writing to the Medical Executive Committee.

18.4.3 Departmental Action

The appropriate chair(s) shall:

1. Review the application, the supporting documentation, and such other information available to him/her that may be relevant to the applicant's qualifications for the requested staff category, department affiliation and clinical privileges. The appropriate chair or Credentials Committee member may interview an applicant by telephone before the Credentials Committee reviews the applicant's file. Triggers for a telephone interview include the following:

   Gaps in education, training or practice experiences;

   Discrepancies between information provided on the applications and responses from references, NPDB, State Licensure Board or insurance carrier;

   Frequent moves and relocations;

   Requests for privileges that are outside the list provided in the application; or,

   The applicant will not be joining an existing medical practice or has not had an interview with any entity in the organization prior to receipt of the application.

2. Include the results of the above interview in his or her written report to the Credentials Committee. If at any point in the review of the application, the department chair or Credentials Committee representative feels a more in-depth interview is necessary, the Credentials Committee will invite the applicant to attend its regularly scheduled meeting or will have an additional telephone conversation held with the voting members of the Credentials Committee.

3. Complete this review within thirty (30) days of notification.

4. Transmit to the Credentials Committee a written report assessing the applicant's qualifications for Medical Staff appointment and clinical privileges after the department chair completes the review.

5. Support the assessment by referencing the completed application and all other considered documentation.

6. Not recommend adversely until or unless the department chair or his or her designee interviews the applicant.

18.4.4 Credentials Committee Action

After the department chair has reviewed the application, the Credentials Committee shall review all the information available concerning the applicant (at its next regularly scheduled meeting) provided that the file is: (1) complete, and (2) has been signed off by the department chair. The Credentials Committee
may request a personal interview. After such review, the Credentials Committee chair shall transmit to the respective or joint MECs a written report setting forth the Committee's recommendations.

18.4.5 Medical Executive Committee Action

After receipt of the Credentials Committee report, the respective or joint MECs, acting consistently with Section 6.2, shall review all relevant information available to it at its next regularly scheduled meeting, and then forward to the respective Hospital Board a written report and recommendations as to Medical Staff appointment and, if appointment is recommended, as to staff category, department affiliation, clinical privileges to be granted and any special conditions or restrictions to be attached to appointment. The committee may also defer action on the application pursuant to Section 18.4.6. The report shall state the Committee's reasons for its recommendation and shall include any minority views.

18.4.6 Effect of Medical Executive Committee Action

Deferral: If the application is deferred by the MEC, the recommendation must be made within forty-five (45) days. This time period may be extended with the applicant's consent.

Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Medical Staff President shall promptly forward the recommendation, together with the application form and its accompanying information, to the respective Hospital Board;

Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the Medical Staff President shall so inform the applicant within five (5) days by special notice, and he/she shall be entitled to the procedural rights as provided in Section 14. For the purposes of this Section 18.4.60, an "adverse recommendation" by the MEC is as defined in Section 14.1 and Section 14.2 of the Medical Staff Bylaws.

18.4.7 Board Action

All actions taken or required by Part III of these Bylaws, relating to credentialing decisions or otherwise are subject to review and approval by the respective Hospital Board. In the event that the Hospital Boards reach inconsistent or contradictory decisions or recommendations regarding any recommendation concerning a Medical Staff applicant, such matter shall be referred to the Inter-Hospital Committee for consideration. The recommendations of the Inter-Hospital Committee shall be subject to final review and approval by the Summit Board, as applicable, pursuant to Section 2.9.1.

On Favorable MEC Recommendation: The respective Hospital Board shall adopt or reject, in whole or in part, a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which MEC shall make a subsequent recommendation. If the final board action is adverse to the applicant, as defined in Section 14.1 – 14.2 of the Medical Staff Bylaws, the Medical Staff President shall so inform the applicant within five (5) days by written notice, and he/she shall be entitled to the procedural rights as provided in Section 14.

If the respective Hospital Board does not receive an MEC board recommendation within ninety (90) days from the date the Medical Staff deems the application complete, the applicant may request the Hospital
Title: MS Bylaws - Section 18 - Initial Appointment Procedure CH

Board to act on its own initiative, in accordance with the review process above. If such action is favorable, it shall become effective as the final decision. If such action is adverse, as defined in Section 14.1 – 14.2 of the Medical Staff Bylaws, the Medical Staff President shall so inform the applicant within five (5) days by written notice, and he/she shall be entitled to the procedural rights as provided in Section 14.

After Procedural Rights: In the case of an adverse board decision pursuant to 18.4.6 or 18.4.7, final action in the matter will be completed only after the applicant has exhausted or has waived his/her procedural rights as provided in Section 14.

Board Applied Criteria: In addition to any criteria stated in these Bylaws, the Hospital Board may consider any other lawful criteria for granting or denying Medical Staff membership and clinical privileges including, but not limited to, the adequacy of the Hospital's facilities and supportive services needed by the practitioner for rendering care to his/her patients, and the need for additional practitioners with the skill and qualifications of the practitioner, or any considerations involving the health, safety or wellbeing of Hospital patients, employees or the community, or any other lawful considerations.

18.4.8 Notice of Final Decision

The respective Hospital Board or the Inter-Hospital Committee, with review and approval by the Summit Board as applicable pursuant to Section 2.9.1, shall give its notice of final decision to the Medical Staff President, the chair of each department concerned, and to the applicant by means of written notice;

A decision and notice to appoint shall include:

(i) The staff category to which the applicant is appointed;
(ii) The provider’s Medical Staff department;
(iii) The clinical privileges he/she may exercise; and,
(iv) The Hospital or Hospitals at which such clinical privileges may be exercised; and,
(v) Any special conditions or restrictions attached the appointment.

18.4.9 Reapplicant after Adverse Appointment Decision

A practitioner seeking appointment or reappointment who has received a final adverse decision shall not be eligible to reapply to the Medical Staff for a period of three (3) years, unless the decision itself, or other provisions of these Bylaws, provide otherwise. The Medical Staff shall process any such reapplication as an initial application, and the applicant shall submit such additional information as the Medical Staff, the Hospital Boards may require to clearly demonstrate that the basis for the earlier adverse action no longer exists or will not recover.

18.4.10 Failure to Complete Application.

If the Hospital President, the Credentials Committee, the MEC or Hospital Board requests the applicant to provide additional information, or if the Medical Staff deems the application to be incomplete, and the
applicant does not provide such information within sixty (60) days from the request, the Medical Staff shall deem the application to have been voluntarily withdrawn by the applicant. The Hospital Board will not deem such withdrawal as an adverse appointment decision, and the applicant shall not be entitled to any procedural rights. In such event, the applicant may not submit another application for a period of one (1) year, absent special exception granted by the respective Hospital Board.

18.4.11 Time limitations.

No applicant shall be entitled to Medical Staff membership or clinical privileges due to the failure of any committee or Hospital Board to act on the application within a specified period. The time limits set forth in this Article are guidelines only and do not convey any substantive rights on the applicant.

18.4.12 Timetable for Processing

Every attempt will be made to have an application for initial appointment and clinical privileges acted upon by the Hospital Board within ninety (90) days of the date that the application is deemed complete per the complete application policy, with the understanding that (1) failure to meet a specific time requirement will not be deemed a waiver of the Medical Staff’s right to review and reject the application, if appropriate, and (2) that the time limits may be extended sixty (60) days if deemed necessary MEC or the respective Hospital Board. Where any provision in these Bylaws requires notice to or action by either Hospital Board, such additional procedural step(s) shall not be deemed to extend the procedural time requirements specified herein.
19.1 REAPPOINTMENT PROCESS

19.1.1 Form for Reappointment.

Reappointment will be continuous with approximately one twenty-fourth (1/24) of the staff processed per month. The Medical Staff President shall, six months before the expiration date of the present staff appointment of each Medical Staff member, provide such staff member with a reappointment application and request for clinical privileges prescribed by the Hospital Board for use in considering reappointment. Each Medical Staff member who desires reappointment shall, at least ninety (90) days before such expiration date, send his/her reappointment application and request for clinical privileges to the Medical Staff President or designee, or authorized Medical Staff Representative. Failure, without good cause, to return the form shall constitute a resignation of staff membership effective at the expiration of the member’s current term, without entitlement to the procedural rights provided in Section 14.

19.1.2 Credentials Committee Action

The Hospital President or Medical Staff Representative shall, in timely fashion, seek to collect or verify the additional information made available on each reappointment application and request for clinical privileges and to collect any other materials or information deemed pertinent, including information regarding the staff member’s professional activities, performance and conduct in the Hospital, any history of professional liability claims; limitations imposed upon insurance coverage; previously completed or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction or loss of clinical privileges, or denial of requested clinical privileges at another hospital.

The appropriate chair shall commence a review of the reappointment application and request for clinical privileges, the supporting documentation, and such other information available to him/her that may be relevant to consideration of the applicant's qualifications for the staff category, department affiliation, and clinical privileges requested, and the Hospital(s) at which the applicant wishes to exercise such clinical privileges. After the department chair completes this review, the department chair shall transmit to the Credentials Committee a report assessing the qualifications of the applicant for staff appointment and clinical privileges. The department chair will state the assessment in the report and support it by reference to the completed application and all other documentation considered by the department, all of which the department chair will transmit with the report.

The Credentials Committee, after reviewing each reappointment application and request for clinical privileges and all other relevant information available to it, including the recommendation(s) of the relevant department(s), shall transmit to the respective or joint MECs its report that shall include any minority views.
19.1.3 Medical Executive Committee Processing and Board Action

Thereafter, the Medical Staff shall follow the procedure provided in Sections 18.4.5 through 18.4.8. For purposes of reappointment, the Medical Staff shall read the terms "applicant" and "appointment" as used in those sections, respectively, as "staff member" and "reappointment."

19.1.4 Bases for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon evaluation of such member’s professional ability and clinical judgment in the treatment of patients, as indicated in part by the results of quality assessment and improvement activities (to include, but not be limited to, invasive procedure review, medication use evaluation and blood and blood product evaluation), his/her professional ethics, his/her discharge of staff obligations, his/her compliance with the Medical Staff Bylaws, rules and regulations, and all other established standards, policies and rules of the Hospital, his/her participation in continuing medical education activities, his/her cooperation with other practitioners, Hospital personnel and with patients, his/her participation in teaching programs, any other matters bearing on his/her ability and willingness to contribute good patient care practices at the Hospital, and any other lawful criteria.

19.1.5 Time Periods for Processing

Transmittal of the reappointment application and request for clinical privileges to a staff member and his/her return of it shall be in accordance with Section 19.1.1. Thereafter, except for good cause, the Hospital President, the Credentials Committee, the respective or joint MECs, as applicable, or the respective Hospital Board shall complete all actions before the expiration date of the staff membership of the member under consideration for reappointment.

If the processing of a reappointment has not been completed by the date of the expiration of the Medical Staff member’s current appointment, and such delay is not caused by the staff member’s failure to provide requested information, such appointment shall remain in effect until such processing has been completed. However, if the staff member is under suspension or a restriction of privileges previously imposed, such suspension or limitation shall continue in effect until such processing has been completed and a final decision made by the respective Hospital Board, or Inter-Hospital Committee in accordance with Section 2.9.1.

19.2 REQUEST FOR MODIFICATION OF APPOINTMENT

A Medical Staff member may, in connection with reappointment or at any other time, request modification of his/her staff category, Hospital affiliation, department assignment, or clinical privileges by submitting a written application to the Hospital President or designee, or authorized Medical Staff Representative, which shall be processed in substantially the same manner as provided in Section 19.1 for reappointment.

Whenever a practitioner anticipates performing a procedure or providing a service that is not included in his/her present privileges, the practitioner shall submit a written application to the Hospital President or designee(s), or authorized Medical Staff Representative, and the Medical Staff shall process such application in substantially the same manner as provided in Section 18.3.
Whenever a practitioner requests new or additional clinical privileges, for which the respective Hospital Board has not yet approved the criteria, the appropriate department chair, the MEC and the respective Hospital Board, (subject to Section 2.9.1) must approve the credentialing criteria before any action by the Credentials Committee. In such cases, the Medical Staff may request the practitioner to be present at the Credentials Committee’s review of the request.

19.3 VOLUNTARY RESIGNATION

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the respective or joint MECs or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner’s credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.
SECTION 20. CLINICAL PRIVILEGES

20.1 EXERCISE OF PRIVILEGES

Every practitioner or allied health professional providing direct clinical services at the either or both Hospitals by virtue of staff membership or otherwise shall, in connection with such practice and except as provided in Sections 20.5 and 20.6, be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted pursuant to the provisions of these Bylaws and the staff rules and regulations.

Granting of clinical privileges shall be subject to the provisions of any policy of exclusivity adopted by the Hospital Board (subject to Section 2.9.1 if applicable) and any adverse recommendation or action respecting clinical privileges based on the policy of exclusivity shall not give rise to any right to a hearing or appellate review provided in these Bylaws, including those provided in Section 14.

20.2 DELINEATION OF PRIVILEGES IN GENERAL

20.2.1 Requests

The Medical Staff will consider requests for clinical privileges only when the applicant accompanies it with evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in the criteria for clinical privileges as approved by the Hospital Board.

20.2.2 Bases for Privileges Determination

Requests for clinical privileges will be consistently evaluated based on prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. The Medical Staff may use additional factors in determining privileges including patient care needs, the Hospital’s capability to support the type of privileges the applicant is requesting, and the availability of qualified coverage in the applicant’s absence. The Medical Staff will base the privileges determination in connection with periodic reappointment or a requested change in privileges on such criteria noted in this Section 20.2.2, and such determination must include documented clinical performance and results of the practitioner’s performance improvement program activities. The Medical Staff will also base privileges determinations on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

20.2.3 Surgical Privileges

All applicants for staff appointment seeking surgical privileges other than for minor surgery must have completed the number of years of residency in a surgical residency or other specialty residency with a substantial surgical component, sufficient to satisfy the requirements for eligibility to become certified by
a specialty board recognized by the Committee on Post-Graduate Education, in effect at the date
application for staff membership is submitted;

A dentist applicant for staff appointment seeking oral and maxillofacial surgery privileges must have
completed the number of years residency in an oral and maxillofacial surgery residency program
approved by the American Dental Association Commission on Dental Accreditation sufficient to satisfy
the specialty board requirements for eligibility to become certified by the American Board of Oral and
Maxillofacial Surgery, in effect at the date application for staff membership is submitted;

The residency requirements in Section 20.2.3 do not apply to practitioners who presently hold Medical
Staff appointments and for whom the respective Hospital Board previously waived these requirements,
unless outlined in the Department Rules and Regs.

20.2.4 Procedure

The Medical Staff will process all requests for clinical privileges pursuant to the procedures outlined in
Section 20 of the Medical Staff Bylaws.

20.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

The Medical Staff will process requests for clinical privileges from dentists in the manner specified in
Section 20.2. All dental patients shall receive the same basic medical appraisal as patients admitted to
other surgical services; the medical executive committee may designate oral and maxillofacial surgeons
who may perform the physical examinations and prepare the histories for their own patients. A physician
member of the 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 and shall determine the risk and effect of the
proposed surgical procedure on the total health status of the patient. Except in the event of an emergency
admission, the Medical Staff will identify the responsible physician member of the staff before admission
of the patient for surgery that a dentist member of the staff will perform.

20.4 ALLIED HEALTH PROFESSIONALS

Scope of practice for allied health professionals, including, but not limited to, physicians' assistants,
CRNAs, nurse practitioners, psychologists, certified nurse midwives and clinicians, shall be based upon
investigation and evaluation of the education, training, experience and demonstrated ability and judgment
of individuals requesting scope of practice as allied health professionals, according to criteria and
procedures recommended by the Medical Staff and approved by the Hospital Board, subject to Section
2.9.1 as applicable. A recommendation by or on behalf of the Medical Staff not to grant scope of practice
to an applicant for appointment as an allied health professional, or to suspend, to terminate, or to
discontinue such scope of practice, or such a decision by the respective Hospital Board, shall not give rise
to any procedural rights set forth in Section 14.

The Medical Staff or MEC shall recommend criteria for granting scope of practice to allied health
professionals in accordance with the procedures set forth in these Bylaws. Such criteria shall become
effective upon approval of the respective Hospital Board, subject to Section 2.9.1 as applicable, provided
that such recommendation shall not restrict, or in any way interfere with or supersede, any legal rights of
the Hospital or the Medical Group (Summit Physician Services) to terminate the employment of any allied health professional consistent with employment, contractual or other applicable laws.

20.5 TEMPORARY PRIVILEGES

20.5.1 Circumstances

Upon the written concurrence of or notice to the chair of the department where the privileges will be exercised, the Medical Staff President or the Hospital President, subject to Hospital Board approval if warranted, may grant temporary privileges in the following circumstances, after receipt and verification of written request for temporary privileges, curriculum vitae, evidence of current professional liability insurance, evidence of current license to practice medicine/dentistry in the state of Pennsylvania and evidence of current DEA certificate:

Care of Specific Patients: Upon receipt of items requested in Section 20.5.1, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients;

Locum Tenens: Upon receipt of items requested in Section 20.5.1, an appropriately licensed practitioner who is serving as a locum tenens for a member of the staff may, without applying for membership on the staff, be granted temporary privileges for an initial period of no more than ninety (90) days. Locum tenens requiring privileges for a period greater than ninety (90) days shall be required to apply for appointment to the Medical Staff. The clinical privileges of a locum tenens physician terminate upon cancellation of his or her contract with the Hospital or employing physician. Locum tenens shall not be entitled to the procedural rights afforded by Section 14 as a result of denial of temporary privileges or because of any termination or suspension of temporary privileges.

Special Circumstances: Where (1) the Hospital has processed an application for appointment which has been deemed complete per the policy regarding a complete application and (2) the appropriate department chair/chairs has/have recommended the applicant for appointment and (3) the respective MEC has reported that the applicant is trained, experienced and qualified for the privileges requested, and (4) where patient care would be adversely affected by a delay in the granting of privileges, limited clinical privileges may be granted for a period not to exceed sixty (60) days, subject to Hospital Board approval if warranted. Requests for extension of these privileges would require endorsement of the Credentials Committee at their next regularly scheduled meeting. Any practitioner granted such privileges would act under the supervision of the chair of the department to which MEC assigns him/her. The Medical Staff may not use this section to grant privileges where the applicant has failed to submit a timely application or has failed to provide requested information.

20.5.2 Conditions

The respective Hospital Board shall grant temporary privileges only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has provided evidence of professional liability insurance coverage or other evidence of financial responsibility in accordance with Section 2.6.6. The chair of the department responsible for supervision of a practitioner granted temporary privileges might impose special requirements of consultation. Before a Hospital Board
grants temporary privilege, the practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, and rules and regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

20.5.3 Termination.

The Hospital may terminate any temporary privileges (after consultation with the department chair responsible for supervision or the Medical Staff President). Any person entitled to impose summary suspensions under Section 4 may cause such termination if he/she determines that the continued treatment by a practitioner with temporary privileges endangers the life or well-being of a patient. In the event of any termination, the department chair shall assign the practitioner’s patients then in the Hospital to another practitioner for supervision. The department chair shall consider the wishes of the patient, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

20.5.4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by Section 14 resulting from denial of temporary privileges or because of any termination or suspension of temporary privileges.

20.5.5 Residents Working With Medical Staff Members

Upon written concurrence of the chair (or, if not available, vice-chair) of the department where privileges will be exercised, and the Medical Staff President (or, if not available, officer of the staff), the Hospital President (or, if not available, officer of the Hospital) may grant temporary privileges to a resident who will be working with a member of the Medical Staff, subject to approval of the respective Hospital Board.

The Hospital Board may grant such privileges for an initial period of thirty-one (31) days. The Hospital Board may renew such privileges for a maximum of two consecutive additional periods of thirty-one (31) days.

The Hospital Board may grant temporary privileges for a resident working with a staff member only after the Medical Staff receives the following items:

An application form that has all required attachments and no unexplained blanks as well as a request for specific privileges and which has been signed and dated by the resident and by the supervising staff member;

Copy and verification of current, valid Pennsylvania license to practice medicine;

Copy of current, valid DEA registration, if applicable;

Reference from the Residency Director; and

Evidence of current liability policy that covers the resident for work within the Hospital, and applicable affiliates.
In exercising the privileges granted, the resident shall act under the direct supervision of the supervising Medical Staff member, as well as under the supervision of the chair of the supervising staff member's department.

The resident may perform procedures within the scope of his/her practice only within the presence of the supervising Medical Staff member before, during, and after the procedure.

The supervising staff member must countersign all chart entries made by the resident.

On the discovery of any adverse information, or the occurrence of any event of a professionally questionable nature, pertinent to an individual's qualifications to exercise any or all of the temporary privileges granted, the privileges in question may be terminated by the Medical Staff President after consultation with the supervising department chair or the Hospital President, or by any individual or body entitled to impose a summary restriction or suspension under the policy for summary restrictions or suspensions in a case where the life or well-being of a patient is determined to be endangered by continued exercise of the privileges.

A resident shall not be entitled to procedural rights because of his inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

The Medical Staff must query the National Practitioner Data Bank for all residents requesting temporary privileges to work with staff members.

20.6 EMERGENCY PRIVILEGES

For the purposes of this Section, the Bylaws define an "emergency" as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license, regardless of department, staff status or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm.

20.7 BOARD CERTIFICATION

Nothing in these Bylaws prohibits the use of board certification as criteria for obtaining clinical privileges, if the board has authorized such use.
SECTION 21. CLINICAL COMPETENCY EVALUATION

21.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, after receiving a recommendation from the department chair, and with the approval of the MEC will define the circumstances that require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including, but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

21.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. The Medical Staff shall undertake OPPE as part of its evaluation, measurement, and improvement of practitioner’s current clinical competency. In addition, each practitioner may be subject to FPPE when the Medical Staff identifies (through its OPPE process) issues affecting the provision of safe, high quality patient care. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual’s current clinical competence, practice behavior, and ability to perform a specific privilege.

21.3 PHYSICIAN RE-ENTRY

A practitioner who has not provided acute inpatient care within the past two (2) years (unless there are extenuating circumstances at the department chair’s discretion) who requests clinical privileges at the Hospital must arrange for a preceptorship, that is acceptable to the Credentials Committee and the respective or joint MECs, either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the Hospital. If a practitioner has not provided any clinical care within the past five (5) years as determined by the Pennsylvania medical licensing board or the MEC, he/she shall be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other formal process to assess and confirm clinical competence. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the department chair and/or credentials committee and the respective or joint MECs. At a minimum, the preceptorship or training program description must include the following:
Title: MS Bylaws - Section 21 - Clinical Competency Evaluation CH

A. The scope and intensity of the required activities;

B. The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant’s demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

21.4 EFFECT OF CONTRACT OR EMPLOYMENT EXPIRATION OR TERMINATION

The terms of a practitioner’s contract with the Hospital will solely govern the effect of expiration or other termination of a contract upon a practitioner’s staff appointment and clinical privileges. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner’s staff appointment status or clinical privileges.
SECTION 22. MEDICAL ADMINISTRATIVE OFFICERS

22.1 A medical administrative officer is a practitioner engaged by the Hospital, either full or part time, in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

22.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

22.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

22.3.1 Where a contract exists between the officer and the Hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

22.3.2 In the absence of a contract, or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the respective Hospital Board, subject to Section 2.9.1 as applicable.

22.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.
SECTION 23. LEAVE OF ABSENCE

23.1 LEAVE REQUEST

A leave of absence is a period of time when the respective Hospital Board excuse a practitioner from his/her Medical Staff responsibilities (e.g., emergency department call, committee participation, etc.). The provider must request a leave of absence for any absence from the Medical Staff and/or patient care responsibilities longer than sixty (60) days. The request should indicate whether the absence is due to the individual’s physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the reasons for the leave and approximate period of the leave, which may not exceed one year except for military service or express permission by the respective Hospital Board. The practitioner must forward requests for leave with a recommendation from the respective or joint MECs as affirmed by the respective Hospital Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where the respective Hospital Board does not grant a request for an extension, the determination shall be final, with no recourse to a hearing and appeal.

23.2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or respective Hospital Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Hospital Board may have as part of considering the request for reinstatement. The MEC will make a recommendation to the respective Hospital Board concerning reinstatement, and will follow the applicable procedures concerning the granting of privileges. If the practitioner’s current grant of membership and/or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

23.3 FAILURE TO REQUEST REAPPOINTMENT

23.3.1 The respective Hospital Board will deem that failure of the provider, without good cause, to request reappointment is a voluntary resignation from the Medical Staff and shall result in automatic termination or revocation of membership, privileges, and prerogatives; said terminated provider is not entitled to the procedural rights provided in Part II of these Bylaws. If the terminated provider subsequently submits a request for Medical Staff membership, the Medical Staff shall process it in the manner specified for applications for initial appointment and/or clinical privileges.