BYLAWS OF

THE PROFESSIONAL MEDICAL STAFF

Amended: Approved by the Board of Governors: October 22, 2024
(Historical amended and approved dates are located on the last page)

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PREAMBLE

TEMPLE UNIVERSITY HOSPITAL, INC. (“Temple University Hospital or the “Hospital”) is an affiliate of the Temple University Health System, Inc. (“TUHS”), a wholly owned not-for-profit subsidiary corporation of Temple University, of the Commonwealth System of Higher Education, organized under the laws of the Commonwealth of Pennsylvania; and

The Hospital is part of TUHS, whose entities collaborate with each other to achieve high quality, high value, patient-focused, safe healthcare services across the spectrum of care; and

Its purpose is to provide health care, education, and research; and

The Board of Governors has delegated to the Professional Medical Staff the responsibility for the quality of medical care delivered in the Hospital by individuals to whom clinical privileges have been recommended by the Professional Medical Staff and granted by the PAC. It is recognized that the Professional Medical Staff must accept and discharge this responsibility, that the authority for administration of the Hospital is vested in the CEO (as delegated by the Board Chair and Chief Executive Officer of Temple University Health System, and subject to the ultimate authority of the Board of Governors of Temple University Hospital) and that the cooperative efforts of the Professional Medical Staff, the Administrative Staff, and the Board of Governors are necessary to fulfill the Hospital's obligation to its patients. It is further recognized that the Board is obligated to inform the Professional Medical Staff of matters that pertain to the role and responsibility of the Medical Staff; and

These Bylaws of the Professional Medical Staff (1) provide for the organization of the Professional Medical Staff of Temple University Hospital, (2) provide a framework to permit the Professional Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and (3) govern the orderly resolution of those purposes.

The physicians, podiatrists, dentists and oral surgeons practicing in Temple University Hospital organize themselves into a Professional Medical Staff in conformity with these Bylaws and Rules and Regulations.

DEFINITIONS

1. ACADEMIC CHAIR means an individual who has been appointed by the Dean of the Medical School to be the Chair of an academic department of the Medical School; in some but not all cases this is the same individual as the Department Chair of a corresponding Hospital clinical Department.

2. ACADEMIC YEAR means a twelve (12) month period, beginning on July 1 and ending on June 30, of any Year. See also, YEAR.

3. ACGME means the Accreditation Council for Graduate Medical Education.

4. ADMINISTRATION or HOSPITAL ADMINISTRATION means the CEO and those senior administrative Staff who report to him/her.

5. ADVERSE ACTION means a recommendation by the Medical Staff Executive Committee or a decision by the Professional Affairs Committee that will adversely affect a Medical Staff Member's or Applicant's appointment to, or status as, a Medical Staff Member, or will adversely affect his/her exercise of Clinical Privileges.

6. APPLICANT means a physician, podiatrist, dentist, oral surgeon or SPP who has, or is in the process of, seeking Professional Medical Staff membership and/or Clinical Privileges, as applicable.

7. ATTENDING/ATTENDING PHYSICIAN means the member of the Professional Medical Staff who has overall responsibility for the management of the care of his/her patients.

8. BOARD means the Board of Governors of the Hospital. Unless prohibited by law or these Bylaws, the Board may act through its CEO as its authorized representative.

9. BUSINESS DAY is defined as a day of the week, Monday through Friday between the hours of 7:00 A.M. and 5:00 P.M., except for Federal Holidays.

10. BYLAWS means these Bylaws of the Professional Medical Staff, including the Rules and Regulations and Appendices attached hereto, as they may be amended from time to time.

11. CEO means the person appointed by the Board of the Hospital to act on its behalf as Chief Executive Officer in the overall management of the Hospital or, the person designated to act for the CEO if he/she is unavailable.

12. CHIEF MEDICAL OFFICER (CMO) means the person appointed by the CEO to act on the hospital's behalf as a liaison between the physicians and the Hospital at the main campus located at 3401 and 3509 N. Broad Street, Philadelphia, PA 19140. He/she is considered a Medical Administrative Officer.

13. CLINICAL PRIVILEGES means the specific patient services a Professional Medical Staff Member or SPP may provide.

14. CORRECTIVE ACTION means informal Collegial Intervention or Formal Corrective Action as more fully described in Articles VII and VIII herein.

15. DAYS mean calendar days, unless otherwise specified in the Bylaws.

16. DENTIST means an individual who holds a current and valid license to practice dentistry.

17. DEPARTMENT means a clinical department of the Hospital or Medical Staff, which may be different from the Academic Department.

18. DEPARTMENT CHAIR means the director of the Hospital clinical Department, or the physician designated to act for the Department Chair if he/she is unavailable. This position is distinct from the Academic Chair position, which is designated and vested with responsibilities through the Lewis Katz School of Medicine at Temple University, the Maurice H. Kornberg School of Dentistry – Temple University, and/or School of Podiatric Medicine – Temple University.

19. ENDOSCOPY CENTER OF THE NORTHEASTERN CAMPUS, A DIVISION OF TEMPLE UNIVERSITY HOSPITAL ("ECNC") means a licensed facility located at 2301 E. Allegheny Avenue, Philadelphia, PA 19134, for the performance of endoscopic procedures at Northeastern Campus. ECNC is a fully integrated provider-based Department of the Hospital that falls within the medical governance structure set forth in the Bylaws.

20. EPISCOPAL CAMPUS (EC) means a Satellite Campus of Temple University Hospital located at 100 E. Lehigh Avenue, Philadelphia, PA 19125, that falls within the medical governance structure set forth in these Bylaws.

21. EXECUTIVE SESSION means a closed portion of a Medical Staff Committee Meeting, PAC meeting or Board meeting when only voting members of the committee (and, if invited, non-voting legal counsel) deliberate and vote on highly sensitive matters.

22. FACULTY means Physicians on the faculty of the Lewis Katz School of Medicine at Temple University, Podiatrists on the faculty of the School of Podiatric Medicine – Temple University, and Dentists and Oral Surgeons on the faculty of the Maurice H. Kornberg School of Dentistry – Temple University.

23. FINAL ACTION means a non-appealable action taken by the Professional Affairs Committee (PAC) after a Practitioner's or Applicant's waiver or exhaustion of their rights under Article VIII, herein.

24. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) means an intensive assessment of a Practitioner's credentials and current competence as described in the Hospital's FPPE Policy.

25. GOOD CAUSE means circumstances, not reasonably avoidable, that provide reason to deviate from action otherwise prescribed by these Bylaws.

26. GRADUATE MEDICAL TRAINEES mean physicians, podiatrists, dentists and oral surgeons who are in training in Hospital-sponsored graduate medical education programs or who are rotating from other institutions in Hospital-approved graduate medical education activities (See also, RESIDENTS AND FELLOWS).

27. HCQIA means the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-499, as amended.

28. HOSPITAL means Temple University Hospital, Inc. including its main campus at 3401 and 3509 N. Broad Street, Philadelphia, PA 19140, in-patient and out-patient sites and Satellite Campuses, including its EC, ECNC and JC.

29. HOSPITAL CAMPUS CMO (HCCMO) means a Chief Medical Officer of any Satellite Campus of the Hospital who acts under the authority of and reports to the HCED.

30. HOSPITAL CAMPUS EXECUTIVE DIRECTOR (HCED) means the Executive Director of any Satellite Campus of the Hospital who acts under the authority of and reports to the CEO.

31. HOSPITALIST means a hospital-based general physician who assumes the responsibility of admitted patients.

32. HOSPITAL POLICIES mean the Bylaws of the Professional Medical Staff, policies, procedures, protocols, guidelines, rules and regulations, or other requirements properly adopted by the Hospital, as they may be amended from time to time.

33. JEANES CAMPUS (JC) - means a Satellite Campus of Temple University Hospital located at 7600 Central Ave, Philadelphia, PA 19111, that falls within the medical governance structure set forth in these Bylaws.

34. JUST CULTURE means a culture that requires full disclosure of mistakes, errors, near misses, patient safety concerns, and sentinel events in order to facilitate learning from such occurrences and identifying opportunities for process and system improvement. It is also a culture of accountability in which individuals will be held responsible for their actions within the context of the system in which they occurred; such accountability may involve system improvement or individual counseling, coaching, education, or corrective action. It is a culture that balances the need to learn from mistakes with the need to take corrective action against an individual if the individual's conduct warrants such action.

35. MCARE means the Medical Care Availability and Reduction of Error Act (Act 13 of 2002, as amended) established by the Commonwealth of Pennsylvania to ensure that medical care is available in the Commonwealth through a comprehensive and high quality health care system.

36. MEMBER means a member of the Professional Medical Staff.

37. NATIONAL PRACTITIONER DATA BANK (NPDB) means the national clearinghouse established pursuant to the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-499, as amended, for obtaining and reporting information with respect to Adverse Actions or malpractice claims against physicians and other practitioners.

38. NOTICE means the process of informing Medical Staff Members or other individuals of Medical Staff activities such as meetings, elections, Bylaws and Policy amendments, and the like. Notice may be provided by first class mail, hand delivery or electronic transmission (See also, SPECIAL NOTICE).

39. OFFICER means an officer of the Professional Medical Staff elected by the voting members of the Professional Medical Staff.

40. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) means a summary of ongoing data collected for the purpose of assessing a Practitioner's clinical competency and professional behavior as described in the Hospital's OPPE Policy.

41. ORAL SURGEON means an individual who holds a current and valid license to practice oral surgery.

42. OUTSIDE SERVICE OR ENTITY means an external credentialing service utilized at the discretion of the MSEC and the PAC.

43. PAC means the Professional Affairs Committee of the Board.

44. PHYSICIAN means an individual who holds a current and valid license to practice medicine and/or surgery.

45. PODIATRIST means an individual who holds a current and valid license to practice podiatric medicine and/or podiatric surgery.

46. PRACTITIONER means a Physician, Podiatrist, Dentist, Oral Surgeon, or an SPP as defined herein.

47. PRESIDENT OF THE PROFESSIONAL MEDICAL STAFF OR PRESIDENT OF THE MEDICAL STAFF means the Medical Staff Member elected by the Members of the Professional Medical Staff to serve as its President or the Officer designated by these Bylaws to act for the President of the Medical Staff if he/she is unavailable.

48. PROFESSIONAL MEDICAL STAFF, MEDICAL STAFF or MEDICAL STAFF MEMBERS means those physicians, dentists, oral surgeons and podiatrists who have been appointed as members of the Professional Medical Staff pursuant to the terms of these Bylaws.

49. PROFESSIONAL MEDICAL STAFF POLICIES OR MEDICAL STAFF POLICIES means the Medical Staff Bylaws, Rules and Regulations, policies, procedures, protocols, guidelines, or other requirements properly adopted by the Professional Medical Staff, MSEC, or other Professional Medical Staff Committee, as they may be amended from time to time.

50. PROXY means a voting member of the Medical Staff or of a Medical Staff Committee: (1) who has been granted authority by another voting member to vote on her/his behalf at a Medical Staff Meeting or Medical Staff Committee meeting; (2) who may, at the discretion of the grantor, either exercise the grantor's pre-determined vote or vote by exercising the Proxy's own judgment after participating in discussion/deliberation,; and (3) whose identity and type of voting authority has been provided before such meeting, in writing, to the Immediate Past-President of the Professional Medical Staff or Committee Chair, as applicable.

51. QUALIFIED MEDICAL PERSONNEL mean physicians and SPP (within their scope of practice) who may perform Medical Screening Examinations on patients seeking care for an emergency medical condition as described in the Hospital's EMTALA Policy.

52. RESIDENTS AND FELLOWS means physicians, podiatrists, dentists and oral surgeons who are in training in Hospital-sponsored graduate medical education programs or who are rotating from other institutions in Hospital-approved graduate medical education activities (See also, GRADUATE MEDICAL TRAINEES).

53. SATELLITE CAMPUS means any Hospital campus not located at 3401 and/or 3509 N. Broad Street, Philadelphia, PA 19140. Satellite Campuses include EC, ECNC and JC.

54. SECTION means a clinical section of a Hospital Department or Medical Staff, which may be different from Academic Sections.

55. SECTION CHIEF means the director of a Section of the Hospital or, the physician designated to act for the Section Chief if he/she is unavailable.

56. SCHOOL OF DENTISTRY means the Maurice H. Kornberg School of Dentistry - Temple University.

57. SCHOOL OF MEDICINE means the Lewis Katz School of Medicine at Temple University.

58. SCHOOL OF PODIATRIC MEDICINE means the School of Podiatric Medicine - Temple University.

59. SPECIAL NOTICE means a written notice transmitted by Hand Delivery or Overnight Carrier with tracking capability (See also, NOTICE).

60. SPECIFIED PROFESSIONAL PERSONNEL (SPP) - Specified professional personnel are individuals who are duly licensed practitioners or persons otherwise qualified to render direct medical care under the supervision of a member of the medical staff and who are capable of effectively communicating with patients, the medical staff and hospital personnel. .

61. STATE means the Commonwealth of Pennsylvania.

62. TELEMEDICINE/TELEHEALTH means the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration which includes videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

63. THE JOINT COMMISSION (TJC) means the accrediting body for the Hospital, whose standards are referred to in these Bylaws.

64. TUHS HOSPITAL means a hospital, including its satellite hospital campuses which have Temple University Health System as its sole corporate member.

65. UNIVERSITY means Temple University, Of the Commonwealth System Of Higher Education, organized under the laws of the Commonwealth of Pennsylvania.

66. VOID means invalid from the outset.

67. YEAR means a calendar year beginning on January 1 and ending on December 31 (See also, ACADEMIC YEAR).

ARTICLE I: NAME

1.1 NAME

1.1.1 The name of the organization is the “Professional Medical Staff of Temple University Hospital.”

ARTICLE II: OBJECTIVES

2.1 THE OBJECTIVES OF THE PROFESSIONAL MEDICAL STAFF ARE:

a) To create standards regarding the professional performance and ethical conduct of its Medical Staff Members and to strive to ensure that patients treated by the Hospital will receive medical care within appropriate standards of care;

b) To promote quality medical care by providing an ongoing review and evaluation of the overall care provided by the Hospital, and the performance of each Medical Staff Member and SPP in the delivery of that care;

c) To provide a mechanism for reviewing the qualifications of Medical Staff Members and SPP with respect to their appointment, reappointment, and determination of Clinical Privileges;

d) To make recommendations to the PAC regarding Medical Staff membership and Clinical Privileges in connection with initial appointments, reappointments and Clinical Privilege requests, and Corrective Action as appropriate;

e) To monitor the performance of Medical Staff Members and SPP and to initiate and pursue Corrective Action when a Medical Staff Member's or an SPP's performance falls below the standards established by the Professional Medical Staff;

f) To educate physicians and other health care professionals, conduct educational programs, maintain high educational standards, and encourage continuous advancement in professional knowledge and skill;

g) To initiate and maintain Rules and Regulations for self-governance of the Professional Medical Staff; and

h) To provide a means whereby issues concerning the Professional Medical Staff, SPP and the Hospital may be resolved.

These Bylaws are adopted by Temple University Hospital and its Professional Medical Staff solely for internal governance. They are not intended to serve either as (1) evidence of a standard of reasonable conduct for the determination of civil liability between any consumer of health care services and the University, the Hospital, or any person employed by or associated with the Hospital or (2) an undertaking by TUHS, the University, the Hospital or its Professional Medical Staff to any consumer of health care services.

ARTICLE III: MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

3.1.1 Privilege. Membership on the Professional Medical Staff is a privilege that is extended only to licensed, competent physicians, podiatrists, dentists, and oral surgeons who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

3.1.2 Provision of Medical Services. No physician, podiatrist, dentist, or oral surgeon, including those in a medical administrative position or those under contract with the Hospital, will admit or provide medical or health-related services to patients in the Hospital unless (a) he/she is a member of the Professional Medical Staff and has been granted the Clinical Privileges to provide such services in accordance with the procedures set forth in these Bylaws, or (b) he/she has been granted Temporary Privileges to provide such services in accordance with the procedures set forth in these Bylaws.

3.1.3 Cessation of Clinical Privileges. A physician, podiatrist, dentist, or oral surgeon who ceases to be a Professional Medical Staff member ceases to have any Clinical Privileges.

3.1.4 Cessation of Medical Staff Membership. A physician, podiatrist, dentist, or oral surgeon on the Active Medical Staff, Associate Medical Staff, Consulting Medical Staff or Coverage Medical Staff who ceases to have any Clinical Privileges and is ineligible for Affiliate or Emeritus status ceases to be a Professional Medical Staff member unless otherwise specifically recommended by the Credentials and Practitioner Review Committee and the MSEC, subject to approval by the PAC.

3.1.5 Specified Professional Personnel. SPP are not members of the Medical Staff, but certain SPP may be granted Clinical Privileges to practice within the scope of their licensure or certification, training, and demonstrated competence, and as defined by the Medical Staff in accordance with the Medical Staff SPP policy. SPP may be appointed as voting or non-voting members of Medical Staff committees.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2.1 No Entitlement. Physicians, podiatrists, dentists, and oral surgeons applying for appointment to the Professional Medical Staff must meet the requirements set forth in these Bylaws, Professional Medical Staff Policies and Hospital Policies unless such requirement is waived in accordance with these Bylaws.

No physician, podiatrist, dentist or oral surgeon is automatically entitled to appointment to the Professional Medical Staff because they meet the requirements of these Bylaws.

3.2.2 General Qualifications. Physicians, podiatrists, dentists, and oral surgeons applying for appointment or reappointment to the Professional Medical Staff must comply with the following general qualifications for appointment to the Staff:

(a) Satisfactorily document their (1) licensure, (2) appropriate experience, education, and training, (3) professional competence and good judgment, (4) appropriate personal and professional qualifications, and (5) adequate physical and mental health status, so as to demonstrate that they are professionally competent and behave in an ethical manner, and that patients treated by them can reasonably expect to receive quality medical care;

(b) Agree to (1) adhere to the ethics of their respective professions, (2) work cooperatively with others so as to not adversely affect patient care and the efficient administration of the Hospital, and (3) participate in and properly discharge those responsibilities determined by the Professional Medical Staff;

(c) Have skills and training to fulfill patient care needs provided that the Hospital has adequate facilities and support services for the Applicant and his/her patients; and

(d) Except for Medical Staff Members in the Affiliate or Emeritus Categories, maintain in force professional liability insurance in not less than the minimum amounts, if any, as required by law or such higher minimum amounts, if any that from time to time may be established by the MSEC, the CEO, the PAC or the Board applicable to the Clinical Privileges sought or granted. The MSEC, CEO the PAC or the Board may establish other requirements with respect to such professional liability insurance including, but not limited to, criteria relating to the type of and financial standing of the entity providing the insurance.

3.3 EFFECT OF OTHER AFFILIATIONS

No physician, podiatrist, dentist, or oral surgeon is entitled to membership on the Professional Medical Staff or to the exercise of certain Clinical Privileges solely because he/she holds a certain degree, is licensed to practice in a state, is a member of a professional organization, is certified by a specialty clinical board, is associated with a university or medical school, holds certain employment, is affiliated with any practice, or because such Practitioner had, or currently has, Medical Staff membership or privileges at another health care facility or in another practice setting.

3.4 NONDISCRIMINATION

No aspect of Professional Medical Staff membership or of particular Clinical Privileges will be granted or denied on the basis of race, age, religion, ancestry, color, national origin, sexual orientation, gender identity, or other unlawful basis.

3.5 WAIVER OF QUALIFICATIONS

Any qualification for membership required in these Bylaws that is not required by law or for TJC accreditation or ineligibility to apply for Professional Medical Staff membership set forth in these Bylaws may be waived at the discretion of the Credentials and Practitioner Review Committee and the MSEC, subject to the approval of the PAC or its designee, upon determination that: (1) based on an objective and comprehensive review of the Applicant's qualifications, he or she meets or exceeds the standards of competence and professionalism of those Practitioners who possess the specific qualification that is being waived; and (2) such waiver will serve the best interests of the patients and the Hospital.

3.6 RESERVED

3.7 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each member of the Professional Medical Staff include:

a) Providing patients with the quality of care that meets the standards of the profession and of the Professional Medical Staff;

b) Abiding by the Professional Medical Staff Bylaws, Medical Staff Policies and Hospital Policies;

c) Discharging in a responsible and cooperative manner such responsibilities and assignments imposed upon the Medical Staff Member by virtue of Professional Medical Staff membership, including committee assignments;

d) Preparing and completing in timely and appropriate fashion medical records for all the patients for whom the Medical Staff Member provides care at the Hospital;

e) Preparing and completing medical histories and physical examinations consistent with the Hospital policy regarding the same. All histories and physicals must be timely, pertinent and complete.

f) Abiding by legal requirements and payor requirements, including without limitation, the requirements of Medicaid, Medicare or any other federal or state health care program, as applicable;

g) Abiding by ethical principles of the Medical Staff Member's profession, including a written acknowledgment that:

   i. The Member shall not rebate a portion of a fee or accept other inducements in exchange for patient referral;

   ii. The Member shall not deceive a patient as to the identity of an operating surgeon, or any other medical practitioner providing treatment or services; and

   iii. The Member shall not delegate the responsibility for diagnosis or care of patients to another medical practitioner unless the Member believes such practitioner to be qualified to do so;

h) Aiding in Professional Medical Staff approved educational programs as reasonably requested;

i) Working cooperatively with other Professional Medical Staff Members, Specified Professional Personnel, Hospital Administration, and others so as to not adversely affect patient care or disrupt Hospital operations;

j) Making appropriate arrangements for coverage to ensure the provision of continuous care for his/her patients as required by the Department Chair and determined by the MSEC and the Hospital;

k) Being located closely enough (office and residence) to the Hospital during coverage periods to provide continuous care to patients as defined by the applicable Department Chair or Section Chief or Satellite Campus Division Chief;

l) Carrying out any applicable supervisory duties, as a supervisory or collaborating physician for SPP, in accordance with applicable law and any applicable supervisory/collaborative agreements.

m) Participating in continuing education programs as recommended by the Credentials and Practitioner Review Committee or Peer Review Committee and required by applicable licensing laws and regulations, the MSEC or the

Hospital. These include programs that may be sponsored by the Hospital or Medical School and relate to the type or nature of care offered at the Hospital and to the findings of Performance Improvement activities;

n) Fully cooperating with the Professional Medical Staff and Hospital Administration in connection with lawsuits and potential lawsuits, government investigations and queries, quality, safety and utilization reviews, TJC, licensure, and other surveys, and payor inquiries. In turn, the Hospital must promptly notify insured members of the Medical Staff of accepting notice of service of a subpoena or other legal process on behalf of the Medical Staff Member;

o) Notifying the Department Chair, the Medical Staff Office and CEO immediately of:

    i. The termination, revocation, suspension, surrender or voluntary relinquishment of his/her professional license or the imposition of terms of probation or limitation of practice by any state licensing agency;

    ii. The termination, revocation, suspension, surrender or voluntary relinquishment of Medical Staff membership or clinical privileges or any final action regarding application for medical staff membership or credentials that is unfavorable, and the basis thereof, at any hospital or other health care institution or the imposition of terms of probation or limitation of practice by any hospital or health care institution;

    iii. The receipt of a notice of exclusion or proposed exclusion from participation in Medicare, Medicaid, or any other federal or state health care program or of an investigation that could result in such a notice;

    iv. Being arrested or charged with a misdemeanor involving the use or possession of alcoholic beverages or drugs or with any felony;

    v. Being involved in any complaints, offenses or disciplinary actions reportable under MCARE, including (1) medical malpractice complaints; (2) disciplinary actions taken by other States; (3) convictions for offenses above a summary offense; (4) arrests for a felony or an offense under the Controlled Substance, Drug Device and Cosmetic Act, (5) arrests for criminal homicide, aggravated assault and sexual offenses per the MCARE Statute; and (6) privilege terminations or reductions by health care facilities;

vi. Being convicted of any crime (including a plea of nolo contendre or guilty plea);

vii. The loss or failure to maintain any status or credential that is required for the Medical Staff Member's Professional Medical Staff membership or category of membership or Clinical Privileges;

viii. For Members in the Active or Associate Staff categories, the entrance into an employment or other contractual relationship with another hospital, health system, or university, or with an organization controlled by, or aligned or affiliated with, another hospital, health system, or university; and

ix. Any change in the status of a work Visa.

p) Fully participate in hospital investigations, including but not limited to Root Cause Analysis meetings or Peer Review activities;

q) Carrying out duties assigned by his/her Department Chair(s) and Section Chief(s) and Satellite Campus Division Chief(s); and

r) Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Professional Medical Staff, the Credentials and Practitioner Review Committee, the MSEC, and the Hospital Administration, the PAC or the Board.

ARTICLE IV: CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of Professional Medical Staff membership are: Active Medical Staff, Associate Medical Staff, Affiliate Medical Staff, Consulting Medical Staff, Coverage Medical Staff and Emeritus Medical Staff.

4.2 ACTIVE MEDICAL STAFF

4.2.1 Defined. The Active Medical Staff consists of Physicians, Podiatrists, Dentists, and Oral Surgeons who shall:

(a) Meet any of the following criteria:

(1) Are Faculty; or

(2) Have at least twelve (12) clinical patient contacts per year, which include inpatient admissions, consultations, or inpatient or outpatient invasive procedures, except as expressly waived for Practitioners with at least ten (10) years of service in the Active Category or for those Practitioners who document their efforts to support the Hospital's patient care mission to the satisfaction of the MSEC and the PAC; or

(3) Hold a Clinical Department Chair position at another TUHS Hospital; and

(b) Maintain and exercise Clinical Privileges unless such requirement is waived at the discretion of the PAC

(c) Attend Medical Staff, department and committee meetings, as assigned.

4.2.2 Multiple Sites. A Physician, Podiatrist, Dentist, or Oral Surgeon may practice at more than one hospital within TUHS, but must designate one hospital or Satellite Campus as his/her primary site.

4.2.3 Qualifications. The qualifications for an Active Medical Staff Member include:

(a) Meet the qualifications for membership set forth in this section 4.2 and the general qualifications as set

forth in Bylaws section 3.2; or be granted a waiver of particular qualifications in compliance with Bylaws section 3.5;

(b) Be licensed to practice in the Commonwealth of Pennsylvania;

(c) Board Certification.

(i) An Applicant or Member must be Board Certified, meaning that the individual is certified or has been re-certified as a specialist for the primary specialty and/or subspecialty applicable to his/her practice by a specialty board recognized by: (1) the American Board of Medical Specialties or an equivalent international Board recognized by the Pennsylvania Board of Medicine; or (2) the American Osteopathic Association's Council for Graduate Medical Education; or (3) the Pennsylvania Board of Dentistry; or (4) the American Board of Maxillo-Facial Surgery; or (5) the Council on Podiatric Medical Education, as applicable; or

(ii) If not Board Certified, then a Board Eligible Applicant or Member (i.e., an Applicant or Member who has met the threshold educational, post-graduate training and skill qualifications but has not yet passed the board certification examination) may be appointed to the Medical Staff for up to five (5) years from the completion of the applicant's highest level of post-graduate training to achieve board certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Dental Association or the American Podiatric Medical Association or the equivalent international boards of the Applicant or Member, as applicable. If Board Certification is not attained within the time period specified above, the Applicant will not be eligible for initial membership on the Medical Staff absent a waiver granted pursuant to section 3.5 of these Bylaws;

(iii) The Board Certification provisions set forth in subsections (c)(i) and (ii) shall only apply to applicants for initial membership whose applications are submitted on or after July 1, 2013; and

(iv) Any Active Staff Member who, at the time of reappointment review, does not meet the provisions of subsection 4.2.3(c)(i) or (ii) may undergo FPPE under the direction of the Department Chair for a minimum period of at least ninety (90) days to assess the individual's continued proficiency in his/her area of specialty and/or subspecialty.

(d) Pay dues and assessments as determined by the Professional Medical Staff policy; and

(e) If an Active Medical Staff Member does not fulfill the requirements under subsection 4.2.1 (a) i or ii, and if the member is otherwise abiding by all Bylaws Medical Staff and Hospital Policies, the Member will automatically be reassigned to the Associate Category, unless the Member's contract or separation agreement does not permit that.

4.2.4 Prerogatives. Except as otherwise provided, the prerogatives of an Active Medical Staff Member include:

(a) Exercise Clinical Privileges that have been granted pursuant to Article VI;

(b) Teach and supervise Undergraduate and Graduate Medical Trainees;

(c) Attend and vote on matters presented at general and special meetings of the Professional Medical Staff and of the Department, Section, and committees of which he/she is a member;

(d) Hold Staff, Department, and Section office and serve as a voting member of committees to which he/she is duly appointed or elected by the Professional Medical Staff;

(e) Propose a new or amended rule, regulation, or policy to the MSEC;

(f) Communicate issues or concerns in writing directly to the CEO and Board; and

(g) Receive such other prerogatives as may be designated by the PAC after consultation with the MSEC.

4.3 ASSOCIATE STAFF

4.3.1 Defined. The Associate Medical Staff consists of Physicians, Podiatrists, Dentists, and Oral Surgeons who: (1) have been granted Clinical Privileges; and (2) perform their professional activities primarily at another healthcare institution or do not satisfy the criteria of subsection 4.2.1 (a) i or ii.

4.3.2 Qualifications. The qualifications for an Associate Medical Staff Member include:

(a) Meet the qualifications for membership set forth in this section 4.3 and the general qualifications as set forth in Bylaws section 3.2; or be granted a waiver of particular qualifications in compliance with Bylaws section 3.5;

(b) Be licensed to practice in the Commonwealth of Pennsylvania;

(c) Meet the Board Certification criteria set forth in subsection 4.2.3(c) of these Bylaws; and

(d) Pay dues and assessments as determined by the Professional Medical Staff policy.

4.3.3 Prerogatives. Except as otherwise provided, the prerogatives of an Associate Medical Staff Member include:

(a) Exercise Clinical Privileges in accordance with his/her Clinical Privileges as are granted pursuant to Article VI;

(b) Teach and supervise Undergraduate and Graduate Medical Trainees;

(c) Attend open meetings of the Professional Medical Staff and mandatory meetings of the Department, Section, and committees of which he/she is a member;

(d) While an Associate Medical Staff Member is not eligible to vote or hold Staff, Department or Section office, he/she may serve as a voting or non-voting member of committees to the extent permitted by and in accordance with these Bylaws;

(e) Propose a new or amended rule, regulation, or policy to the MSEC;

(f) Communicate issues or concerns in writing directly to the CEO and Board; and

(g) Receive such other prerogatives as may be designated by the PAC after consultation with the MSEC.

4.4 AFFILIATE MEDICAL STAFF

4.4.1 Defined. The Affiliate Medical Staff consists of Physicians, Podiatrists, Dentists and Oral Surgeons who (1) do not have Clinical Privileges, but who meet the qualifications for Affiliate Staff; and (2) are not otherwise members of the Professional Medical Staff.

4.4.2 Qualifications. The qualifications for an Affiliate Medical Staff Member include:

(a) Meet the qualifications for membership set forth in this section 4.4 and the general qualifications as set forth in Bylaws section 3.2; and

(b) Be licensed to practice in the Commonwealth of Pennsylvania.

4.4.3 Prerogatives. Except as otherwise provided, the prerogatives of an Affiliate Medical Staff Member include the following:

(a) May not admit patients, exercise Clinical Privileges or document in the patient medical record;

(b) With consent of a patient followed by the Affiliate Member, may visit the patient, review the medical record, and discuss patient status with the patient's Attending physician;

(c) May, but are not obligated to, attend general meetings of the Professional Medical Staff and of the Department and Section of which he/she is a member;

(d) Affiliate Medical Staff are not eligible to vote or hold Staff, Department or Section office or serve as Satellite Campus Division Chief, serve on committees;

(e) Affiliate Medical Staff are not required to pay Medical Staff Dues;

(f) Affiliate Medical Staff will not be afforded any preferential treatment or consideration in changing Medical Staff category or status; and

(g) Receive such other prerogatives as may be designated by the PAC after consultation with the MSEC.

4.5 CONSULTING MEDICAL STAFF

4.5.1 Defined. The Consulting Medical Staff consists of Physicians, Podiatrists, Dentists, and Oral Surgeons who (1) have been granted Clinical Privileges, (2) possess skills not generally provided by other members of the Staff, and (3) are not otherwise members of the Professional Medical Staff.

4.5.2 Qualifications. The qualifications for a Consulting Medical Staff Member include:

(a) Meet the qualifications for membership set forth in this section 4.5 and the general qualifications as set forth in Bylaws section 3.2;

(b) Meet the Board Certification criteria set forth in subsection 4.2.3(c) of these Bylaws.

(c) Be licensed to practice in the Commonwealth of Pennsylvania; and

(d) Be willing to serve in the areas of his/her qualifications.

4.5.3 Prerogatives. Except as otherwise provided, the prerogatives of a Consulting Medical Staff Member include the following:

(a) Upon request of an Active or Associate Medical Staff Member who serves as the Attending physician or Consultant for a patient, may exercise Clinical Privileges as are granted pursuant to Article VI with respect to such patients;

(b) May, but are not obligated to, attend open meetings of the Medical Staff and of the Department and Section of which he/she is a member;

(c) Consultant Medical Staff are not eligible to vote or hold Staff, Department or Section office, or serve on committees;

(d) Consultant Medical Staff will not be afforded any preferential treatment or consideration in changing Medical Staff category or status;

(e) Consultant Medical Staff are not required to pay Medical Staff Dues;

(f) Consultant Medical Staff may not have independent admitting privileges; and

(g) Receive such other prerogatives as may be designated by the PAC after consultation with the MSEC.

4.6 COVERAGE MEDICAL STAFF

4.6.1 Defined. The Coverage Medical Staff consists of Physicians, Podiatrists, Dentists and Oral Surgeons who (1) have been granted Clinical Privileges, (2) upon approval of the Department Chair, provide coverage for a member in good standing of the Medical Staff in the Active category on a contractual, voluntary or fee for services basis where Good Cause exists, and (3) are not otherwise members of the Professional Medical Staff.

4.6.2 Qualifications. The qualifications for a Coverage Medical Staff Member include:

(a) Meet the qualifications for membership set forth in this section 4.6 and the general qualifications as set forth in Bylaws section 3.2;

(b) Meet the Board Certification criteria set forth in subsection 4.2.3(c) of these Bylaws.

(c) Be licensed to practice in the Commonwealth of Pennsylvania;

(d) Be granted Clinical Privileges in the same scope of practice as the Active or Associate Medical Staff Member for whom they are covering; and

(e) Be bound by all provisions of the Bylaws of the Professional Medical Staff during the term of appointment.

4.6.3 Prerogatives. Except as otherwise provided, the prerogatives of a Coverage Medical Staff Member include:

(a) Upon request of an Active or Associate Medical Staff Member who serves as the admitting physician for a patient, may exercise Clinical Privileges as are granted pursuant to Article VI with respect to such patients during the coverage period;

(b) Coverage Medical Staff are eligible to independently admit patients to the Hospital to the service of an Active or Associate Medical Staff Member during the coverage period;

(c) May, but are not obligated to, attend open meetings of the Medical Staff and of the Department and Section of which he/she is a member, and do not pay Medical Staff dues;

(d) Coverage Medical Staff are not eligible to vote or hold Staff, Department or Section office, or serve on committees;

(e) Coverage Medical Staff will not be afforded any preferential treatment or consideration in changing Medical Staff category or status; and

(f) Receive such other prerogatives as may be designated by the PAC after consultation with the MSEC.

4.7 EMERITUS MEDICAL STAFF

4.7.1 Defined. The Emeritus Medical Staff consists of physicians, podiatrists, dentists and oral surgeons who have retired from active practice and are deemed deserving of life membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, and their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

4.7.2 Nomination and Approval. Emeritus Medcial Staff status is obtained by nomination from a current member of the Medical Staff and with the approval from the Credentials and Practitioner Review Committee and the MSEC. Such Nomination shall identify the basis(es) upon which the nominee satisfies the requirements of subsection 4.7.1.

4.7.3 Prerogatives. The Emeritus Medical Staff may, but are not obligated to, attend meetings of the Professional Medical Staff and of the Department,

Section, and Committees of which he/she is a member. Emeritus Medical Staff may not exercise Clinical Privileges and are not eligible to vote or hold Staff, Department or Section office. With patient consent, a member of the Emeritus Medical Staff may visit a patient, review the medical record, and discuss patient status with the Attending physician of patients who are admitted to the Hospital. Emeritus Medical Staff may not make entries in a patient's medical record.

ARTICLE V: APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL

Except as otherwise specified herein, no Practitioner may exercise Clinical Privileges in the Hospital unless and until he/she applies for and receives an appointment to the Professional Medical Staff and/or is granted Clinical Privileges as set forth in these Bylaws. By applying to the Professional Medical Staff for appointment, or by accepting an appointment to the Staff, or by applying for and accepting Clinical Privileges, the Applicant or Medical Staff Member acknowledges responsibility to first review these Bylaws and the Rules and Regulations and agrees that throughout any period of Professional Medical Staff membership and/or holding Clinical Privileges he/she will comply with the responsibilities of Professional Medical Staff membership, as applicable, with the Bylaws of the Professional Medical Staff, the Rules and Regulations of the Professional Medical Staff, and applicable Hospital and Medical Staff Policies and Procedures, as they may be modified from time to time. All Medical Staff Members will be assigned to one or more specific Departments and, if applicable, at least one Section within each such Department. Appointment to the Professional Medical Staff will confer on the appointee only such Clinical Privileges and prerogatives as have been granted in accordance with these Bylaws. Applications for appointment to the Professional Medical Staff will only be accepted if the Hospital has available facilities and resources to support the Clinical Privileges sought, and will not be accepted from applicants who fall outside the scope of existing exclusive contracts.

5.1.1 Specified Professional Personnel

(a) All references and requirements in Article V regarding appointment or reappointment to the Medical Staff and/or to a Medical Staff Category and/or Department Section shall not apply to SPP applying for Clinical Privileges. In all other respects, the process and requirements in Article V shall apply to SPP who are eligible to apply for Clinical Privileges, as set forth in the Medical Staff SPP policy.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, additional Clinical Privileges, advancement, or transfer, the Applicant has the burden of producing information for evaluation of the Applicant's qualifications and suitability for the Clinical Privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. If there are issues related to an Applicant’s ability to perform an essential function of his/her Medical Staff appointment (including, but not limited to, medical and/or psychological issues), the Applicant may be required to have a medical or psychological examination, at the Applicant’s reasonable expense, if deemed appropriate by the applicable Department Chair(s), MSEC and/or CEO or PAC, which may select the examining physician. The

Hospital will pay the cost of any required medical or psychological examination for existing Medical Staff Members requesting reappointment, consistent with Hospital Policy. The Applicant or Medical Staff Member has a duty to advise the Department Chair and Section Chief (if applicable), within fifteen (15) days, of any change with respect to information previously submitted by him/her related to his/her credentials. The failure of an Applicant or Medical Staff Member to comply with these duties will cause the application to be deemed incomplete and not eligible for further processing and/or can result in termination of the Applicant's Medical Staff membership and Clinical Privileges.

The Applicant has the burden of producing any supplemental information required to evaluate fully his/her clinical and professional background and resolve any doubts regarding competence or professional conduct, which may include, without limitation: (1) quality metrics, evaluations and/or treatment logs from prior hospitals and/or training sites, (2) medical records of patients for peer review, (3) supplemental peer review information and references, and/or (4) additional interviews. Failure to produce requested additional information may be grounds for determining that the application is incomplete. Furthermore, any material omissions or misstatements discovered on an application and not immediately corrected by the applicant to the satisfaction of the Credentials and Practitioner Review Committee will be considered incomplete and ineligible for further processing of the application, and will not be subject to any hearing or appellate rights herein.

5.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments to the Professional Medical Staff will be for a period that will not exceed two (2) years.

Initial appointments and reappointments to the Professional Medical Staff may be granted for less than two (2) years and subject to such conditions as may be imposed by the PAC upon recommendation of the MSEC.

5.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

5.4.1 Forms. A single standard application form for initial appointment/reappointment will be utilized at all hospitals in the Temple University Health System. This application may be provided and completed through an online system, and authenticated by a legally binding electronic signature. The entire application process, including communications regarding an Applicant's or Medical Staff Member's credentials and the application process, are part of a peer review process. The forms will require detailed information, which, as applicable, may include, but not be limited to, information concerning:

(a) The Applicant's qualifications, including, but not limited to, graduation from an approved medical school, professional training and experience, current licensure, current DEA registration (unless not

required by the specialty to practice), and an attestation of completion of required continuing medical education credits;

(b) Residency, fellowships, and other medical training;

(c) Current references of peers familiar with the Applicant's professional competence and ethical character and who recently have worked closely with the Applicant and observed his/her professional competence, and ability to work with others;

(d) Specific requests for Medical Staff category, Department, Section, if applicable, and Clinical Privileges;

(e) Past or pending professional disciplinary actions, past or pending licensure limitations (voluntary or involuntary), including DEA registrations, past or pending professional liability actions, voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility, and any past or pending investigations that affected or could affect the Applicant's participation in Medicare, Medicaid, or another federal or state health program;

(f) All convictions or guilty pleas within the last ten (10) years and any pending charges;

(g) Physical and mental health condition as it relates to the Applicant's ability to exercise the Clinical Privileges requested;

(h) Evidence of compliance with the Board Certification requirements set forth in Bylaws subsection 4.2.3(c), as applicable;

(i) Previous practice experience, including the names and addresses of all hospitals and other health care facilities where the Applicant has practiced;

(j) Research and publications;

(k) Written proof, in the form specified by the Credentials and Practitioner Review Committee and the MSEC, of professional liability insurance in amounts required

by law, or as otherwise required by the MSEC and approved by the PAC;

(l) Written proof, in the form specified by the Credentials and Practitioner Review Committee and the MSEC, of current criminal check clearance for all Applicants and child abuse check clearance in accordance with State law;

(m) Evidence of quality data supporting requested Clinical Privileges; and

(n) Written claims history for the previous five (5) years.

Each application for initial appointment and reappointment to the Professional Medical Staff will be in writing, submitted on the prescribed forms, electronically or otherwise, with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the Applicant or Medical Staff Member.

5.4.2 Applicant Agreement. In addition to the matters set forth in Bylaws subsection 5.4.1, by applying for appointment or reappointment to the Professional Medical Staff, or by applying for Clinical Privileges, each Applicant:

(a) Signifies his/her willingness to appear for interviews in regard to the application by any of the individuals or committees involved in reviewing the application;

(b) Authorizes consultation with members of the medical staff of other hospitals and others who have been associated with the Applicant and who may have information bearing on his/her competence, qualifications, performance, ability to work cooperatively and professionally with others, and ethical qualifications, and authorizes such individuals and organizations to provide all such information candidly;

(c) Consents to the inspection of all records and documents that may be material to an evaluation of his/her qualifications and ability to carry out the Clinical Privileges requested, as well as his/her moral and ethical qualifications for Medical Staff membership, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) Consents to the right of the various bodies acting on behalf of the Medical Staff to use outside consultants to provide information or evaluation with respect to the Applicant's qualifications;

(e) In order to protect the health, life, or well-being of any patient, prospective patient or other person in the Hospital, each Applicant agrees to submit to a physical and/or mental health examination and/or pertinent laboratory tests, as requested by the Practitioner Health Committee or medical staff leadership under the ultimate oversight of the PAC, upon reasonable belief of the necessity for such examination or test, either during processing of his/her appointment application or at any time during his/her membership on the Professional Medical Staff;

(f) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the Applicant or Medical Staff Member;

(g) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith regarding the Applicant's competence, ethics, character, and other qualifications, including otherwise confidential information;

(h) Consents to the disclosure to other hospitals, medical societies, licensing boards, the National Practitioner Data Bank, and to any other entity to which disclosure is required by law, any information regarding his/her professional or ethical standing that the Hospital or Professional Medical Staff may have, and releases the Professional Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law;

(i) If a requirement then exists for Professional Medical Staff dues, acknowledges responsibility for timely payment in accordance with the Medical Staff Dues and Assessments policy;

(j) Agrees that the discovery of any misrepresentations, misstatements or omissions, whether intentional or

not, during the application process or after appointment, will cause the application to be deemed incomplete and not eligible for further processing and/or can result in termination of the Applicant's Medical Staff membership or Clinical Privileges;

(k) Pledges to use the applicable Medical Staff policies and/or processes and/or Bylaws to resolve disputes or complaints;

(l) Pledges to adhere to the Bylaws of the Professional Medical Staff and Rules and Regulations of the Professional Medical Staff and Hospital and Medical Staff policies and procedures;

(m) Pledges to provide for continuous, quality care for his/her patients;

(n) Pledges to maintain complete, accurate, legible, and up-to-date medical records for his/her patients;

(o) Agrees to submit to a photograph for hospital identification and provide a copy of a government issued photo identification for the medical staff credentials file unless the practitioner can demonstrate a religious or faith based reason for a Good Cause exception to this requirement;

(p) Pledges to treat patient, Hospital and Professional Medical Staff information confidentially;

(q) Pledges to behave in a professional manner, refraining from conduct that is considered below Professional Medical Staff or Hospital standards or disruptive to the orderly operations of the Hospital, including the failure to work harmoniously with others; and

(r) Pledges to refrain from providing medical care to one's immediate family members (spouse, parent, child, grandparent, grandchild) or a sexual partner as an inpatient in the Hospital or for any ambulatory care provided in the Hospital setting, except in cases of emergency.

5.4.3 Application. The Practitioner desiring to apply for appointment or reappointment to the Medical Staff or specific Clinical Privileges will request an application from any Medical Staff Office in the Temple

University Health System and will deliver a completed application to the Medical Staff Office of the TUHS hospital at which the Applicant intends to primarily practice. An application fee payable to the TUHS hospital at which the applicant will be primarily practicing may apply. If the Applicant is submitting an application for reappointment, the completed application must be returned to the TUHS hospital at which the Medical Staff Member intends to primarily practice. The application may be completed and provided through an online system, and authenticated by a legally binding electronic signature. The acceptance of the application fee or dues does not mean that the person is eligible to apply or will be granted the requested Clinical Privileges. Application or reapplication for delineation of Clinical Privileges for clinical practice at the ECNC shall be processed in accordance with these Bylaws, but shall be distinctly evaluated for that purpose. An application for appointment to a department that is closed as the result of an exclusive contract or otherwise unavailable will be returned without further processing and the application fee will be remitted. Applicants seeking faculty appointment should initiate the application for faculty appointment at the time of application for appointment to the Medical Staff, if not yet initiated.

Complete copies of the application and all supporting materials, which are reviewed and verified in accordance with Medical Staff Office policies, will be transmitted by the receiving Medical Staff Office to the Medical Staff Office of any other TUHS Hospital to which the Applicant seeks to apply. Once the TUHS hospital Medical Staff Office receives the application, notice of the application may be transmitted in writing to the Chair of each Department and Chief of each Section in which the Applicant seeks Clinical Privileges. The Medical Staff Office will review the references, licensure status, and other evidence submitted in support of the application in accordance with Medical Staff Office policies and will timely notify the Applicant of any information that is outstanding. If there is any change in the information submitted by the Applicant, the Applicant is required to submit notification in writing to the Medical Staff Office within fifteen (15) days of receiving notice of the change.

The Applicant applying for initial appointment will be notified by the Medical Staff Office of any problems in obtaining the information required, and it will be the Applicant's obligation to obtain the required information within one hundred twenty (120) days of receipt of the application. If requested information is not provided by the Applicant within one hundred twenty (120) days of receipt the application, the application will be deemed withdrawn and the Applicant will be notified of the same in writing.

When collection and verification is complete, as determined by the Medical Staff Office, the application will be deemed complete and transmitted to the appropriate Department Chair(s).

In the sole discretion of the MSEC and the PAC, the primary source verification of the information contained in an application and supporting documents may be delegated to a centralized credentialing service. Such entity will function as an agent of the Credentials and Practitioner Review Committee for purposes of performing the primary source verification of information submitted by those seeking Professional Medical Staff membership or Clinical Privileges, and all relevant state and federal peer review privileges will apply to communications between the entity and the Credentials and Practitioner Review Committee.

For applicants who have been granted Clinical Privileges at another TUHS hospital, the TUH Clinical Department Chair, Credentials Committee, MSEC, and CMO (if applicable) may at their discretion rely upon the applicant's Delineation of Privileges, case logs, attestation by the Clinical Department Chair at the other TUHS hospital and any other relevant supporting documents as the basis for making a recommendation about the practitioner's requested privileges. This decision will be conveyed to the PAC, who may at its discretion approve the recommended privileges on this basis.

5.4.4 Review of Application - Department Chair. After receipt of the completed application, the Chair, or his/her designee, of each Department and, at the discretion of the Chair, the applicable Section Chief to which the application is submitted, will review the application and supporting documentation, and may conduct a personal interview with the Applicant or Medical Staff Member at the discretion of the Chair. The Chair, or his/her designee, will evaluate all matters he/she deems relevant to a recommendation, including information concerning the Applicant's or Medical Staff Member's provision of services, quality of patient care rendered, professional performance, judgment, and clinical/technical skills within the scope of Clinical Privileges granted, and will timely transmit to the Credentials and Practitioner Review Committee a written recommendation as to appointment or reappointment and, if recommended, as to Department and Section, Medical Staff category, as applicable, and Clinical Privileges to be granted, and any special conditions to be attached.

5.4.5 Review of Application - CMO. If the Applicant is a Department Chair, the Review of Application will be conducted by the CMO or his/her designee, who will evaluate all matters he/she deems relevant to a recommendation, including information concerning the Medical Staff Member's provision of services, quality of patient care rendered, professional performance, judgment, and clinical/technical skills within the scope of Clinical Privileges granted, and will timely transmit to the Credentials and Practitioner Review Committee a written recommendation as to appointment or reappointment and, if recommended, as to Department

and Section, Medical Staff category, Clinical Privileges to be granted, and any special conditions to be attached.

5.4.6 Review of Application - Credentials and Practitioner Review Committee. The Credentials and Practitioner Review Committee will review the application, evaluate and verify the supporting documentation, the recommendation of the Department Chair, or his/her designee, and other relevant information. The Credentials and Practitioner Review Committee may elect to interview the Applicant or Medical Staff Member and/or seek additional information. In the discretion of the Credentials and Practitioner Review Committee, in consultation with the CEO, the Credentials and Practitioner Review Committee may request an independent peer review body to review some or all of the information provided by the Applicant or Medical Staff Member and to make recommendations based on such information. Upon completion of the application, as soon as practicable or at the next regularly scheduled meeting, the Credentials and Practitioner Review Committee will transmit to the MSEC its written recommendation as to appointment or reappointment, as applicable, and, if recommended, as to Medical Staff category, Department and Section, as applicable, and Clinical Privileges to be granted, and any special conditions to be attached. However, if the Applicant is requested to participate in an interview and/or to provide additional information, the Committee may defer its recommendation to the MSEC until such requests have been satisfied.

5.4.7 MSEC Consideration. At its next regular meeting after, or within thirty (30) days of receipt of the Credentials and Practitioner Review Committee recommendations, the MSEC will consider the recommendations and any other relevant information. The MSEC may request additional information, return the matter to the Credentials and Practitioner Review Committee or the Department for further investigation, and/or elect to interview the Applicant or Medical Staff Member. Within thirty (30) days after its review of the completed application, the MSEC Chair will make a written recommendation as to appointment or reappointment, as applicable, and, if recommended, as to Department and Section, Medical Staff category, as applicable, and Clinical Privileges to be granted, and any special conditions to be attached. The MSEC Chair shall then take action as set forth in subsection 5.4.8.

5.4.8 MSEC Recommendation. When the recommendation of the MSEC is favorable to the Applicant or Medical Staff Member, the MSEC Chair shall promptly submit such recommendation, together with supporting documentation, to the PAC. When the recommendation of the MSEC is unfavorable to the Applicant or Medical Staff Member, the recommendation shall be handled in accordance with subsection 5.4.9 (c).

5.4.9 Action. At its next regular meeting after receipt of the recommendations of the MSEC, the PAC will take action on the application. The PAC may accept, modify, or reject the recommendations of the MSEC, or may refer the matter back to the MSEC for further consideration, stating the purpose for such referral. The following procedures will apply with respect to action on the application:

(a) Favorable Recommendation of the MSEC Upheld by the PAC. If the MSEC and PAC both act favorably on the application, the Applicant or Medical Staff Member will receive Notice thereof from the CEO. Copies of such Notice will be sent to the CEO, Medical Staff leadership and hospital administration as deemed appropriate.

(b) Favorable Recommendation of the MSEC and Unfavorable Decision by the PAC. If the MSEC issues a favorable recommendation and the PAC's decision, either with respect to appointment, reappointment, Medical Staff category, or Clinical Privileges, is unfavorable to the Applicant or Medical Staff Member in any respect, the PAC Chair shall send Special Notice to the Applicant or Medical Staff Member within five (5) business days of the PAC's decision. The Special Notice shall notify the Medical Staff Member or Applicant of her/his right to a hearing under subsection 8.1.2 unless the Medical Staff Member or Applicant has already received an MSEC hearing in accordance with Article VIII (i.e. MSEC unfavorable recommendation reversed to a favorable recommendation after a hearing), followed by appellate review, if applicable.

(i) Joint Conference Committee Review Following Waiver of Hearing by Applicant. If no hearing is requested by the Applicant or Medical Staff Member within the timeframes set forth in Article VIII, the decision of the PAC will be referred to the Joint Conference Committee for review in accordance with section 8.6.

(ii) PAC Action Following Article VIII Procedures. If, after all of the Article VIII procedures have been completed or waived, the PAC's decision remains unfavorable to the Applicant or Medical Staff Member, the matter will be referred to the Joint Conference Committee for review in accordance with Section 8.6.

(iii) Final Action by the PAC. The recommendation of the Joint Conference Committee will be forwarded to the PAC, which, at its next regularly scheduled meeting, will consider the recommendation of the Joint Conference Committee and take Final Action with respect to the application.

(iv) Notice of Final PAC Action. Special Notice of a Final Action that is unfavorable will be given by the PAC Chair to the Applicant or Medical Staff Member. Notice of a Final Action that is favorable will be given by the PAC Chair to the Applicant or Medical Staff Member by the CEO. In each case, copies will be sent to the President of the Professional Medical Staff, the MSEC Chair, the Credentials and Practitioner Review Committee Chair, the Chair of each applicable Department/Section, and CMO and, if applicable, the CEO. Notice of a decision to appoint or reappoint will include, if applicable: (1) the Medical Staff category to which the individual is appointed; (2) the Department to which he/she is assigned; (3) the Clinical Privileges granted; (4) the duration of the appointment; and (5) any special conditions attached to the appointment.

(c) Unfavorable Recommendation by the MSEC. In the event that the recommendation of the MSEC is unfavorable to the Applicant or Medical Staff Member in any respect, the MSEC Chair shall, within five (5) business days of the recommendation, send Special Notice to the Applicant or Medical Staff Member advising of her/his right to a hearing under subsection 8.1.1. A copy of this Special Notice will be sent to the Department Chair the CEO and CMO. When an Applicant or Medical Staff Member has applied to more than one TUHS Hospital and has received Special Notice of an unfavorable recommendation and a right to hearing from more than one TUHS hospital, the Applicant or Medical Staff Member may request a single consolidated hearing of all issues.

(i) PAC Decision following Waiver of Hearing by Applicant or Medical Staff Member. If no hearing is requested by the Applicant or Medical Staff Member within the timeframes set forth in Article VIII, the Applicant or Medical Staff Member will be deemed to have accepted the unfavorable recommendation of the MSEC and the matter will be referred to the PAC for its

decision. If the PAC concurs in the unfavorable recommendation of the MSEC, the decision of the PAC will be a Final Action. If the PAC does not concur with the unfavorable recommendation of the MSEC, the matter will be referred to the Joint Conference Committee for review in accordance with section 8.6.

(ii) PAC Decision following Article VIII Procedures. If the MSEC recommendation is unfavorable, and after all applicable procedures under Article VIII have been completed, the matter will come before the PAC for its decision. If the PAC concurs with the MSEC's unfavorable recommendation, the decision of the PAC will be a Final Action. If the PAC does not concur with the unfavorable recommendation of the MSEC, the matter will be referred to the Joint Conference Committee for review in accordance with section 8.6.

(iii) Final Action after Joint Conference Committee. At its next regularly scheduled meeting that is not less than ten (10) days from its receipt of a recommendation from the Joint Conference Committee, as specified under subsection (i) or (ii) above, the PAC will consider the recommendation and take Final Action with respect to the application.

(iv) Notice of Final Action. Special Notice or Notice of the Final Action, as specified in subsection 5.4.9 (b)(iv), shall be given to the Practitioner or Applicant by the PAC Chair or the CEO, respectively.

5.4.10 Reapplication - Appointment/Reappointment. An Applicant who has received an unfavorable Final Action regarding appointment or reappointment will not be eligible to reapply to the Professional Medical Staff for a period of two (2) years. Any such reapplication will be processed as an initial application. The basis for the prior Final Action will be evaluated as part of the application process, and the Applicant will submit such additional information as may be required to demonstrate that the basis for the earlier Final Action no longer exists.

5.4.11 Reapplication-Clinical Privileges. An Applicant who has received an unfavorable Final Action regarding Clinical Privileges will not be eligible to reapply for such Clinical Privileges for a period of two (2) years unless invited to reapply by the Credentials and Practitioner Review Committee or the applicable Department Chair. In connection with any such reapplication, the basis for the prior Final Action will be evaluated as part of the application process, and the Applicant will submit such additional

information as may be required to demonstrate that the basis for the earlier Final Action no longer exists.

5.4.12 Maintenance of Credential Files. A copy of each Applicant's credentials file shall be maintained in the Medical Staff Office of any TUHS hospital and/or the ECNC to which the Applicant has applied for appointment or reappointment. The file may be maintained in a secure electronic format.

5.4.13 Time Periods. The time periods set forth in this Section are guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Articles VII and VIII are activated, the time requirements provided therein govern the continued processing of the application.

5.5 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR CLINICAL PRIVILEGES

A Medical Staff Member who at the time of reappointment seeks a change in Medical Staff category or modification of Clinical Privileges may submit such a request at that time utilizing the reappointment application, except that such application may not be filed within two (2) years of the time a similar request has been denied (unless approved to reapply by the Credentials and Practitioner Review Committee or applicable Department Chair(s)). An application for a change at reappointment is subject to the provisions of this Article V, including, but not limited to, Bylaws subsection 5.4.2.

5.6 REAPPOINTMENTS

5.6.1 Form. At least six (6) months prior to the expiration date of each Medical Staff Member's appointment, a reapplication form and timeframe for completion of the reappointment process will be mailed or delivered or sent electronically to the Medical Staff Member by the Temple University Health System Medical Staff Office at the hospital where the Member primarily practices. If the Medical Staff Office has not received a completed application for reappointment from the Staff Member within thirty (30) days, Special Notice will be sent to the Medical Staff Member advising him/her that the application has not been received. The Medical Staff Member will have an additional thirty (30) days to complete and return the application to the Medical Staff Office at the TUHS Hospital where the Member primarily practices. The Medical Staff Office which receives the application will timely complete the verification process and forward the application to the other TUHS Medical Staff Offices where the Member is applying.

5.6.2 Information. The reapplication form will include all information necessary to update and evaluate the qualifications of the Medical Staff Member including, but not limited to, the matters set forth in this Article V, as well as other relevant matters. The information reviewed will include quality

and peer review data generated during the course of the Medical Staff Members' tenure on the medical staff. Special procedures used for credentialing of "low volume" providers, developed by the Credentialing Committee and Practitioner Review Committee, will be followed as appropriate. Upon receipt of the application, the information will be processed as set forth in Bylaws section 5.4.

5.6.3 Burden to Provide Supplemental Information. Failure to provide any supplemental information requested during the review process will be deemed an automatic withdrawal of the application for reappointment, and will result in an expiration of Clinical Privileges at the end of the term.

5.6.4 Automatic Lapse. If the reappointment review is not completed by the expiration of the prior term of appointment, the Medical Staff Member's Clinical Privileges will automatically terminate.

5.6.5 Deemed Resignation. Failure to file a completed application for reappointment in the times proscribed herein will be deemed a resignation by the Medical Staff Member and will result in the automatic termination of the Medical Staff Member's membership in the Professional Medical Staff and Clinical Privileges at the end of the current Medical Staff appointment. In the event Professional Medical Staff membership and Clinical Privileges terminate for the reasons set forth herein, the rights and procedures set forth in Article VIII will not apply. A request for Professional Medical Staff membership received from a Medical Staff Member so terminated will be submitted and processed in the manner specified for initial appointment applications as set forth in section 5.4.

5.7 LEAVE OF ABSENCE

5.7.1 Request. A Medical Staff Member may obtain a voluntary leave of absence from the Medical Staff upon submitting a written request to the Department Chair and verification of (1) adequate coverage arrangements, and (2) complete medical charts for all current patients. During the period of leave, the Medical Staff Member may not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities will be inactive.

5.7.2 Reappointment. A Medical Staff Member who becomes eligible for reappointment during a period of voluntary leave of absence will be provided with an application for reappointment and will be required to submit to the Medical Staff Office a completed application form for renewal of appointment to the Medical Staff within the timeframes established in these Bylaws. Failure to file a completed application for reappointment in a timely manner will be deemed a resignation by the Medical Staff Member and will result in automatic termination of the Medical Staff Member's membership in the Professional Medical Staff and Clinical Privileges at

the end of the current Medical Staff appointment and the rights and procedures set forth in Article VIII will not apply. Review of and action on the application may be deferred until the time the Applicant seeks reinstatement from the leave of absence, and will be consolidated with the reinstatement review process referenced in Bylaws subsection 5.7.3.

5.7.3 Reinstatement. Prior to the termination of the leave of absence, the Medical Staff Member may request reinstatement of Clinical Privileges by submitting written or electronic notice to that effect to the applicable Department Chair(s). The Medical Staff Member will submit a summary of relevant activities during the leave, if the Department Chair so requests. The Department Chair may request additional information regarding the Member's quality of care, professionalism, or health status, as applicable, as part of the return from leave of absence review. Failure to provide the requested information is deemed a withdrawal of the application for reinstatement. The Department Chair will make a recommendation concerning the reinstatement of the Medical Staff Member's Clinical Privileges and prerogatives, and the procedure provided in this Article V will be followed. If the leave of absence is for a period of greater than six (6) months, the Department Chair and the Credentials and Practitioner Review Committee will make a recommendation concerning reinstatement of the Medical Staff Member's Clinical Privileges and prerogatives, and the procedure provided in this Article V for initial appointments will be followed.

5.7.4 Deemed Resignation. Failure, without Good Cause, to request reinstatement at least thirty (30) days prior to termination of the leave of absence will be deemed a resignation from the Professional Medical Staff and will result in automatic termination of Professional Medical Staff membership and Clinical Privileges. In the event that Professional Medical Staff membership and Clinical Privileges terminate via Deemed Resignation, the rights and procedures set forth in Article VIII will not apply. A request for Professional Medical Staff membership received from a Medical Staff Member so terminated will be submitted and processed in the manner specified for applications for initial appointments as set forth in section 5.4.

5.7.5 Denial of Request for Reinstatement. A Medical Staff Member whose request for return from a leave of absence is denied will be entitled to invoke the procedural rights set forth in Article VIII.

ARTICLE VI: CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a Medical Staff Member will be entitled to exercise only those Clinical Privileges specifically granted to such Member pursuant to this Article VI. Such Clinical Privileges may be Hospital or site specific for the ECNC or otherwise limited, must be within the scope of any license or other required legal credential, and will be subject to the Bylaws of the Professional Medical Staff, the Rules and Regulations of the Professional Medical Staff, Professional Medical Staff Policies and Hospital Policies, and under the authority of the President of the Professional Medical Staff, the CEO, and applicable Department Chair(s) and Section Chief(s).

Except as otherwise provided in these Bylaws, Clinical Privileges will be granted for a period that will not exceed two (2) years but may be granted for less than two (2) years and subject to such conditions as may be imposed by the PAC upon recommendation of the MSEC. When Clinical Privileges are granted to Medical Staff Members as set forth in Article V, Section 5.1, the duration of Clinical Privileges should align with the term of their respective Medical Staff Membership.

SPP are not members of the Medical Staff, but certain SPP are eligible to apply for and be granted Clinical Privileges to practice at the Hospital in accordance with the Medical Staff SPP policy.

Physicians who practice pursuant to a contractual relationship with the Hospital will be governed by all applicable contractual provisions with regard to the nature, extent, and duration of Clinical Privileges.

6.2 DELINEATION OF CLINICAL PRIVILEGES IN GENERAL

6.2.1 Application. Each application for appointment and reappointment to the Professional Medical Staff in a Medical Staff category that may hold Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Applicant or Professional Medical Staff Member. A request by a Medical Staff Member for a modification of Clinical Privileges may be made at any time, subject to any limitations in these Bylaws, and must be supported by documentation of training and/or experience and any other criteria supportive of the request.

6.2.2 Evaluation. Requests for Clinical Privileges will be evaluated on the basis of the Medical Staff Member's education, training, experience, demonstrated professional competence and judgment, clinical performance, documented results of patient care, review of the records of the Professional Medical Staff that document the evaluation of the Medical Staff Member's delivery of medical care, and other quality review and monitoring as the Credentials and Practitioner Review Committee and MSEC deems appropriate. Privilege determinations also may be based on pertinent information concerning clinical performance obtained from

other sources, especially other institutions and health care settings where a member exercises clinical privileges.

6.3 PROFESSIONAL PRACTICE EVALUATION

6.3.1 Focused Professional Practice Evaluation (FPPE). All initially requested Clinical Privileges will be subject to a period of FPPE, as set forth in the Hospital FPPE Policy. FPPE may also be initiated in other circumstances, as set forth in the Hospital FPPE Policy and these Bylaws.

6.3.2 Ongoing Professional Practice Evaluation (OPPE). The Medical Staff will also engage in OPPE, as set forth in the Hospital OPPE Policy, in order to identify professional practice trends that influence quality of care and patient safety. Information from this evaluation process will be considered in 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 OPPE will be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of each practitioner's current clinical competency. In addition, each Medical Staff Member may be subject to a FPPE on the basis of OPPE when issues affecting the provision of safe, high quality patient care are identified. 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.

6.3.3 Peer Review Protection. The activities described in this section 6.3 constitute professional peer review.

6.4 SPECIAL CONDITIONS FOR CLINICAL PRIVILEGES OF DENTISTS

6.4.1 Privilege Requirements. Dentists are subject to the privilege requirements that are developed by the Credentials and Practitioner Review Committee for dentists, as well as the special conditions listed in this section 6.4.

6.4.2 History & Physical. A dentist may only admit a patient as an inpatient if a physician member of the Active or Associate Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry), and assumes responsibility for the care of the patient's medical problems whether present at the time of admission or that may arise during hospitalization and are outside of the dentist's lawful scope of practice.

6.4.3 Surgery. Surgical procedures performed by a dentist will be under the overall supervision of the Chair of the Department of Surgery or his/her designee.

6.4.4 Appraisal. All patients admitted for care as inpatients in the Hospital by a dentist will receive the same basic medical appraisal as patients admitted to other services, and a physician member of the Active or Associate Medical Staff will determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. If a dispute exists regarding proposed treatment between a physician member of the Active or Associate Medical Staff and a dentist Medical Staff Member based upon medical or surgical factors outside of the scope of licensure of the dentist, the proposed treatment will be suspended in the sole discretion of the physician member of the Active or Associate Staff.

6.5 SPECIAL CONDITIONS FOR CLINICAL PRIVILEGES OF ORAL SURGEONS

6.5.1 Privilege Requirements. Oral Surgeons are subject to the privilege requirements that are developed by the Credentials and Practitioner Review Committee for oral surgeons, as well as the special conditions listed in this section 6.5.

6.5.2 History & Physical. An oral surgeon may only admit a patient as an inpatient if the patient has no known medical problems. The oral surgeon may conduct or directly supervise the admitting history and physical examination of such patient. Patients with known medical problems must be admitted by a physician member of the Active or Associate Medical Staff who conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry), and assumes responsibility for the care of the patient's medical problems whether present at the time of admission or that may arise during hospitalization and are outside of the oral surgeon's lawful scope of practice.

6.5.3 Surgery. Surgical procedures performed by an oral surgeon will be under the overall supervision of the Chair of the Department of Surgery or his/her designee.

6.5.4 Appraisal. All patients admitted for care as inpatients in the Hospital by an oral surgeon will receive the same basic medical appraisal as patients admitted to other services, and, if known medical problems exist, a physician member of the Active or Associate Medical Staff will determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. If a dispute exists regarding proposed treatment between a physician member of the Active or Associate Medical Staff and an oral surgeon Medical Staff Member based upon medical or surgical factors outside of the scope of licensure of the oral surgeon, the proposed treatment will be suspended in the sole discretion of the physician member of the Active or Associate Staff.

6.6 SPECIAL CONDITIONS FOR CLINICAL PRIVILEGES OF PODIATRISTS

6.6.1 Privilege Requirements. Podiatrists are subject to the privilege requirements that are developed by the Credentials and Practitioner Review Committee for Podiatrists, as well as the special conditions listed in this section 6.6.

6.6.2 History & Physical. A podiatrist may only admit a patient as an inpatient if a physician member of the Active or Associate Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to podiatry), and assumes responsibility for the care of the patient's medical problems whether present at the time of admission or that may arise during hospitalization and are outside of the podiatrist's lawful scope of practice.

6.6.3 Surgery. Surgical procedures performed by a podiatrist will be under the overall supervision of the Chair of the Department of Surgery or his/her designee.

6.6.4 Appraisal. All patients admitted for care as inpatients in the Hospital by a podiatrist will receive the same basic medical appraisal as patients admitted to other services, and a physician member of the Active or Associate Medical Staff will determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. If a dispute exists regarding proposed treatment between a physician member of the Active or Associate Medical Staff and a podiatrist Medical Staff Member based upon medical or surgical factors outside of the scope of licensure of the podiatrist, the proposed treatment will be suspended in the sole discretion of the physician member of the Active or Associate Staff.

6.7 TEMPORARY CLINICAL PRIVILEGES

6.7.1 Grant or Renewal. The CEO, upon the written concurrence of the President of the Medical Staff or the Chair of the applicable Department, and where the application raises no concerns, may grant or renew Temporary Privileges to appropriately licensed practitioners under the following circumstances: (1) for initial Applicants to the Medical Staff whose applications have been recommended for approval by the Credentials and Practitioner Review Committee and who are awaiting approval by the MSEC and PAC; or (2) to fulfill important service needs such as the care of a specific patient, teaching specified clinical procedures, or clinical monitoring. Such Temporary Privileges may be subject to monitoring requirements such as those set forth in section 6.3, or restricted as otherwise deemed appropriate. Temporary Privileges shall not exceed one hundred twenty (120) days.

6.7.2 Criteria. Prior to the granting of Temporary Privileges, the CEO will ensure that the practitioner is appropriately licensed and insured; that the National Practitioner Data Bank and any other applicable data base have been properly queried; that the practitioner appears to have the qualifications, ability and judgment for such Temporary Privileges; and that he/she meets any other required criteria for Temporary Privileges.

6.7.3 Waiver of Qualifications. Any qualification for Temporary Privileges in these Bylaws that is not required by law or for TJC accreditation may be waived at the discretion of the CEO, upon consultation with the President of the Medical Staff and/or the Department Chair, upon determination that such waiver will serve the best interests of the patients and the Hospital.

6.7.4 Supervision. In exercising such Temporary Privileges, the practitioner will act under the supervision of the Department Chair of each applicable Department, the President of the Professional Medical Staff, or such other practitioner(s) to whom he/she is assigned. It is the obligation of the practitioner to ensure that the Department Chair, President of the Professional Medical Staff, and/or such other practitioner(s) to whom the practitioner is assigned are kept closely informed as to his/her activities within the Hospital.

6.7.5 Termination. Temporary Privileges will automatically terminate at the end of the designated period, unless terminated earlier by the CEO, in consultation with the Department Chair, or unless affirmatively renewed as set forth in Bylaws subsection 6.7.1. If Temporary Privileges are terminated by the CEO, as they may be at any time, the CEO will advise the applicable Department Chair(s), who will assign or have the applicable Section Chief(s) assign one or more members of the Professional Medical Staff to assume responsibility for the care of such practitioner's patient(s).

6.7.6 No Rights. A practitioner with Temporary Privileges shall not be a member of the medical staff and will not be entitled to the procedural rights afforded by Article VIII because a request for the grant or renewal of Temporary Privileges is refused or because all or any portion of the Temporary Privileges are terminated or suspended.

6.7.7 Bound. All practitioners requesting or receiving Temporary Privileges will be bound by the Bylaws of the Professional Medical Staff

6.8 DISASTER CLINICAL PRIVILEGES

6.8.1 General. Nothing in this section 6.8 prevents a Medical Staff Member from providing all necessary services consistent with the Member’s scope of licensure as a life-saving measure.

6.8.2 Grant. The CEO, upon the written concurrence of the President of the Professional Medical Staff or the Department Chair, or his/her designee,

concerned, may grant Disaster Privileges to an appropriately licensed practitioner when: (1) the Federal Government or the Commonwealth of Pennsylvania or local government leaders or the CEO declares a disaster; AND (2) the Emergency Operations Plan has been activated; AND (3) the organization is unable to handle the immediate patient care needs. Disaster Privileges must fall within the scope of privileges currently held by the practitioner at another institution and may be restricted to the care of a specific patient, limited to teaching specific clinical procedures, subject to specific monitoring requirements such as those set forth in Bylaws section 6.3, or restricted as otherwise deemed appropriate.

6.8.3 Criteria. Within seventy-two (72) hours after granting of Disaster Privileges, the CEO will ensure that the practitioner is appropriately licensed and insured, and the National Practitioner Data Bank and any other applicable data base have been properly queried, appears to have the qualifications, ability and judgment for such Disaster Privileges, and meets any other required criteria for Disaster Privileges. In order for the CEO to grant a practitioner Disaster privileges, the practitioner must present a valid, government-issued photo identification and current medical license AND one (1) of the following additional forms of identification: (a) current hospital photo identification card; (b) identification that certifies that the individual is a member of a disaster medical assistance team (DMAT); (c) identification that certifies a state, federal or municipal entity has granted the individual the authority to administer patient care under disaster circumstances (e.g.: FEMA, State Medical Examiners, etc.); (d) presentation by a current Hospital or Medical Staff member who can vouch for the practitioner's identity. The practitioner must also complete the Disaster Privileges Form prior to being granted Disaster Privileges. As soon as possible, but no later than seventy-two (72) hours after the immediate situation is under control, the Credentials and Practitioner Review Committee and the CEO, or his/her designee, at the request of the Credentials and Practitioner Review Committee, will collect or verify the references, licensure status, and other evidence submitted by the practitioner in support of the request for Disaster Privileges.

6.8.4 Supervision. In exercising such Disaster Privileges, the practitioner will act under the supervision of the Chair of each applicable Department, the President of the Professional Medical Staff, or such other practitioner(s) to whom he/she is assigned. It is the obligation of the practitioner to ensure that the Department Chair, President of the Professional Medical Staff, or such other practitioner(s) to whom the practitioner is assigned are kept closely informed as to his/her activities within the Hospital.

6.8.5 Termination. Disaster Privileges will automatically terminate at the end of the declared disaster, unless earlier terminated by the CEO, in consultation with the Department Chair. If Disaster Privileges are

terminated by the CEO, as they may be at any time, the CEO will advise the applicable Department Chair(s), who will assign or have the applicable Section Chief(s) assign one or more members of the Professional Medical Staff to assume responsibility for the care of such practitioner's patient(s).

6.8.6 No Rights. A practitioner with Disaster Privileges shall not be a member of the Medical Staff and will not be entitled to the procedural rights afforded by Article VIII because a request for the grant of Disaster Privileges is refused or because all or any portion of the Disaster Privileges are terminated or suspended.

6.8.7 Bound. All practitioners requesting or receiving Disaster Privileges will be bound by the Bylaws of the Professional Medical Staff.

6.9 TELEMEDICINE/TELEHEALTH PRIVILEGES FOR TUH MEDICAL STAFF

6.9.1 Practitioners who provide telemedicine/telehealth services to a patient who is not located at a licensed healthcare facility must be granted Telemedicine/Telehealth Privileges at the Hospital.

6.10 TELEMEDICINE/TELEHEALTH PRIVILEGES FROM A DISTANT SITE OR DISTANT SITE HOSPITAL

Practitioners providing only telemedicine/telehealth services to the Hospital from a distant site will not be appointed to the Medical Staff. These practitioners must be granted appropriate Telemedicine/Telehealth Privileges at the Hospital. Practitioners who provide telemedicine/telehealth services for a patient at the Hospital from a distant site hospital must be granted Telemedicine/Telehealth Privileges at the Hospital, as well as the privileges required at the distant site hospital to perform the relevant services.

6.10.1 Requests. Requests for Telemedicine/Telehealth Privileges at the Hospital will be processed through either of two procedures. Information included in the completed practitioner application for Telemedicine/ Telehealth Privileges at the Hospital may be:

(a) Collected in the usual manner and processed in accordance with section 6.2 of the Bylaws, or

(b) Collected from the distant site hospital or telemedicine entity in accordance with TJC standards and CMS rules and regulations and may be relied upon when making recommendations on privileges for the individual practitioners. In the event the Applicant is to be reviewed under Bylaws subsection 6.10.2(b) or (c) below, the CEO will provide to the Credentials and Practitioner Review Committee confirmation that there is an appropriate contract in place between the hospital and the distant site

hospital or telemedicine entity meeting the requirements set forth in those sections.

6.10.2 Criteria. In order for the Hospital to utilize and rely upon the credentialing and privileging decisions from the distant site hospital or distant site telemedicine/telehealth entity when making recommendations on Telemedicine/Telehealth Privileges for the individual practitioners and to make a final privileging decision, the following conditions must be met:

(a) The distant site hospital and/or distant site telemedicine/telehealth entity and Temple University Hospital must comply with applicable standards and regulations as follows:

(i) The practitioner is privileged at the distant site for those services to be provided at Temple University Hospital; and

(ii) Temple University Hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by TJC that result from the telemedicine/ telehealth services provided and complaints about the practitioner from patients, other Licensed Independent Providers (LIPs), or staff at Temple University Hospital.

(b) In the case of reliance on a distant site hospital the distant site hospital and Temple University Hospital must comply with the CMS regulations as follows: The governing body of Temple University Hospital must ensure that telemedicine/ telehealth services are furnished to Temple University Hospital's patients through an agreement with the distant site hospital, the agreement is written and it specifies that it is the responsibility of the governing body of the distant site hospital to meet the requirements of CMS for governing body Conditions of Participation and Pennsylvania Department of Health regulations, with regard to the distant site hospital's physicians and practitioners providing telemedicine services.

When telemedicine/telehealth services are furnished to Temple University Hospital's patients through an agreement with a distant site hospital, the PAC may choose to, in lieu of

Article 6.2 of these Bylaws, have its medical staff rely upon the credentialing and privileging decisions made by the distant site hospital when making recommendations on Telemedicine Privileges for the individual distant site physicians and practitioners providing such services. However, the PAC must ensure, through written agreement with the distant site hospital, that the distant site hospital is a Medicare-participating hospital.

(c) In the case of reliance on a distant site telemedicine entity, the distant site telemedicine entity and Temple University Hospital must comply with the CMS regulations as follows: The PAC must ensure that telemedicine services are furnished to Temple University Hospital's patients through an agreement with a distant site telemedicine/telehealth entity, the written agreement specifies that the distant site telemedicine entity is a contractor of services to Temple University Hospital and, as such, in accordance with the CMS contracted services regulations, furnishes the contracted services in such a manner that permits Temple University Hospital to comply with all of the applicable CMS conditions of participation for the contracted services, including, but not limited to, the requirements of CMS for governing body Conditions of Participation with regard to the distant site telemedicine entity's physicians and practitioners providing telemedicine services.

When telemedicine/telehealth services are furnished to Temple University Hospital's patients through an agreement with a distant site telemedicine entity, the PAC may choose to, in lieu of Article 6.2 of these Bylaws, have its medical staff rely upon the credentialing and privileging decisions made by the distant site telemedicine entity when making recommendations on Telemedicine Privileges for the individual distant site physicians and practitioners providing such services. However, the PAC must ensure, through its written agreement with the distant site telemedicine entity that the distant site telemedicine entity furnishes services that, in accordance with CMS contracted services regulations, permit the Temple University Hospital to comply with all applicable conditions of participation for the contracted services. The PAC must also ensure, through its written agreement with the distant site telemedicine entity, that the distant site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards for CMS governing body Conditions of Participation and traditional credentialing and privileging procedures.

(d) In either the case of reliance on a distant site hospital or a distant site telemedicine entity, the following CMS Conditions must be met:

(i) The individual distant site physician or practitioner is privileged at the distant site providing the telemedicine services, which provides to Temple University Hospital a current list of the distant site physician's or practitioner's privileges at the distant site;

(ii) The individual distant site physician or practitioner holds a license issued or recognized by the Commonwealth of Pennsylvania; and

(iii) With respect to a distant site physician or practitioner, who holds current privileges at Temple University Hospital, Temple University Hospital has evidence of an internal review of the distant site physician's or practitioner's performance of these privileges and sends the distant site such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant site physician or practitioner to Temple University Hospital's patients and all complaints Temple University Hospital has received about the distant site physician or practitioner.

6.11 MODIFICATION OF CLINICAL PRIVILEGES OR STAFF CATEGORY

A Medical Staff Member or SPP, with the concurrence of the Department Chair, or his/her designee, (or the CMO if the Applicant is a Department Chair), may seek a modification of Clinical Privileges and/or Medical Staff category, as applicable, by submitting this request in writing with supporting documentation to the Credentials and Practitioner Review Committee. If accepted, the Credentials and Practitioner Review Committee will recommend the modification to the MSEC, who may recommend a change in the Clinical Privileges and/or Medical Staff category, as applicable, of a Professional Medical Staff Member or SPP to the PAC. The MSEC also may recommend that the granting of additional Clinical Privileges to a current Professional Medical Staff Member be made subject to monitoring in accordance with an FPPE, as outlined in Bylaws section 6.3.1. A Medical Staff Member will be entitled to invoke the procedural rights set forth in Article VIII if such request is denied.

If a Professional Medical Staff Member or SPP requesting a modification of Clinical Privileges, Department or Section assignment or Medical Staff category, as applicable, fails to furnish the information necessary to evaluate the request within forty-five (45) days of submission of the request, the application will automatically lapse, and the Applicant will not be entitled to invoke the procedural rights identified above .

ARTICLE VII: CORRECTIVE ACTION AND AUTOMATIC LIMITATIONS

7.1 OVERVIEW

These Bylaws encourage informal, collegial, and educational efforts by Professional Medical Staff leaders including Department/Section/Division Chairs/Chiefs, and/or the Medical Staff President to identify and address concerns relating to clinical practice and professional conduct, using a systems-based analysis and Just Culture principles, as defined in the Definitions, and reserving Formal Corrective action procedures for those infrequent situations in which collegial efforts have not succeeded and/or where material patient safety concerns have arisen. The provisions of this section are applied in concert with specific Hospital/Medical Staff policies regarding: (1) peer review; (2) professional conduct (including sexual and/or other harassment); (3) physician wellness/impairment; and (4) late career practitioner matters involving these issues. Matters involving these issues should be referred to the relevant committees or individuals as specified in those policies. Action taken by or information sent to the CMO or CEO under Article VII may be taken by or sent to the HCCMO or HCED, respectively, when the practitioner's conduct at issue occurred, in whole or in part, at a Hospital Satellite Campus.

A Practitioner has the right to be represented by legal counsel in connection with any action undertaken pursuant to Article VII. The role and interactions of a Practitioner's counsel shall be subject to Article VIII, subsection 8.1.3 and they shall not be permitted to attend or participate in any Medical Staff Committee or PAC or Board meetings or participate in any investigation or collegial intervention unless otherwise specified in the Bylaws. However, nothing herein is intended to prevent the Practitioner from consulting with legal counsel in preparation for such activities.

7.2 REPORTING AND NOTICE

7.2.1 Initiation of a Concern. Members of the Professional Medical Staff have the responsibility to report to the relevant Department Chairs, the Medical Staff President, or the CMO and/or HCCMO, as applicable, any Practitioner whose activities or professional conduct are reasonably likely to: (1) be detrimental to patient safety or the delivery of quality patient care, including matters related to physician wellness; (2) disrupt Hospital operations; (3) constitute inappropriate interactions with medical staff members, graduate medical trainees, students, hospital staff (e.g. nurses) on or off the hospital campus(es), or with patients or other persons on the Hospital campus(es); or (4) violate ethical standards, these Bylaws and/or Medical Staff or Hospital policies and/or the law.

7.2.2 Initial Receipt and Review. Recipients of a report made pursuant to subsection 7.2.1 shall consider all of the information received/known and, in good faith, determine whether the concern warrants: (1) no further action; (2) Informal Collegial Intervention under Section 7.3.2; (3) Formal Corrective Action under subsection 7.3.4; (4) referral to the CEO and/or

HCED, as applicable, for potential Summary Suspension under section 7.4; or (5) referral to the Practitioner Wellness Committee.

7.3 CORRECTIVE ACTION

7.3.1 Peer Review Activity. All Corrective Action that is undertaken by the Professional Medical Staff leaders and/or Hospital Administration constitutes peer review activity.

7.3.2 Informal Collegial Intervention. Whenever concerns raised under subsection 7.2.1 are not perceived to warrant Summary Suspension or Formal Corrective action, the relevant Department Chair, working in collaboration with the Medical Staff President and, if deemed appropriate, other Medical Staff leaders and/or Hospital Administration, will address such concerns through collegial intervention. Collegial Interventions are encouraged, but are not mandatory. Collegial interventions are voluntary action(s), agreed to by the Practitioner, to resolve clinical and/or behavioral concerns that have been raised. Such interventions include, but are not limited to, verbal warning, written warning, training, education, counseling, monitoring and proctoring. Collegial intervention does not preclude making report to appropriate licensing boards, the Department of Health or other governmental entities as required by law. Collegial Intervention does not include Formal Corrective Action or any action taken pursuant to a wellness policy. If a Practitioner declines a Collegial Intervention, the matter may be submitted to the MSEC for potential Formal Corrective Action or other action as deemed appropriate.

7.3.3 Formal Corrective Action. Whenever concerns raised under subsection 7.2.1 are not perceived to warrant Summary Suspension and are not perceived to be appropriate for informal Collegial Intervention, either due to the seriousness of the issue(s) raised or because previous collegial intervention(s) did not resolve the concerns, the Medical Staff President, the Practitioner's Department Chair and the CEO and/or HCED, as applicable, and CMO and/or HCCMO, as applicable, shall be advised of the matter and it shall be submitted to the MSEC Chair for review by the MSEC in Executive Session. If the Practitioner has previously been evaluated pursuant to any medical staff or hospital policy regarding the current concern, any report and/or evidence prepared and/or obtained in connection with that evaluation shall be provided to the MSEC for its consideration. The MSEC shall decide, in its sole discretion, whether to initiate an MSEC investigation or refer the matter for disposition as otherwise set forth in these Bylaws.

7.3.4 Notice of Investigation. If the MSEC initiates an investigation, it will advise the Practitioner, in writing, of the basis(es) for the investigation. However, the MSEC may defer notifying the Practitioner about the investigation until such time it deems appropriate if, under extraordinary circumstances, it

determines that immediately informing the Practitioner might compromise the investigation or disrupt the operations of the Hospital or the Professional Medical Staff. The MSEC Chair will keep the Practitioner's Department Chair, the CEO and CMO and/or HCED and HCCMO, as applicable, fully informed of the question raised and of any actions taken in connection therewith.

7.3.5 MSEC Investigation. The MSEC shall conduct investigations in a thorough and unbiased manner to find facts and make credibility determinations. Investigations shall be undertaken to the best of the MSEC's ability under all of the circumstances (e.g. witness availability/cooperation, reasonably available evidence, etc.). If the MSEC has received a report and/or evidence previously prepared and/or obtained in connection with an evaluation described in subsection 7.3.3 (above), it may adopt such report and/or evidence to the extent it is satisfied that the report/evidence sufficiently answers pertinent questions and is based upon reasonable and appropriate efforts. If the MSEC has not received such report and/or evidence, or does not believe the same is satisfactory for its purposes it shall appoint a three (3)-physician ad hoc committee to investigate the matter.

The ad hoc committee may, but is not obligated to, review medical records or other documents/evidence, retain external consultant(s), and interview witnesses. The ad hoc committee shall invite the Practitioner under investigation to be interviewed. The Practitioner shall be asked to produce and/or identify any evidence (e.g. documents, witnesses, etc.) that he/she believes is relevant to the concerns that have been raised. If the Practitioner declines to be interviewed or to provide or identify such evidence, no adverse inference may be drawn by the *ad hoc* committee or MSEC. During every interview, at least two (2) members of the *ad hoc* committee shall be present and at least one member of the committee shall take and preserve contemporaneous notes. If the Practitioner has previous Collegial Intervention(s), Summary Suspension(s) and/or Adverse Action(s), the ad hoc committee may obtain and consider such information to provide context and to determine if behavioral patterns exist, and may include such information in its report to the MSEC. The ad hoc committee should seek to complete its investigation within thirty (30) days, but no longer than sixty (60) days, of the MSEC decision to investigate. Within fourteen (14) days thereafter, the ad hoc committee shall forward a written report of the investigation to the MSEC Chair. The report shall include recommendation(s) for corrective action, if any. At least one (1) member of the ad hoc committee shall be present to discuss the ad hoc committee's report and recommendation(s) with the MSEC.

Regardless of the status of an investigation, at all times the MSEC, in consultation with the CEO and CMO and/or HCED and HCCMO, as applicable, will retain authority and discretion to take whatever action may be warranted by the circumstances, including

Summary Suspension, termination of the investigation, or other action, as otherwise set forth in these Bylaws.

7.3.6 Action. After receipt of the ad hoc committee's report and recommendation(s) the MSEC shall, at its next scheduled meeting or at an *ad hoc* meeting, consider and evaluate the report in Executive Session. The MSEC may question any member of the *ad hoc* committee who is present at the executive session about any aspect of the investigation, report or recommendation(s). The MSEC shall then take action, which includes, without limitation:

(a) Taking no corrective action and, if the MSEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner's credentials file;

(b) Referring the matter back to the ad hoc committee with specific directions for further investigation and the time frame within which to complete such investigation, or to clarify or more fully explain the content of its report;

(c) Issuing a letter of admonition, reprimand, or warning that shall also advise the Practitioner that he/she may submit a written response to such letter. Any such letter and, if applicable, written response, shall be maintained in accordance with the Professional Conduct Policy (TUH-ADMIN-950.1044);

(d) Imposing a remedial action plan to be designed in consultation with the Department Chair or their designee and subject to the oversight of the Department Chair or their designee and the MSEC, with specific outcome measures and a compliance monitoring plan. The action plan shall be in writing and maintained in accordance with the Professional Conduct Policy;

(e) Removal from a Medical Staff Officer, Section Chief, or Satellite Campus Division Chief position;

(f) Recommending reduction, modification, suspension, or termination of specific Clinical Privileges;

(g) Recommending reductions of Professional Medical Staff membership category or limitation of any prerogatives related to the Practitioner's delivery of patient clinical care or teaching of Undergraduate and Graduate medical trainees;

(h) Recommending suspension or termination of Professional Medical Staff membership;

(i) Removal from a medical staff committee, including serving as Chair of such committee; or

(j) Taking other actions deemed appropriate under the circumstances.

7.3.7 Notice to Practitioner. The MSEC Chair, or her/his designee, shall send the Practitioner Special Notice of any recommendation or action taken by the MSEC, including a decision that no corrective action is necessary. If the MSEC makes an unfavorable recommendation (entitling the Practitioner to the hearing rights set forth in subsection 8.1.1), the MSEC Chair, or her/his designee, shall send Special Notice to the Practitioner in accordance with subsection 8.3.1 with copies to the CEO and CMO and/or HCED and HCCMO, as applicable, and the applicable Department Chair(s).

7.4 SUMMARY SUSPENSION OR RESTRICTION

7.4.1 Grounds. Summary suspension or restriction of a Practitioner's clinical privileges may be imposed if a Practitioner:

(a) Disregards and/or violates these Bylaws, Medical Staff Policies or Hospital Policies in a manner that imminently endangers the health, life or well-being of any patient, prospective patient, or other person in the Hospital;

(b) Engages in conduct, or it is reasonably believed that the Practitioner may engage in conduct, that imminently endangers the health, life or well-being of any patient, prospective patient, other person in the Hospital or to them self;

(c) Engages in conduct that materially disrupts any aspect of the Hospital's operations, so as to create an imminent safety risk; or

(d) Exhibits signs of impairment, including but not limited to alcohol or drug use, while providing, or available to provide, patient care.

7.4.2 Authority. The CEO and/or HCED, or his/her designee, as applicable, in consultation with the MSEC Chair and the Professional Medical Staff President, has the authority to impose Summary Suspension or restriction, which may involve the Practitioner's Professional Medical Staff membership and/or all or any portion of the Practitioner's Clinical Privileges, as applicable. Such Summary Suspension or restriction will become effective immediately upon imposition and the CEO and/or HCED, as applicable, will send Special Notice of the suspension promptly

to the Practitioner in accordance with subsection 8.3.1, with copies to the applicable Department Chair(s), CMO and/or HCCMO, as applicable, the MSEC Chair, PAC Chair, and the Board Chair. The summary suspension or restriction may be limited in duration and will remain in effect for the period stated or, if not so limited, will remain in effect until resolved by the procedures specified in Article VIII.

7.4.3 Review. Within two (2) business days of a Summary Suspension or restriction, the MSEC Chair, or her/his designee, shall appoint two (2) members of the MSEC to investigate the basis(es) for the action taken. The appointed investigators may not be anyone who was involved in the events or decision that led to the suspension. The investigators shall invite the Practitioner under investigation to be interviewed and to produce or identify any evidence (e.g. documents, witnesses, etc.) that he/she believes is relevant to the suspension. If the Practitioner declines an interview and/or to provide or identify such evidence, no adverse inference may be drawn by the investigators or the MSEC. The investigators may, but are not obligated to, review medical records and/or other information/evidence and interview witnesses. During every interview, both investigators shall be present and at least one investigator shall take and preserve contemporaneous notes. Within five (5) business days of the appointment of the investigators, the investigation shall conclude and the MSEC will convene in Executive Session to review and consider the findings and recommendation(s) of the investigators. However, the MSEC may extend the period of review, for Good Cause, for up to five (5) additional business days.

The MSEC may recommend to the PAC that the Summary Suspension be voided, modified in duration, or converted to a termination of Professional Medical Staff Membership and/or all Clinical Privileges, as applicable. The MSEC recommendation shall be in writing and shall concisely state the reasons for its recommendation and shall enclose all documentation/evidence that it considered in making its recommendation. However, if the recommendation is unfavorable to the Practitioner, the MSEC shall defer sending its recommendation to the PAC until the Practitioner completes or waives the section 8.4 MSEC hearing process.

7.4.4 Notice to Practitioner. Within two (2) business days after the MSEC has decided its recommended action to the PAC, the MSEC Chair, or her/his designee, shall send the Practitioner Special Notice of the MSEC's recommendation, with copies to the CEO and/or HCED, CMO and/or HCCMO and applicable Department Chair(s). If the MSEC recommends anything other than voiding the Summary Suspension, the Special Notice shall be sent in accordance with section 8.3.1. to advise the Practitioner of her/his rights under Article VIII. In the event that the Article VIII procedures are requested timely, the Summary Suspension shall remain in effect throughout the pendency of the hearing and appeal process.

7.4.5 Recommendation to Void a Summary Suspension. If the MSEC recommends voiding the summary suspension, the MSEC Chair, or her/his designee, shall immediately submit that recommendation to the PAC Chair for review and decision.

7.4.6 PAC Decision. At its next regularly scheduled meeting or at an ad hoc meeting neither of which are less than five (5) business days from its receipt of an MSEC Summary Suspension recommendation, the PAC shall review the recommendation and supporting documentation/ evidence and decide to affirm, modify, or reverse the recommendation of the MSEC. If the PAC decision is different from the MSEC recommendation, a Joint Conference Committee (JCC) shall be convened in accordance with Section 8.6. and the PAC shall make its decision at its next scheduled meeting or at an ad hoc meeting that is not less than five (5) business days from its receipt of the JCC recommendation. Otherwise, the PAC decision shall become a Final Action pursuant to subsection 7.4.7.

7.4.7 PAC Final Action. After exhaustion or waiver of all hearing and appellate procedures, and consideration of the MSEC recommendation and the Joint Conference Committee, if applicable, the PAC decision regarding Summary Suspension shall become a Final Action. The PAC Chair shall promptly send Special Notice to the Practitioner with copies to the MSEC Chair, the relevant Department Chair(s), the CEO and CMO and/or HCED and HCCMO, as applicable, and the Board Chair.

7.5 AUTOMATIC LIMITATIONS

7.5.1 Automatic Limitation. The Professional Medical Staff membership and privileges of a Member in the Active Staff category who no longer satisfies the requirements of Section 4.2.3 will automatically be re-assigned to the Associate Staff category as of the date of such cessation, unless the Member’s contract or separation agreement does not permit that.

7.5.2 Staff Providing Services Pursuant to a Contract (all medical staff categories). In the event that a Practitioner is providing services directly or indirectly at the hospital pursuant to a contract and such contractual relationship terminates or the Staff member’s relationship with his/her employer (which is contracting with the hospital) terminates, then the Practitioner’s membership and/or Clinical Privileges, as applicable, shall be governed by the terms of the contractual relationship.

7.5.3 Grounds and Notice. In the instances discussed below, the Practitioner's membership and/or Clinical Privileges, as applicable, will be terminated, suspended or limited as set forth below. It is the obligation of each Practitioner to advise the CEO and/or HCED, as applicable, and the Medical Staff Office immediately upon learning of an event that could lead

to the termination, suspension or limitation of his/her Professional Medical Staff membership or Clinical Privileges, as set forth below. Promptly upon learning of such an event, the CEO and/or HCED, as applicable, will send Special Notice of the Automatic Limitation to the Practitioner and advise the Chair of the MSEC, who will promptly advise the MSEC. If a suspension is lifted or Voided or a termination is Voided, as set forth in Subsection 7.5.4, the Medical Staff Office shall send Special Notice to the Practitioner regarding such action with copies to the CEO and CMO and/or HCED and HCCMO, as applicable, and the relevant Department Chair(s).

(a) Termination, Revocation, Suspension, Restriction or Limitation of License or Other Legal Credential. If a Practitioner's license or other legal credential authorizing practice in the Commonwealth of Pennsylvania is: (1) terminated or revoked; (2) knowingly and voluntarily non-renewed by the Practitioner or (3) surrendered while under investigation or in return for not conducting an investigation, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will terminate as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office.

If a Practitioner's license or other legal credential authorizing practice in the Commonwealth of Pennsylvania is: (1) suspended; (2) expired because it was non-renewed due to an oversight by the Practitioner; (3) limited or restricted by a licensing or certifying authority, or (4) subject to a period of probation, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will be suspended as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office, and shall remain suspended until such circumstance concludes.

If a Practitioner's license or other legal credential authorizing practice in a state other than one in which the Hospital has a facility is suspended, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will be suspended as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office and shall remain suspended until such circumstance concludes. In such circumstance, the Special Notice shall advise the Practitioner of the opportunity to submit information to the MSEC as provided in subsection 7.5.4 (c).

If a Practitioner's license or other legal credential authorizing practice in a state other than one in which the Hospital has a facility is (1) terminated or revoked; or (2) surrendered while under investigation or in return for not conducting an investigation, the Practitioner's Professional medical Staff membership and/or Clinical Privileges, as applicable, will terminate as of the date such circumstance is reported to or discovered by the CEO and/or the HCED and/or the Medical Staff Office. In such circumstance, the Special Notice shall advise the Practitioner of the opportunity to submit information to the MSEC as provided in subsection 7.5.4 (c).

(b) Termination, Revocation, Suspension, Restriction or Limitation on DEA Certificate. If a Practitioner's DEA certificate is terminated, revoked, or surrendered, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will terminate as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office.

If a Practitioner's DEA certificate is suspended, limited or subject to a period of probation or expired because it was non-renewed due to an oversight by the Practitioner, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will be suspended as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office and shall remain suspended until such circumstance concludes. This provision does not apply to a Practitioner whose practice does not require a DEA Certificate and who has elected not to maintain one.

(c) Professional Liability Insurance. If a Practitioner fails to maintain professional liability insurance in amounts and of a type required by law, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will be suspended as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office. If, within thirty (30) days thereafter, the Practitioner does not provide evidence of required professional liability insurance, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will terminate.

(d) Exclusion or Suspension from Government Program. If a Practitioner is excluded or suspended from Medicare,

Medicaid or participation in another state or federal government health care program, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will terminate as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office;.

(e) Conviction of Certain Crimes. If a Practitioner is convicted (including a guilty plea) of any felony or is convicted of a misdemeanor related to the provision of healthcare services, the Controlled Substance, Drug, Device and Cosmetic Act (P.L. 233, No. 64), criminal homicide, aggravated assault and/or sexual offenses in a court of this State, a Federal court or court of any other state, territory or an equivalent offense in a court/tribunal of another country, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will terminate as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office;

(f) Work Visa. If a Practitioner requires a work visa and such visa elapses, expires, terminates or otherwise becomes invalid, the Practitioner’s Professional Medical Staff membership and/or Clinical Privileges, as applicable, automatically will be suspended as of the date such circumstance is reported to or discovered by the CEO and/or HCED, as applicable, and/or the Medical Staff Office. During such suspension, the Practitioner shall have one (1) year to obtain/renew a work visa, otherwise the Practitioner’s Medical Staff membership and/or Clinical Privileges, as applicable, automatically terminate.

(g) Medical Records. Members of the Professional Medical Staff are required to complete medical records according to the time periods set forth in these Professional Medical Staff Bylaws, Medical Staff Policies and Hospital Policies. A temporary suspension in the form of withdrawal of Clinical Privileges until medical records are completed or the suspension is lifted will be imposed by the MSEC Chair or the CEO, after Special Notice of delinquency for failure to complete medical records within such period. The suspension will be lifted upon completion of the delinquent records, or for Good Cause shown, by the person who imposed the suspension.

(h) Medical Staff Dues and Assessments. If a Member of the Professional Medical Staff who is subject to pay medical staff dues and assessments fails to pay such dues or assessments in accordance with the Medical Staff policy, the Practitioner's Professional Medical Staff membership and/or Clinical Privileges, as applicable, will automatically be suspended until such payments, including late fees (if any) are paid.

7.5.4 MSEC Review of Automatic Limitation. The MSEC shall convene to review an automatic limitation imposed pursuant to Bylaws subsection 7.5.3(a) through (d) within five (5) business days of such limitation.

(a) In the event that the MSEC decides to maintain the automatic limitation in place as mandated by the nondiscretionary terms of Bylaws subsection 7.5.2 (a) through (d) above, the MSEC's decision is final and the rights and procedures of Article VIII will not apply.

(b) In the event that the MSEC votes to exercise its discretion to modify, extend, or expand an automatic suspension beyond that which is dictated by the nondiscretionary provisions of Bylaws subsection 7.5.3(a) through (d) above, the MSEC Chair will send the Practitioner Special Notice in accordance with subsection 8.3.1 with copies to the CEO and CMO and/or HCED and HCCMO, as applicable, and relevant Department Chair(s). In the event that the Article VIII procedures are requested timely, the automatic suspension, as modified, extended or expanded by the MSEC, shall remain in effect throughout the pendency of the hearing and appeal process. If the Practitioner waives his/her right to a hearing by failing to request a hearing within the timeframe required by Article VIII, the matter shall be sent to the PAC Chair for review and action by the PAC, in accordance with the procedures set forth in Bylaws sections 7.4.6 and 7.4.7, above, regarding Summary Suspension.

(c) In the event that a Practitioner's Professional medical Staff membership and Clinical Privileges have terminated or been suspended based upon an action taken in a state other than one in which the Hospital has a facility, as set forth in subsection 7.5.3 (a), the Practitioner may submit information to the MSEC to attempt to establish Good Cause why such termination or suspension of Medical Staff Membership and Clinical Privileges should be Voided. It shall be within the MSEC's sole discretion whether to recommend Voiding such termination or suspension. If the MSEC upholds the termination or suspension, its decision shall be final and the

rights and procedures of Article VIII shall not apply. If the MSEC decides to recommend Voiding the termination or suspension, the MSEC shall send its recommendation to the PAC Chair for review and decision by the PAC at its next meeting that is not less than five (5) days from the PAC Chair's receipt of the MSEC recommendation. The PAC shall have the sole discretion to accept or reject the MSEC's recommendation to Void the termination or suspension. The PAC's decision shall be final and the rights and procedures of Article VIII shall not apply. The MSEC Chair and PAC Chair shall send Special Notice to the Practitioner of their respective Committee's recommendation or decision, as applicable, with copies to the CEO and CMO and/or HCED and HCCMO, as applicable, and the relevant Department Chair(s).

7.5.5 Corrective Action. Suspension does not preclude the imposition of other corrective action, nor does it require the prior imposition of other corrective action. Additional corrective action may be implemented if a suspended Practitioner admits, treats, consults, performs or assists in surgery or otherwise exercises any Clinical Privileges during the period of suspension.

7.6 APPLICATION FOR MEDICAL STAFF MEMBERSHIP AFTER TERMINATION

A Practitioner whose membership on the Professional Medical Staff and Clinical Privileges have been terminated as a Final Action or as the result of an Automatic Limitation will not be eligible to reapply to the Professional Medical Staff for a period of two (2) years unless invited to reapply by the President of the Professional Medical Staff and the applicable Department Chair Department. Any reapplication will be processed as an initial application, except that the Applicant will submit such additional information as may be required to demonstrate that the basis for the termination no longer exists.

7.7 CONTINUITY OF PATIENT CARE

Upon termination, suspension, restriction or resignation of Professional Medical Staff membership or Clinical Privileges, as applicable, the President of the Professional Medical Staff or, at his/her request, the applicable Department Chair, Section Chief or Satellite Campus Division Chief, will assign the Practitioner's patients to one or more other members of the Professional Medical Staff. Reasonable efforts will be made to respect patient preference in making such assignments.

ARTICLE VIII: HEARING AND APPELLATE REVIEW

8.1 RIGHT TO HEARING

8.1.1 MSEC Hearing. Except for Members in, or Applicants to, the Affiliate and/or Emeritus categories, SPP or, as otherwise specified in these Bylaws, when any Practitioner or Applicant receives Special Notice of an unfavorable recommendation by the MSEC he/she will be entitled to an MSEC hearing as set forth in Article VIII.

8.1.2 PAC Hearing. Except for Members in, or Applicants to, the Affiliate and/or Emeritus categories, SPP or, as otherwise specified in these Bylaws, when any Practitioner or Applicant receives Special Notice of an unfavorable decision by the PAC and this decision is not based on a prior unfavorable recommendation by the MSEC with respect to which the Practitioner or Applicant was entitled to an MSEC hearing, the Practitioner or Applicant will be entitled to a PAC hearing, as set forth in Article VIII, before the PAC takes Final Action on the matter.

8.1.3 Counsel. A Practitioner or Applicant has the right to be represented by legal counsel in connection with any action undertaken pursuant to this Article VIII. The practitioner's counsel must give notice of such representation to the Profession Medical Staff leader of the Practitioner's or Applicant's choice either on the attorney's letterhead or via email from the attorney's law office email. Upon receipt of such notice, counsel for the Medical Staff shall send all Special Notice required under the Bylaws to counsel for the Practitioner or Applicant. Consistent with the Pa. Rules of Professional Conduct for attorneys, particularly Rule 4.2, counsel for a Practitioner or Applicant may not directly contact or interact with any Medical Staff Member or hospital administrator about any matter undertaken pursuant to Article VIII, but may only communicate with counsel for the Medical Staff. The role of Counsel for a Practitioner or Applicant during a hearing or appellate review pursuant to the Bylaws may be restricted as set forth in the Bylaws. However, nothing herein is intended to prevent the Practitioner or Applicant from consulting with legal counsel in preparation for such activities.

8.2 GROUNDS FOR HEARING

8.2.1 Grounds for Hearing. The following actions or recommended actions constitute grounds for a hearing, if such action is based on professional conduct, professional competence, or character/ethical concerns, and are not excluded below:

(a) Denial of Professional Medical Staff membership;

(b) Denial of Professional Medical Staff reappointment;

(c) Summary Suspension pursuant to section 7.4 (excluding Temporary Privileges);

(d) Suspension of Professional Medical Staff membership or Clinical Privileges;

(e) Termination of Professional Medical Staff membership;

(f) Denial of requested Clinical Privileges (excluding Temporary Privileges);

(g) Sustaining, expanding, modifying or continuing previously imposed corrective action, that results in greater restriction or limitation of privileges than existed before;

(h) Discretionary modification, extension, or expansion of an Automatic Limitation pursuant to subsection 7.5.3;

(i) Termination of Clinical Privileges (excluding Temporary Privileges);

(j) Denial of a request for reinstatement to the Medical Staff after a leave of absence; or

(k) Denial of request for modification of Clinical Privileges or Medical Staff Category at times other than reappointment, provided that such request is made in compliance with the requirements of section 6.11.

8.2.2 Not Grounds for Hearing. The following activities and actions shall not constitute Adverse Actions nor grounds for a hearing or appellate review, as set forth in Article VIII:

(a) MSEC meetings, during which a Practitioner/Applicant is the subject of discussion;

(b) PAC meetings, during which a Practitioner/Applicant is the subject of discussion;

(c) Credentials and Practitioner Review Committee meetings, during which the Practitioner/Applicant is the subject of discussion;

(d) Investigative or evaluative processes (e.g. interviews of witnesses and/or the Practitioner, document review, evidence gathering, etc.) undertaken pursuant to these Bylaws or Medical Staff or Hospital policies, conducted in response to concerns raised under subsection 7.2.1;

(e) Letters of admonition, reprimand, or warning;

(f) Remedial Action Plans, including, but not limited to, FPPE;

(g) Collegial Interventions of any type;

(h) Removal from a Medical Staff Officer position, a Medical Staff Committee, a Section Chief or Satellite Campus Division Chief position;

(i) Denial of requested privileges because the Practitioner/ Applicant failed to satisfy the basic qualifications set forth in these Bylaws;

(j) Applications for Medical Staff appointment, reappointment or reinstatement that have been deemed withdrawn and/or deemed resignations because of the Practitioner's/Applicant's failure to abide by the requirements set forth in Bylaws Article V;

(k) Ineligibility for Medical Staff appointment or reappointment for the clinical privileges requested because a Department or Service has closed;

(l) Termination or revocation of a Medical Staff appointment or clinical privileges in whole or in part because the hospital has decided to close or has closed a Department or Service;

(m) Suspension or termination of Medical Staff membership and/or Clinical Privileges identified under subsection 7.5.3 (a) through (g), regarding Automatic Limitations;

(n) Limitation on prerogatives regarding teaching of Undergraduate or Graduate medical trainees; and

(o) Any action or activity that is not set forth in subsection 8.2.1.

8.3 HEARINGS

8.3.1 Notice. In all cases in which an Adverse Action has been taken, as set forth in Bylaws section 8.2, the PAC Chair or the MSEC Chair, as applicable, or their respective designee, will send the affected Practitioner

or Applicant Special Notice of: (1) his/her right to a hearing and the time within which to request a hearing; (2) clear and concise reasons for the Adverse Action recommended or taken, including the act(s) by or omission(s) of the Practitioner or Applicant; (3) a list of the medical charts in question, if applicable: and (4) his/her rights at such hearing, including the hearing procedures described in Bylaws section 8.4. The Special Notice shall enclose a copy of Article VIII. Special Notice, without enclosures, shall be copied to the MSEC Chair or PAC Chair, as applicable, and to the CEO and CMO and/or HCED and HCCMO, as applicable, and the applicable Department Chair(s).

8.3.2 Request. The Practitioner or Applicant will have thirty (30) days following her/his receipt of Special Notice of an Adverse Action to request a hearing. The request must be in writing, addressed to the Chair who issued the Special Notice, and sent within the 30 day period. The Chair receiving the request, or her/his designee, will send a copy of the request to the MSEC Chair or PAC Chair, as applicable, and to the CEO and CMO and/or HCED and HCCMO, as applicable, and the applicable Department Chair(s).

8.3.3 Schedule. Upon receipt of a request for hearing, the MSEC or the PAC, as applicable, will schedule a hearing and send Special Notice to the Practitioner or Applicant of the time, place, and date of the hearing and the proposed members of the hearing committee. Each party will provide the other with a list of witnesses within fifteen (15) days of the hearing date, unless both parties agree otherwise. Witness lists will be finalized and a copy of proposed evidence shall be provided to the other party no later than five (5) business days before the hearing. The date of the hearing will be not less than thirty (30) days, nor more than ninety (90) days, from the date of receipt of the hearing request, provided that the Practitioner or Applicant may request scheduling modification(s) as set forth in subsection 8.3.10.

8.3.4 MSEC Hearing Committee. When a hearing is requested based on an unfavorable recommendation of the MSEC, the MSEC Chair in consultation with the CEO or HCED, as applicable, may in his/her sole discretion, direct that the hearing be held: (1) before a committee of three (3) Medical Staff Members in the Active Category, or (2) by an independent peer review committee of three (3) physicians from outside the Hospital Members of the hearing committee and a hearing committee chair shall be chosen by the MSEC Chair.

8.3.5 PAC Hearing Committee. When a hearing is requested based on an unfavorable decision of the PAC, the PAC may, in its sole discretion, direct that the hearing be held: (1) before a committee of three (3) members of the PAC, or (2) by an independent peer review committee of three (3)

physicians from outside the Hospital. Members of the hearing committee and a hearing committee chair shall be chosen by the PAC Chair.

8.3.6 Composition. Prior to appointment of the hearing committee, all potential hearing committee members shall be notified of their nomination to serve on the committee. Knowledge of the matter will not preclude a person from serving as a member of a hearing committee. Nominees who agree to serve on the committee, shall attest, in writing, that they have no real or potential conflict with the Practitioner or Applicant and that they are able to review and decide the matter objectively, fairly and without prejudice or bias. Submission of such attestation shall complete their appointment to the committee absent any objection pursuant to subsection 8.3.7.

8.3.7 Objection to Committee Member(s). The Practitioner or Applicant must raise any objections to any proposed committee member(s), and state the basis therefor, to the issuer of the Special Notice within five (5) days of receipt of such notice. Otherwise, they will be deemed to have waived such an objection in future proceedings under the Bylaws. It shall be within the sole discretion of the MSEC Chair or PAC Chair to replace a proposed committee member after receipt of an objection raised pursuant to this paragraph.

8.3.8 Attendance. If the Practitioner or Applicant fails to appear at the hearing without Good Cause, the hearing committee may, in their sole discretion: (1) conduct the hearing in the Practitioner's or Applicant's absence and the hearing committee's recommendation(s) shall be deemed accepted by the Practitioner or Applicant, without the right to request Appellate Review; or (2) cancel the hearing and the Adverse Action shall be submitted to the PAC and the Adverse Action shall be deemed accepted by the Practitioner or Applicant, without the right to request Appellate Review; or (3) continue the hearing until another date.

8.3.9 Discovery. The Practitioner or Applicant requesting a hearing shall not be entitled to discovery of evidence that is beyond the scope of the issues that gave rise to the Adverse Action, including credentialing or other performance related information about other Practitioners at the Hospital.

8.3.10 Scheduling Modifications. Once a request for hearing is initiated, the Practitioner may request an expedited hearing, a postponement, and/or extensions of time other than the times permitted in these Bylaws. Such requests may be permitted by the hearing committee, or its Chair acting upon its behalf, within the sole discretion of the committee or its Chair, upon a showing of Good Cause or by mutual agreement of the parties. Requests for scheduling modifications, and the reasons therefor, may be made with the initial request for a hearing or thereafter, provided that any such later request must be sent to the hearing committee chair, in writing, no later than five (5) business days before the scheduled hearing. If a

Practitioner or Applicant requests an expedited hearing, such request shall constitute a knowing and voluntary waiver of HCQIA, section 11112 (b) (2) (A).

8.4 HEARING PROCEDURE

8.4.1 Representation. The Practitioner or Applicant will be entitled to be accompanied by legal counsel or another person of the Practitioner's or Applicant's choice at a hearing. The hearing committee and the MSEC or PAC, as applicable, shall be entitled their own, respective, legal counsel to advise them in preparation for and during the hearing. The MSEC Chair or PAC Chair, as applicable, will designate one of its members as its advocate during the hearing. Legal counsel present on behalf of either party are restricted to providing private counsel to their respective client, without active participation at the hearing (i.e. attorneys are prohibited from making opening remarks or closing arguments, presenting or cross-examining witnesses, and/or making objections, etc.). If attorneys are not present at the hearing, nothing herein is intended to prevent the Practitioner or Applicant, MSEC, PAC or hearing committee from consulting with legal counsel in preparation for the hearing.

8.4.2 Hearing Committee Chair. The hearing committee chair will endeavor to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral, documentary or other evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing committee chair will be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing and will have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence. If the hearing committee chair determines that either side in a hearing is not proceeding in an efficient and expeditious manner, he/she may take such discretionary action as deemed warranted by the circumstances.

8.4.3 Record. A court reporter will be present to make a record of the hearing proceedings. All costs associated with the court reporter service will be borne by the Hospital. All parties and witnesses shall swear or affirm to tell the truth before giving testimony at the hearing. After adjournment of the hearing, the Hearing Committee Chair shall instruct the court reporter to submit the hearing transcript to the parties, on the same date, on an expedited basis by overnight carrier with tracking capability.

8.4.4 Witnesses & Evidence. All hearing committee members shall be present during opening statements, the presentation of evidence and, if presented, oral closing arguments. Within reasonable limitations, the MSEC or PAC advocate, as applicable, the hearing committee, and the Practitioner or Applicant may call and examine witnesses for relevant

testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified, and otherwise rebut evidence. The Practitioner or Applicant may be called as a witness by the MSEC or PAC representative, as applicable, or the hearing committee, and be examined/cross-examined.

8.4.5 Burden. The MSEC or PAC advocate, as applicable, shall present facts, and cross-examine witnesses, and make opening statements and closing arguments on behalf of the MSEC or PAC, as applicable. It will be the obligation of such advocate to present appropriate evidence in support of the unfavorable recommendation or decision. The Practitioner or Applicant will then have the burden of supporting his/her challenge to the unfavorable recommendation or decision by providing appropriate evidence showing that the charges or grounds involved lack sufficient factual basis, or that such basis or any action based thereon, is arbitrary, unreasonable, or capricious.

8.4.6 Rules of Evidence & Procedures. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence will not apply to a hearing conducted under Article VIII. Any relevant evidence, including hearsay, will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Evidence that is beyond the scope of the issues that gave rise to the Adverse Action, as identified in subparagraph 8.3.9, shall be inadmissible. The hearing committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. After the close of all evidence by the parties, each party shall either make an oral closing argument or submit a written closing statement to the hearing committee.

8.4.7 Conclusion of Hearing. The hearing committee chair may recess the hearing and reconvene the same without notice at such times and intervals as may be reasonable, with due consideration for reaching an expeditious conclusion to the hearing. Upon the hearing committee's receipt of closing arguments, the hearing will be adjourned.

8.4.8 Hearing Briefs. Within seven (7) business days after the parties' receipt of the hearing transcript, the parties shall submit Hearing Briefs to the hearing committee chair, with a copy to the other party, setting forth their respective arguments and referencing any evidence presented at the hearing. The parties may attach, as exhibits, any hearing evidence referenced in their respective Hearing Briefs and shall attach a copy of the entire hearing transcript to their respective briefs. Such briefs shall be on 8 ½ inch by 11 inch paper and shall not exceed fifteen (15) single side pages, excluding exhibits, of double spaced, Times New Roman, twelve (12) point font, with all margins at least one (1) inch. Failure by any party

to a submit Hearing Brief in accordance with the terms of this subsection shall preclude the hearing committee from considering that party's brief and shall preclude that party from submitting such brief for any purpose during any proceeding under Article VIII.

8.4.9 Hearing Committee Recommendation. Within seven (7) business days after Hearing Briefs are due, the hearing committee will: (1) convene to deliberate and make a recommendation; (2) send the MSEC Chair or PAC Chair, whichever appointed it, a written report and recommendation(s) regarding the Adverse Action that will contain a concise statement of the reasons in support of the recommendation(s), a copy of any Hearing Briefs (including exhibits) submitted by the parties; and (3) send the Practitioner or Applicant Special Notice of the hearing committee's written report and recommendation. The hearing committee's written report and recommendation shall be copied to the CEO and CMO and/or HCED and HCCMO, as applicable, and applicable Department Chair(s). The hearing committee's recommendation(s) regarding Corrective Action, if any, shall be by majority vote based upon a preponderance of credible evidence regarding each allegation at issue.

8.4.10 Post-Hearing Recommendation or Decision. At its next regularly scheduled meeting or at an ad hoc meeting that in not less than ten (10) business days from its receipt of the hearing committee's report, the MSEC, or the PAC, as applicable, shall review and consider the hearing committee's report and recommendation(s), the parties' respective Hearing Briefs (including exhibits) and the hearing transcript. The MSEC shall recommend to the PAC, or the PAC shall decide, as applicable, to affirm, modify, or reverse the recommendation(s) of the hearing committee. Within two (2) business days after the meeting, the MSEC or the PAC, as applicable, will send Special Notice to the Practitioner or Applicant of its recommendation/decision affirming, reversing, or modifying the hearing committee's recommendation(s) with a copy to the MSEC Chair or PAC Chair, as applicable, the CEO and CMO and/or HCED and HCCMO, as applicable, and Department Chair(s) of the Practitioner or Applicant.

8.5 APPELLATE REVIEW

8.5.1 Right to Request. A Practitioner or Applicant shall have the right to request Appellate Review by an Appeals Board, appointed by the PAC Chair, of any Adverse Action that has been the subject of a Section 8.4 hearing by the MSEC or PAC.

8.5.2 Timeframe for Request. Within five (5) business days from the Practitioner's or Applicant's receipt of Special Notice of an Adverse Action taken after a section 8.4 hearing, the Practitioner or Applicant may request appellate review. The request must be in writing and addressed to the

PAC Chair, with a copy to the MSEC Chair. Legal counsel may assist the Practitioner or Applicant in the preparation of the appeal. If a request for appellate review of an unfavorable MSEC recommendation is not made within such period, the recommendation will be referred to the PAC for a decision as soon as practicable, but in no event later than thirty (30) calendar days from the date of the Adverse Action. If a request for appellate review of an unfavorable PAC decision is not made within such period, the decision shall become a Final Action pursuant to subsection 8.5.13.

8.5.3 Contents of Request. The request for appellate review shall include the grounds for appeal and a clear and concise statement of the facts in support of such grounds. The request shall be on 8 ½ inch by 11 inch paper and shall not exceed five (5) single side pages of double spaced, Times New Roman, twelve (12) point font, and all margins shall be at least one (1) inch. The only permitted grounds for appeal from the hearing will be: (1) a showing of demonstrable prejudice to the Practitioner or Applicant based upon substantial noncompliance with the procedures required by these Bylaws or applicable law; or (2) insufficient evidence in the hearing record to support the Adverse Action. Failure to comply with the requirements of this subsection shall be deemed a waiver of appellate review. However, the Practitioner or Applicant may, based upon Good Cause, ask the PAC Chair for additional time to request appellate review. The PAC Chair, in her/his sole discretion, shall decide whether to grant such request for additional time and shall promptly send Special Notice of that decision to the Practitioner or Applicant, with a copy to the MSEC Chair.

8.5.4 Rebuttal. When the MSEC has recommended an unfavorable action to the PAC after an MSEC hearing, the MSEC Chair may, within ten (10) business days after receipt of a request for appellate review by a Practitioner or Applicant, submit a written rebuttal to the PAC Chair, with a copy to the Practitioner or Applicant by Special Notice. The rebuttal statement shall concisely state the reasons why appellate review is not warranted and shall be on 8 ½ inch by 11 inch paper and shall not exceed five (5) single side pages of double spaced, Times New Roman, twelve (12) point font, and all margins shall be at least one (1) inch. Failure to comply with the requirements of this subsection shall be deemed a waiver of the opportunity to rebut a request for appellate review.

8.5.5 Representation. The PAC, the Appeal Board and, if applicable, the Joint Conference Committee (JCC), shall be entitled to joint representation by an attorney to provide counsel and assistance during proceedings under Article VIII. That attorney shall neither vote nor advocate regarding the vote with respect to any recommendation by an Appeal Board or JCC or a decision by the PAC.

8.5.6 Appellate Review. Upon receipt of a request for Appellate Review, the PAC Chair shall appoint an Appeal Board in accordance with Section 8.7. The Appeal Board shall meet no fewer than ten (10) nor more than twenty (20) business days after receipt of the rebuttal statement or a deemed waiver to rebut, to determine whether the grounds cited by the Practitioner or Applicant are sufficient to warrant appellate review.

8.5.7 Composition. The PAC Chair shall, within five (5) business days from the date an appeal is requested, appoint an Appeal Board which will be comprised of three (3) members of the PAC. Knowledge of the matter involved will not preclude any person from serving as a member of the Appeal Board. However, no member of a PAC hearing committee on the same matter may sit on the Appeal Board. Appeal Board members shall attest, in writing, that they have no real or potential conflict with the Practitioner or Applicant and that they are able to review and make recommendations about the matter objectively, fairly and without prejudice or bias. Within two (2) business days of appointing the Appeal Board, the PAC Chair shall identify the members of the Appeal Board, and its Chair, by Special Notice to the Practitioner or Applicant and the MSEC Chair.

8.5.8 Grant/Denial of Appeal. After convening and making its decision to grant or deny appellate review, the Appeal Board Chair shall, within three (3) business days of the decision, send Special Notice of its decision to the Practitioner or Applicant, with copies to the PAC and MSEC Chairs. If a request for appellate review is granted, the Special Notice shall advise the Practitioner or Applicant and the MSEC Chair that, within five (5) business days of their receipt of such Special Notice, each party must submit their respective hearing briefs (and exhibits), the hearing transcript, and the record of the post-hearing recommendation or decision by the MSEC and/or PAC, as applicable, (collectively, appellate submissions) to the Appeal Board Chair. If a request for appellate review of an unfavorable MSEC recommendation is denied, the recommendation will be referred to the PAC for a decision as soon as practicable, but in no event later than thirty (30) Days from the date of the denial. If a request for appellate review of an unfavorable PAC decision is denied, the decision shall become a Final Action pursuant to subsection 8.5.13.

8.5.9 Scheduling. When Appellate Review has been granted, the Appeal Board will, within ten (10) business days of its receipt of the parties' appellate submissions (as identified in Section 8.5.8), set a review date and send Special Notice to the parties of the time, place, and date of the appellate review. The date of appellate review will not be less than five (5) nor more than fifteen (15) business days from the date that appellate submissions are received by the Appeal Board Chair However, the Appeal Board Chair may extend the time for appellate review in his/her sole discretion. If a Practitioner or Applicant fails to submit her/his appellate

submissions in accordance with Section 8.5.8, the matter shall be treated as a denial of Appellate review in accordance with that section.

8.5.10 Review and Recommendation. The Appeal Board shall review and consider the parties' respective appellate submissions, as identified in Section 8.5.8. The Appeal Board shall decide the appeal based upon review and consideration of these written submissions but may, in its sole discretion, invite the Practitioner or Applicant and the physician advocate from the Medical Staff, by Special Notice, to make oral argument before the Appeal Board. When such invitation is made, the Appeal Board shall allot an equal amount of time to each party for argument. Attorneys may be present on behalf of either party but are restricted to providing private counsel to their respective clients, without active participation during Appellate Review (i.e. the attorneys are prohibited from making any remarks or arguments and/or making objections, etc.). Within five (5) business days after concluding its review, the Appeal Board will privately deliberate the matter and send its written recommendation by Special Notice to the Practitioner or Applicant, as applicable, with copies to the PAC and MSEC Chairs, the CEO and CMO and/or HCED and HCCMO, as applicable, and Department Chair(s) of the Practitioner or Applicant. The Appeal Board may recommend affirming, reversing or modifying the MSEC recommendation or the PAC decision, as applicable. The Appeal Board may also recommend that the PAC request additional information from either or both parties before the PAC makes a decision.

8.5.11 PAC Decision. At its next meeting, or an ad hoc meeting, that is not less than ten (10) business days after receipt of the Appeal Board recommendation, the PAC will render a written decision regarding the matter. The PAC may affirm, modify, or reverse the recommendation of the MSEC or the prior decision of the PAC. The PAC Chair will promptly notify the parties, by Special Notice, of the PAC's decision with a copy to the MSEC Chair. However, the PAC may, on its own or upon the recommendation of the Appeal Board, request further information from either or both parties before making its decision. If such request is made by the PAC, the party or parties shall provide concise, written responses to the PAC within ten (10) business days of the party's receipt of the PAC's request. In such case, after receipt of such responses, the PAC shall decide the matter at its next scheduled meeting or at an ad hoc meeting and notify the parties, as described above.

8.5.12 Joint Conference Committee. If the PAC's determination in any matter differs substantially from the MSEC's most recent recommendation in the matter, the PAC will refer the matter to a Joint Conference Committee as provided in Bylaws section 8.6, and shall consider the recommendations of the Joint Conference Committee before taking Final Action on the matter.

8.5.13 Final Action. A PAC decision after exhaustion or waiver of all hearing rights and the right to request appellate review, and receipt of the recommendation of the Joint Conference Committee, if applicable, will constitute a Final Action. The PAC Chair shall submit Special Notice to the Practitioner or Applicant, as applicable, with copies to the MSEC Chair, the CEO and CMO and/or the HCED and HCCMO, as applicable, the applicable Department Chair(s). The PAC Chair shall also send Notice to the Board Chair concisely summarizing the issue or issues, the procedural history under Articles VII and VIII and the basis(es) upon which the PAC decided the Final Action. The Board Chair shall disclose the Final Action to the Board, in Executive Session, at its next meeting.

8.6 JOINT CONFERENCE COMMITTEE

8.6.1 Composition. The Joint Conference Committee will be composed of four (4) Medical Staff Members in the Active Category selected by the Medical Staff Executive Committee Chair and three (3) PAC Members selected by the PAC Chair. The PAC Chair shall also select a Chair of the Joint Conference Committee. Members will be selected within fifteen (15) business days of a decision of the PAC requiring referral to a Joint Conference Committee. No member of any section 8.4 MSEC or PAC hearing committee may be a member of the Joint Conference Committee. Members of the committee shall attest, in writing, that they have no real or potential conflict with the Practitioner or Applicant and that they are able to review and decide the matter objectively, fairly and without prejudice or bias. Once the committee has been selected, the PAC Chair promptly shall send Special Notice to the Practitioner or Applicant identifying the members of the committee with copies to the MSEC Chair, the CEO and CMO and/or HCED and HCCMO, as applicable, and the applicable Department Chair. The Practitioner or Applicant shall have no right to object to the appointment of any Joint Conference Committee Member.

8.6.2 Review and Recommendations. The Joint Conference Committee will review and consider the records from any preceding hearing and/or appeal. Within fourteen (14) days of the selection of the Committee, unless extended for Good Cause, the Joint Conference Committee will meet and consider the matter and give its written recommendation to the PAC Chair for consideration and decision by the PAC at its next scheduled meeting or an ad hoc meeting. The written recommendation(s) of the Joint Conference Committee shall be by majority vote and will contain a concise statement of the reasons in support of the recommendation(s).

8.7 DISCOVERY RULE

8.7.1 Request to Submit Newly Discovered Evidence. If at any time subsequent to a section 8.4 hearing by the MSEC or PAC or waiver of such hearing, but before a Final Action, a party discovers relevant evidence that was not

known and could not have been known through reasonable efforts prior to the hearing or waiver of a hearing, that party may request that such evidence be considered before a Final Action is taken. If a Joint Conference Committee or an Appeal Board has been appointed but has not made a recommendation, it shall not proceed unless a JCC or Appeal Board is still required after action has been taken in accordance with section 8.7.

Within two (2) business days of discovery of such evidence, the party shall submit a written request that such evidence be considered. If the MSEC has not made its recommendation(s) to the PAC, the party shall submit such request to the MSEC Chair. Otherwise, the party shall submit such request to the PAC Chair. A copy of the written request shall be submitted to the opposing party by Special Notice and shall concisely and specifically state the following: (1) how and when (time/date) the party became aware of such evidence; (2) the purported relevance of the evidence; (3) the type of evidence (e.g. witness(es), documents, photos, video); and (4) any information tending to establish the authenticity of the evidence. If the evidence is other than witness testimony, the requesting party shall attach a copy of the evidence to the request via appropriate media (e.g. paper, audio or video recording, etc.). If the evidence involves witness testimony, the requesting party shall identify the name and status (e.g. resident, attending, nurse, friend, et al.) of the witness(es) and a summary of the expected testimony to be elicited from the witness(es). Within two (2) business days of the opposing party's receipt of Special Notice of such request, that party may submit a written rebuttal to the MSEC or PAC Chair, as applicable, stating the reasons why such evidence should not be considered.

8.7.2 Response to Request. The MSEC Chair or PAC Chair, as applicable, shall have the sole discretion to grant or deny a request to consider newly discovered evidence. In exercising such discretion, the Chair shall review the content of the written request and any attached evidence, any rebuttal thereto, and shall decide whether such evidence could have been known by the requesting party, through reasonable efforts, prior to the hearing or the expiration of the time within which to request a hearing. The Chair shall also consider the extent to which such evidence is probative, or potentially dispositive, of the relevant issue(s). Within seven (7) business days of the Chair's receipt of the request he/she shall send Special Notice to the parties advising whether the newly discovered evidence will be considered and shall concisely state the reasons therefor.

(a) Request Denied. If the request is denied, the MSEC or PAC, as applicable, shall not be made aware of the newly discovered evidence and no reference to such evidence shall be made for any purpose, by any party, at any proceeding under Article VIII.

(b) Request Granted.

(i) Documentary Evidence. If the request is granted with regard to any evidence other than witness testimony, such evidence and the party's written request to introduce the same will be submitted by the MSEC or PAC Chair, as applicable, to their respective committee. Documentary evidence shall not be submitted at a hearing unless such evidence is pertinent to testimonial evidence that will be presented at a hearing pursuant to subsection 8.7.2 (b) (ii) or if the applicable committee chair believes that a hearing and witness testimony is required to authenticate the documentary evidence. Documentary evidence and the party's written request to introduce the same, shall be considered at the committee's next meeting.

(ii) Testimonial Evidence. Witness testimony will be presented before a hearing committee. If a previous Section 8.4 hearing has taken place, the hearing committee shall be reconvened. If a section 8.4 hearing has not taken place, within five (5) business days from the date the request to consider new evidence was granted, a hearing committee shall be selected in accordance with subsection 8.3.4 or 8.3.5, as applicable, and subsection 8.3.6. The hearing will be not less than five (5) business days, nor more than fifteen (15) business days, from the date the hearing committee is reconvened or appointed. The hearing committee Chair shall issue Special Notice to the parties advising them of the hearing date, time and place. The hearing shall be conducted pursuant to the provisions set forth in section 8.4, except that subsections 8.4.8 (re Hearing Briefs) and 8.4.9 (re Recommendation) shall not apply. The scope of the hearing shall be strictly limited to the newly discovered evidence. In lieu of Hearing Briefs, all arguments shall be made on the record and/or in the written closing arguments, if submitted. Within five (5) days of its receipt of the hearing transcript the hearing committee will: (1) send the MSEC Chair or PAC Chair, whichever appointed it, a written report and recommendation and a copy of the hearing transcript; and (2) send the Practitioner or Applicant Special Notice of the hearing committee's written report and recommendation(s). The report will contain a concise statement of the reasons in support of the recommendation(s). The

hearing committee's report and recommendation(s) and the hearing transcript, shall be considered at the applicable committee's next meeting.

(iii) After considering newly discovered evidence, the MSEC or PAC, as applicable, shall make a recommendation or decision, respectively, and the process set forth in Article VIII shall then resume.

8.8 NOTICES

Unless otherwise specified in these Bylaws, all notices of Adverse Action, requests for hearings and appeals, and the decisions or recommendations related to requests for hearings and appeals must be sent to or by the Practitioner or Applicant by Special Notice. Notices to the CMO or CEO under Article VIII may be sent to the HCED or HCCMO, respectively, when the practitioner's conduct at issue occurred, in whole or in part, at a satellite campus of the hospital.

8.9 LIMITATIONS ON HEARING AND APPELLATE RIGHTS

8.9.1 Strictly Construed. A Practitioner or Applicant is entitled to the procedural rights set forth in this Article VIII only in those situations enumerated in these Professional Medical Staff Bylaws.

8.9.2 Only One Hearing and Review. No Practitioner or Applicant will be entitled to more than one evidentiary hearing and one appellate review on any matter that is the subject of an Adverse Action.

8.9.3 No Other Rights; Waiver. The right of a Practitioner or Applicant to challenge an Adverse Action is limited to the hearing and appellate review set forth in the Bylaws. The failure of a Practitioner or Applicant to timely seek a hearing or appellate review will result in the forfeiture of the Practitioner's or Applicant's right to challenge an Adverse Action.

ARTICLE IX: DEPARTMENTS, SECTIONS AND DIVISIONS

9.1 ORGANIZATION OF DEPARTMENTS, SECTIONS

The Professional Medical Staff is divided into clinical Departments. Each Department is organized as a separate component of the Medical Staff and has a Chair selected and entrusted with the authority, duties, and responsibilities specified in section 9.4. A Department may be further divided, as appropriate, into Sections and Satellite Campus Divisions of such Departments or Sections that are responsible to the Department within which they function.

9.2 CURRENT DEPARTMENTS AND SECTIONS

The Current Departments are: Anesthesiology; Dermatology; Emergency Medicine; Family Medicine; Medicine; Neurology; Neurosurgery; Obstetrics/Gynecology and Reproductive Services; Ophthalmology; Orthopedic Surgery; Oral Surgery; Otolaryngology/Head and Neck Surgery; Pathology & Laboratory Medicine; Pediatrics; Physical Medicine & Rehabilitation; Podiatry; Psychiatry & Behavioral Sciences; Radiation Oncology; Radiology, Surgery; Thoracic Medicine & Surgery, and Urology.

The Anesthesiology Department includes the following sections: General Anesthesiology, Cardiac Anesthesiology, Pain Medicine and Critical Care. The Medicine Department includes the following Sections: Bone Marrow Transplant, Cardiology, Endocrinology, Gastroenterology, Hepatology, Hematology/Medical Oncology, Hospitalists, Infectious Diseases, Internal Medicine, Nephrology, Occupational Medicine, and Rheumatology. The Obstetrics, Gynecology and Reproductive Services Department includes the following sections: Gynecologic Oncology, Maternal Fetal Medicine and Obstetrics, Gynecology, and Urogynecology. The Department of Pediatrics includes a Neonatology Section. The Department of Radiology includes the following Sections: Body Imaging, Breast, Cardiothoracic, Musculoskeletal, Neuroradiology, Nuclear Medicine and Vascular & Interventional Radiology. The Surgery Department includes the following Sections: Abdominal Organ Transplantation, General & Minimally Invasive Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, Plastic & Reconstructive Surgery, Surgical Oncology, Trauma & Surgical Critical Care, and Vascular Surgery. The Department of Thoracic Medicine and Surgery includes the following sections: Pulmonary Medicine and Thoracic Surgery.

9.3 ASSIGNMENT TO DEPARTMENTS AND SECTIONS

Each Medical Staff Member and SPP will be assigned to at least one Department and to a Section or Satellite Campus Section, if any, within such Department, but may be granted Clinical Privileges in one or more other Departments or Sections. The exercise of Clinical Privileges or the performance of specified services within each Department, and/or Section shall be subject to the rules and regulations therein and to the authority of the Department Chair and/or Section Chief. A Medical Staff Member or SPP may attend meetings for any Department and/or Section in which he or she has Clinical Privileges.

Medical Staff Members may only vote in the Department and/or Section in which the Medical Staff Member has his/her primary assignment.

Medical Staff Members may also be assigned to inter-disciplinary service lines, but their primary clinical affiliation will be through their Department and/or Section. Service line leaders will coordinate with Department Chairs and Section Chiefs on issues regarding quality and patient safety, and will refer practitioner-specific peer review matters to the Department Chair, Section Chief, and Peer Review Committee, as appropriate.

9.4 SATELLITE CAMPUS DIVISIONS

A Satellite Campus Division may be established under any Department or Section that provides services at that Satellite Campus. The Department Chair shall assign a Division Chief to any such Division.

9.5 FUNCTIONS OF DEPARTMENTS, SECTIONS AND SATELLITE CAMPUS DIVISIONS

9.5.1 Functions of Departments

Each Department shall, under the direction of the Department Chair be responsible for overseeing the quality, safety, and efficiency of the services provided within the Department through regular peer review activities, including, without limitation, ongoing performance improvement, patient safety, and utilization management activities. The Department will conduct concurrent and retrospective peer-review privileged patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. Each Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information, and develop objective criteria for use in evaluating patient care. All clinical work performed under the jurisdiction of the Department is subject to patient care audits, regardless of whether the Practitioner whose work is subject to such review is assigned to that Department.

9.5.2 Functions of Sections

Each Section shall perform the functions assigned to it by the Department Chair. Such functions may include, without limitation, conducting quality/utilization management activities, patient safety activities, continuing education programs, Peer Review, and credentials review and privileges delineation. Each Section, subject to the approval of the MSEC, may establish rules consistent with overall department, Medical Staff and Hospital policy. Each Section shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

9.5.3 Functions of Satellite Campus Divisions

Each Satellite Campus Division shall perform the functions assigned to it by the Department Chair to assist with local governance at the Satellite Campus. Such functions may include, without limitation, conducting quality/utilization management activities,

patient safety activities, continuing education programs, Peer Review, and credentials review and privileges delineation. Each Division may establish rules consistent with overall department, Medical Staff and Hospital Administrative policies. Each Division shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

9.6 DEPARTMENT CHAIRS

9.6.1 Qualifications: Each Department will have a Clinical Chair who is a member of the Hospital Medical Staff and is qualified by training, experience, and demonstrated ability for that position. The qualifications for a Department Chair include:

(a) Meeting the qualifications for membership in the category of Active Staff as defined in Bylaws section 4.2 and the general qualifications as set forth in Bylaws section 3.2;

(b) Utilize TUH as his/her primary hospital or hold a Clinical Department Chair position at another TUHS Hospital;

(c) Not serve as a Medical Staff Officer, Department Chair or Section Chief at another hospital not affiliated with TUHS during the term of service as Department Chair;

(d) Not have an employment or other contractual arrangement, which may give rise to a conflict of interest, with another entity not affiliated with TUHS;

(e) Be willing to discharge faithfully the duties and responsibilities of the position of Department Chair; and

(f) Be knowledgeable concerning the duties of the position.

9.6.2 Designation: The Clinical Department Chairs, who may also be Academic Chairs at the Lewis Katz School of Medicine, shall be appointed by the Chair of the Board, upon recommendation of the Dean of the Lewis Katz School of Medicine of Temple University, and in consultation with the Hospital's CEO. The Chair of the Department of Podiatric Medicine and Surgery shall be appointed by Chair of the Board upon recommendation of the Dean of Temple University School of Podiatric Medicine in consultation with the Hospital's CEO and shall be a member of its clinical faculty. The term of Department Chairs in the Hospital shall be regulated by the Board Chair and the Dean of the Lewis Katz School of Medicine of Temple University or Temple University School of Podiatric Medicine.

9.6.3 Vacancy. If the position of Chair becomes vacant, the Chair of the Board of the Hospital, upon recommendation of the Dean of the Lewis Katz School of Medicine of Temple University or the Dean of Temple University School of Podiatric Medicine, as applicable, in consultation with the CEO, will select an Acting Chair, who will assume the duties of the Chair until his/her successor is appointed.

9.6.4 Duties of Department Chairs. Each Chair will have the following authority, duties, and responsibilities:

(a) Medical Staff Privileging and Credentialing

(i) Recommend the criteria for Clinical Privileges that are relevant to the care provided in the Department;

(ii) Recommend the criteria for Privileging of new technology or major changes to clinical procedures within a department and those that cross the traditional specialty lines of service;

(iii) Conduct ongoing evaluation of Department applicants and Members and make appropriate recommendations to the Credentials and Practitioner Review Committee and MSEC regarding the qualifications and competence; and

(iv) Transmit to the Credentials and Practitioner Review Committee the Department's recommendations concerning appointment, reappointment, Clinical Privileges, Medical Staff category criteria for Clinical Privileges, and monitoring of specified services for each member of the Department.

(b) Peer Review, Performance Improvement and Patient Safety

(i) With the assistance and support from Hospital Administration, the Performance Improvement and Patient Safety Committee, the Peer Review Committee, and MSEC, monitor the quality of patient care and professional performance rendered by Medical Staff Members with Clinical Privileges and other professional staff in the Department through a planned and systematic process which may include peer review, FPPE and OPPE, and overseeing the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the MSEC and Hospital;

(ii) With the assistance and support from Hospital Administration, develop and implement Department programs for retrospective and concurrent patient care review, orientation to and ongoing monitoring of practice, utilization review, and performance improvement;

(iii) Manage collegial physician issues as appropriate;

(iv) Monitor and report on the quality of care within the Department to appropriate Hospital and medical staff committees;

(v) Support Hospital programs and lead Departmental clinical effectiveness and quality improvement initiatives;

(vi) Develop and support the implementation of policies and procedures that guide the provision of clinical or operational services, and regularly evaluate departmental adherence to Medical Staff and Hospital Policies and sound principles of clinical practice;

(vii) Initiate and support programs designed to ensure patient safety; and

(viii) Integrate the Department into the primary functions of the Hospital.

(c) Medical Education

(i) Ensure compliance with regulatory standards for Medical Students and Graduate Trainees within the department;

(ii) Provide administrative and clinical support to graduate medical education within the department; and

(iii) Facilitate the continuing education in the department.

(d) Research

(i) Where applicable, support research initiatives and ensure compliance with Hospital policies and regulatory agencies' requirements.

(e) Recruitment and Retention

(i) Regularly assess whether the Department has sufficient number of qualified and competent persons to provide care and services and recommend to the Hospital any necessary recruitment and retention needs. Participate in achieving mutually agreed upon goals.

(f) Program Development

(i) Regularly assess and recommend to the CEO, or their designee, space and other resources that require acquisition, enhancement or development; and

(ii) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the CEO;

(g) Administrative Responsibilities

(i) Be a member of the MSEC, and participate in MSEC meetings;

(ii) Act as a communication conduit and represent the interests of the members of the Department;

(iii) Implement within the Department any action recommended by the MSEC;

(iv) Enforce the Bylaws, rules and regulations, and external regulatory requirements (TJC, Local, State and Federal) and Professional Organization standards, as applicable, within the Department;

(v) Support Hospital payor contracting with medical expertise as requested;

(vi) Support collaborative work among Departments and Sections;

(vii) Assess and recommend to the CEO off-site resources needed for patient care treatment and services not provided by the Department or the Hospital;

(viii) Address and continually assess clinical coverage for the Department when appropriate;

(ix) Provide orientation to members of the Department;

(x) Preside over Department meetings;

(xi) Establish, at her/his discretion, Hospital Satellite Divisions for the Department or Sections of the Department;

(xii) Appoint Department Section Chiefs;

(xiii) Appoint Hospital Satellite Campus Division Chiefs to Hospital Satellite Campus Divisions; and

(xiv) Perform such other duties commensurate with the office as may from time to time reasonably be requested by the President of the Professional Medical Staff, the MSEC, Hospital Administration, the PAC or the Board.

9.7 SECTION CHIEFS

9.7.1 Qualifications: Each Section of a clinical Department will have a Section Chief who is a member of the Hospital Medical Staff and is qualified by training, experience, and demonstrated ability for that position. The qualifications for a Section Chief include:

(a) Meeting the qualifications for membership in the category of Active Staff as defined in Bylaws section 4.2 and the general qualifications as set forth in Bylaws section 3.2;

(b) Utilize TUH as his/her primary hospital;

(c) Not serve as a Medical Staff Officer, Department Chair or Section Chief at another hospital not affiliated with TUHS during the term of service as Section Chief;

(d) Not have an employment or other contractual arrangement, which may give rise to a conflict of interest, with another entity not affiliated with TUHS;

(e) Be willing to discharge faithfully the duties and responsibilities of the position of Section Chief; and

(f) Be knowledgeable concerning the duties of the position.

9.7.2 Designation: The Section Chiefs shall be appointed by the Department Chair of their respective Section. The Section Chief shall serve at the

pleasure of the Department Chair who may remove the Section Chief at any time.

9.7.3 Vacancy. If the position of a Section Chief becomes vacant, the Department Chair shall appoint a new Section Chief.

9.7.4 Duties of Section Chiefs. Except as otherwise specified in these Bylaws, Section Chiefs will have the following responsibilities:

(a) Primary responsibility for credentialing/privileging and peer review activities within their Section, in coordination with and subject to the ultimate authority and responsibility of the Department Chair;

(b) Account to the Department Chair for the effective operation of his/her Section and for the Section's discharge of all tasks delegated to it;

(c) Develop and implement, in cooperation with his/her Department Chair, programs to carry out the quality, safety and utilization management activities assigned to the Section;

(d) Exercise general oversight of clinical work performed within the Section;

(e) Conduct investigations and submit reports and recommendations to the Department Chair regarding the Clinical Privileges to be exercised within the Section by members of or applicants to the Medical Staff and the specified services to be provided by professional staff;

(f) Act as presiding officer at all Section meetings;

(g) Report to the Department Chair on the activities of the Section; and

(h) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the MSEC or Hospital Administration.

9.8 SATELLITE CAMPUS DIVISION CHIEFS

9.8.1 Qualifications: Each Satellite Campus Division of a department Section will have a Division Chief who is a member of the Hospital Medical Staff

and is qualified by training, experience, and demonstrated ability for that position. The qualifications for a Division Chief include:

(a) Meeting the qualifications for membership in the category of Active Staff as defined in Bylaws section 4.2 and the general qualifications as set forth in Bylaws section 3.2;

(b) Either primarily practice at the Satellite Campus at which he/she will serve as Division Chief or hold administrative duties at the Satellite Campus that have been assigned by the Department Chair;

(c) Not serve as a Medical Staff Officer, Department Chair, Section Chief or Division Chief at another hospital not affiliated with TUHS during the term of service as Division Chief;

(d) Not have an unmitigated conflict of interest that arises from an employment or other contractual arrangement with another entity not affiliated with TUHS;

(e) Be willing to discharge faithfully the duties and responsibilities of the position of Division Chief; and

(f) Be knowledgeable concerning the duties of the position.

9.8.2 Designation: The Division Chiefs shall be appointed by the Department Chair of their respective Division. The Division Chief shall serve at the pleasure of the Department Chair who may remove the Division Chief at any time.

9.8.3 Vacancy. If the position of a Division Chief becomes vacant, the Department Chair shall appoint a new Division Chief.

9.8.4 Duties of Division Chiefs. Except as otherwise specified in these Bylaws, Division Chiefs will, in consultation with the respective Section Chief and in coordination with and subject to the ultimate authority and responsibility of the Department Chair, have the following responsibilities:

(a) Primary responsibility for credentialing/privileging and peer review activities within her/his respective Satellite Campus Division;

(b) Account to the Department Chair for the effective operation of his/her Satellite Campus Division and for the Division's discharge of all tasks delegated to it;

(c) Develop and implement programs specific to the Satellite Campus Division to carry out the quality, safety and utilization management activities assigned to the Division;

(d) Exercise general oversight of clinical work performed within the Satellite Campus Division;

(e) For Applicants and Providers who will or currently practice primarily at the Satellite Campus, conduct investigations and submit reports and recommendations to the Department Chair regarding the Clinical Privileges to be exercised within the Division by such members of or applicants to the Medical Staff and the specified services to be provided by professional staff;

(f) Act as presiding officer at all Satellite Campus Division meetings;

(g) Report to the Department Chair on the activities of the Satellite Campus Division; and

(h) Perform such other duties commensurate with the position as may from time to time be reasonably requested by the Department Chair, the MSEC or Hospital Satellite Campus Administration.

9.9 ADDITIONAL DEPARTMENTS AND SECTIONS

New Departments and Sections may be formed, and existing Departments and Sections may be renamed, reformulated or abolished, in consultation with the Department Chair and with the approval of the MSEC, the CEO and the Board.

ARTICLE X: OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1.1 Officers. The Officers of the Professional Medical Staff are the President of the Professional Medical Staff, the Immediate Past-President of the Professional Medical Staff, the President-Elect of the Professional Medical Staff, the Secretary-Treasurer of the Professional Medical Staff, two (2) At-Large Officers (Senior and Junior) and the Chair of the TUH – Jeanes Campus Medical Staff Leadership Committee.

10.1.2 Qualifications. Officers must be members of the Professional Medical Staff in the category of Active Medical Staff at the time of their nominations and election, and must remain members of the Active Medical Staff and in good standing during their terms of office. Failure to maintain such status will automatically create a vacancy in the office involved. .

10.1.3 Nominating Committee. The Nominating Committee will be composed of the Medical Staff Officers and two (2) members of the Active Medical Staff who shall be appointed by the Medical Staff President. The Immediate Past-President of the Professional Medical Staff shall serve as Nominating Committee Chair. The Nominating Committee will seek names of candidates from the Professional Medical Staff for each available Officer position except for the TUH – Jeanes Campus Medical Staff Leadership Committee chair, who shall be elected as set forth in Article XII, subsection 12.10.1. From the candidates reviewed, the Nominating Committee will select a ballot of candidates for each available Officer position.

10.1.4 Election. The vote for Officers shall occur over a five (5) day period that shall conclude three (3) business days before the annual Medical Staff Meeting. Voting may occur, at the sole discretion of the MSEC, by electronic or secret written vote. For electronic voting, an electronic link will be provided to the eligible voting Medical Staff Members five (5) days prior to the voting deadline and such Medical Staff Members shall cast their votes electronically. For secret written voting, the Medical Staff Office will provide paper ballots to eligible voting Medical Staff Members five (5) days prior to the voting deadline and such ballots shall be returned to the Medical Staff Office before the deadline. The votes shall be tallied by the Medical Staff Office and confirmed by at least two (2) members of the Nominating Committee. The candidate receiving the most votes for an office will be elected to the office effective July 1, provided that a quorum has been achieved consistent with Article XI, subsection 11.3.1. The Immediate Past-President of the Professional Medical Staff, as Chair of the Nominating Committee, will monitor the election and resolve any questions or disputes that arise.

10.1.5 Election Results. The results of Medical Staff election(s) for any vacant Officer position(s) will be announced by the President of Professional Medical Staff, or her/his designee, at the annual meeting of the Medical Staff, in June.

10.1.6 Term. Each Officer will serve a two (2)-year term, commencing July I following the June annual meeting, or serve the remaining term in the case of a vacancy. Each Officer will serve in such office until the end of his/her term, or until a successor is elected, unless he/she sooner resigns or is removed from office.

10.1.7 Succession. After each Officer's two year term has ended, Officer positions shall succeed as follows: The Immediate Past-President of the Professional Medical Staff shall cease to be an Officer unless elected to another officer position; the President of the Professional Medical Staff shall become the Immediate Past-President of the Professional Medical Staff; the President Elect shall become the President of the Professional Medical Staff; the Secretary-Treasurer shall become the President Elect of the Professional Medical Staff; the Senior At-Large (with the most seniority in the At-Large position) shall become the Secretary-Treasurer of the Professional Medical Staff; and the Junior At-Large Officer shall become the Senior At-Large Officer. If the At-Large Officers have the same seniority, one shall become the Secretary-Treasurer by election in accordance with subsection 10.1.4.

10.2 DUTIES OF OFFICERS

10.2.1 President of the Professional Medical Staff. The duties of the President of the Professional Medical Staff include, but are not be limited to:

(a) Serve as the Chief Officer of the Medical Staff and, if not selected as Chair of the MSEC in accordance with the provisions of Bylaws subsection 12.2.2(a), serve as Vice-Chair of the MSEC and work in close coordination with the Chair of the MSEC to ensure that the duties and responsibilities delegated to the MSEC by the Board of Governors are fulfilled;

(b) Attend meetings of the PAC and Board and represent the interests of the Medical Staff;

(c) Serve as an ex officio voting member of the MSEC;

(d) Call, preside at as Chair, and be responsible for the agenda of all general and special meetings of the Professional Medical Staff;

(e) Work, in close collaboration with the MSEC Chair, for the quality and efficiency of clinical services performed in the Hospital and for the effective assessment and measurement of quality of patient care and professional performance conducted by the Staff,

(f) Enforce the Medical Staff Bylaws, Rules and Regulations, Medical Staff Policies and Procedures, and Hospital Policies and Procedures, implement sanctions where indicated, and promote compliance with procedural safeguards when corrective action has been requested or initiated;

(g) Serve as an ex-officio voting member of all other Medical Staff committees, using his/her judgment as to whether to actively participate on any committee unless his/her membership on a particular committee is required by these Bylaws;

(h) Work in close collaboration with the CEO and CMO, Board and MSEC Chairs on all matters of mutual concern to the Hospital and Medical Staff relative to the provision of professional services by Medical Staff Members;

(i) Represent the views and policies of the Professional Medical Staff to the Board and to the CEO;

(j) Have oversight and investigative authority on behalf of the MSEC for concerns arising under Article VII; and

(k) Serve as spokesperson for the Professional Medical Staff in external professional and public relations.

10.2.2 President-Elect of the Professional Medical Staff. The duties of the President- Elect of the Professional Medical Staff include, but are not limited to:

(a) Assume all duties and authority of the President of the Professional Medical Staff in the absence of the President of the Professional Medical Staff;

(b) Serve as an ex officio voting member of the MSEC; and

(c) Call general meetings of the Professional Medical Staff on the order of the President of the Professional Medical Staff.

10.2.3 Secretary-Treasurer of the Professional Medical Staff. The duties of the Secretary-Treasurer will include, but not be limited to:

(a) Serve as an ex officio voting member of the MSEC;

(b) Maintain a roster of members of the MSEC, the Professional Medical Staff and committees of the Medical Staff;

(c) Keep accurate and complete minutes of all Professional Medical Staff meetings;

(d) Supervise the collection, accounting, and expenditure of all Medical Staff funds, and if requested by the President of the Professional Medical Staff or the Board;

(e) Attend to all appropriate correspondence and notices on behalf of the Medical Staff;

(f) Perform such other duties as ordinarily pertain to the office or as may be assigned from time to time by the President of the Professional Medical Staff.

10.2.4 "At-Large" Officers of the Professional Medical Staff. The duties of the At Large Officers will include, but not be limited to:

(a) Serve as an ex officio voting member of the MSEC;

(b) Assist the other Officers in completing their duties;

(c) Represent the views and policies of the Professional Medical Staff to the President, President-Elect and Secretary-Treasurer; and

(d) Perform such other duties as may be assigned from time to time by the President of the Professional Medical Staff.

10.2.5 The Chair of the TUH Jeanes Campus Medical Staff Leadership Committee. The duties of this At Large Officer will include, but not be limited to:

(a) Serve as an ex officio voting member of the MSEC;

(b) Assist the other Officers in completing their duties;

(c) Represent the views and policies of the Professional Medical Staff at the TUH – Jeanes Campus; and

(d) Perform such other duties as may be assigned from time to time by the President of the Professional Medical Staff.

10.2.6 Immediate Past-President. The duties of the Immediate Past-President will include, but not be limited to:

(a) Serve as an ex officio voting member of the MSEC;

(b) Serve as Chair of the Nominating Committee for Medical Staff Officers;

(c) Monitor Medical Staff Officer elections;

(d) Serve as Chair of the Bylaws Committee; and

(e) Perform such other duties as may be assigned from time to time by the President of the Professional Medical Staff.

10.3 REMOVAL

10.3.1 Removal of Officers. The procedure for removal of Officers will be as follows:

(a) A request for removal of a Professional Medical Staff Officer may be made by a petition signed by at least three-fourths (3/4) of the members of the Professional Medical Staff eligible to vote for Officers, or by motion of the MSEC.

(b) Grounds for removal from Office may include, but are not limited to: (1) failure to carry out the usual and expected duties of the office; or (2) the Officer's ineffectiveness at carrying out his/her duties.

(c) Upon receipt of a petition for removal, the MSEC will vote on a petition for removal of a Professional Medical Staff Officer within sixty (60) days. Upon its own motion for removal, the MSEC shall have the discretion to vote on such motion immediately or at its next scheduled meeting. During any such vote, the Medical Staff Officer at issue shall recuse

herself/himself from the deliberations and vote. A vote for removal of a Medical Staff Officer and a summary of the reasons therefore, shall be submitted to the Board Chair and will only become effective if approved by the Board.

(d) An Officer who ceases to meet the Qualifications set forth in Bylaws subsection 10.1.2, above, will be automatically disqualified and removed from office effective as of the date the Qualifications are no longer met.

10.3.2 Vacancies. Vacancies prior to the end of a term in office may arise due to the death, disability, resignation, or removal of an Officer or such Officer's loss of membership on the Professional Medical Staff in the category of Active Staff. The process for filling vacancies should be completed by the end of June in the year vacancies occur.

(a) If there is a vacancy in the office of President of the Professional Medical Staff, the President-Elect of the Professional Medical Staff will serve out that remaining term, the Secretary-Treasurer of the Medical Staff will serve out the remaining term of the President-Elect of the Professional Medical Staff and the Senior “At Large” Officer will serve out the remaining term of the Secretary-Treasurer. The Nominating Committee will nominate one (1) or more nominees for the remaining “At Large Officer” position and an election will be held by secret written/electronic ballot.

(b) If there is a vacancy in the office of President-Elect of the Professional Medical Staff, the Secretary-Treasurer of the Medical Staff will serve out the remaining term of the President-Elect and the Senior “At Large” Officer will serve out the remaining term of the Secretary-Treasurer. The Nominating Committee will nominate one (1) or more nominees for the remaining “At Large Officer” position and an election will be held by secret written/electronic ballot.

(c) If there is a vacancy in the office of Secretary-Treasurer of the Staff, the Senior “At Large” Officer shall serve out the remaining term of the Secretary-Treasurer. The Nominating Committee will nominate one (1) or more nominees for the remaining “At Large

Officer" position and an election will be held by secret written/electronic ballot.

(d) If there is a vacancy in the Senior "At Large" Officer position, the Junior "At Large" Officer shall serve out the remaining term of the Senior "At Large" Officer. The Nominating Committee will nominate one (1) or more nominees for the remaining "At Large" Officer position and an election will be held by secret written/electronic ballot.

(e) If there is a vacancy in the Junior "At Large" Officer position, the Nominating Committee will nominate one (1) or more nominees for that "At Large" Officer position and an election will be held by secret written/electronic ballot.

(f) If there is a vacancy in the TUH – Jeanes Campus Medical Staff Leadership Committee chair, a new chair shall be elected as set forth in Article XII, subsection 12.10.1.; and

(g) If the Immediate Past President is unable or unwilling to fulfill the duties as delineated in 10.2.6, the MSEC, in consultation with the President of the Medical Staff, will appoint an Active Medical Staff member to be the Chair of the Nominating Committee and Chair of the Bylaws Committee. The appointed individual will serve as an ex officio voting member of the MSEC, and the term of appointment shall end upon succession of the officers of the medical staff as described in 10.1.7.

ARTICLE XI: MEETINGS

11.1 MEETINGS

11.1.1 Annual Medical Staff Meeting. There will be an Annual Meeting of the Professional Medical Staff each June that will include reporting results of the election of Officers, when required. The President of the Professional Medical Staff, or such other Officers, or Committee Chairs as the President of the Professional Medical Staff may designate, will present reports on actions taken during the preceding year and on other matters of interest and importance to the Medical Staff Members.

Notice (as defined in the Definitions) of the Annual Medical Staff Meeting will be given to Medical Staff Members eligible to attend not less than ten (10) business days prior to the meeting.

11.1.2 Regular Medical Staff Meetings. Regular meetings of the Medical Staff Members may be held at the request of the President of the Professional Medical Staff. Notice of regular meetings will be given to the Medical Staff Members eligible to attend not less than five (5) business days prior to the meeting.

11.1.3 Agenda. The order of business at the Annual Meeting or a regular meeting of the Professional Medical Staff will be determined by the President of the Professional Medical Staff. The agenda may include, insofar as feasible:

(a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) Administrative reports from the President and Treasurer of the Professional Medical Staff and the CEO;

(c) Election of Officers when required;

(d) Old business; and

(e) New business.

11.1.4 Special Medical Staff Meetings. Special meetings of the Professional Medical Staff may be called at any time by the President of the Professional Medical Staff, as requested by an Officer of the Medical Staff, the Board or the CEO, or upon the written request of at least twenty-five (25) members of the Medical Staff entitled to vote. The person calling or requesting the special meeting will state the purpose of such meeting in writing. The meeting will be scheduled by the President of the Professional Medical Staff within thirty (30) days after receipt of a valid request. Notice

of special meetings, which includes the stated purpose(s) of the meeting, will be sent to Medical Staff Members eligible to vote not less than five (5) business days prior to the meeting. No business will be transacted at any special meeting except that stated in the Notice calling the meeting.

11.2 COMMITTEE MEETINGS

11.2.1 Date, Time and Location. Except as otherwise specified in these Bylaws or by the President of the Professional Medical Staff, the Chairs of Committees will establish the dates, times and locations for the holding of meetings. The Chairs will make reasonable efforts to ensure the information is disseminated to the members with adequate notice.

11.2.2 Special Meeting. A special meeting of any Professional Medical Staff committee may be called by the Chair thereof, the MSEC, the President of the Professional Medical Staff, or the CEO. Notice of special meetings, which includes the stated purpose(s) of the meeting, will be sent to committee members not as soon as possible. No business will be transacted at any special meeting except that stated in the Notice calling the meeting.

11.3 QUORUM

11.3.1 Medical Staff Meetings. The presence of forty (40) voting members of the Medical Staff at any regular or special Medical Staff meeting in person or by electronic vote prior to the start of the meeting, will constitute a quorum for the transaction of business.

11.3.2 Committee Meetings. Unless a another quorum is specified, the presence of one-third (1/3) of the voting members of any Professional Medical Staff committee in person and/or by virtual means will constitute a quorum for the transaction of business if the committee has five (5) or more voting members; and the presence of at least one-half of the voting members of any Professional Medical Staff committee in person and/or by virtual means will constitute a quorum for the transaction of business if the committee has less than five (5) voting members.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present will be the action of the group. A meeting at which a quorum is present initially may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. With the permission of the President of the Professional Medical Staff, in the case of Professional Medical Staff meetings, and the Committee Chair, in the case of a Professional Medical Staff committee, a member may participate in a meeting by conference call or similar communications equipment by means of which

all persons participating in the meeting can hear each other; any member so participating will be deemed present and may vote at such meeting. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken, which is signed by at least a quorum of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings will be prepared and retained for the time period required by law or Hospital policy. They will include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes will be approved by the Secretary-Treasurer of the Professional Medical Staff, or Medical Staff Officer designee, for Medical Staff Meeting or by the Chair of the applicable Professional Medical Staff Committee for Committee meetings.

The minutes of any peer review meeting will be clearly labeled with at least "CONFIDENTIAL PEER REVIEW – PRIVILEGED," and, to the extent reasonably practicable, maintained in a separate, locked drawer and/or secure electronic files. The minutes of any patient safety meeting will be clearly labeled with at least "CONFIDENTIAL PATIENT SAFETY ACT/MCARE – PRIVILEGED," and, to the extent reasonably practicable, maintained in a separate, locked drawer and/or secure electronic files. For those meetings that cover multiple topics, some of which may be covered by the Peer Review Privilege and/or MCARE privilege and/or the qualified immunity of HCQIA, similar precautions will be taken with respect to that portion of any meeting minutes that include such privileged information.

11.6 ATTENDANCE REQUIREMENTS

11.6.1 Special Request. At the discretion of the President of the Professional Medical Staff or other presiding officer, when a Member's practice or conduct is scheduled for discussion at a committee meeting, the Member may be requested to attend or to not attend. If the Practitioner is requested to attend, he/she will be given at least three (3) business days' Notice prior to the meeting (unless such time period is waived by the Practitioner) and the request will include the time and place of the meeting and a general indication of the issue involved. Failure of a Medical Staff Member to appear at any meeting with respect to which he/she was given such Notice, unless excused by an Officer of the Medical Staff upon a showing of Good Cause, may be a basis for corrective action.

11.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings will be conducted according to the procedure established by the Committee Chair, in his/her discretion. Committee members or attendees may raise objections to the procedure from the floor. Actions taken will not be subject to later challenge on the basis of parliamentary or other decisions from the Chair,

except where the actions were in direct conflict with these Bylaws or related points of order were raised at the meeting in which the action was taken.

ARTICLE XII: COMMITTEES

12.1 DESIGNATION

12.1.1 Committees. The Medical Staff will have a Medical Staff Executive Committee (MSEC) (12.3), eight (8) Core Standing Peer Review Committees reporting directly to the MSEC (12.4-12.10), and eleven (11) subsidiary peer review committees reporting to the MSEC through the Performance Improvement Committee (12.11-12.24), as follows:

(a) MSEC (12.3)

(i) Bylaws Committee (12.4)

(ii) Credentials and Practitioner Review Committee (12.6)

(iii) Graduate Medical Education Committee (12.7)

(iv) Peer Review Committee (12.8)

(v) Practitioner Wellness Committee (12.9)

(vi) TUH – Jeanes Campus Medical Staff Leadership Committee (12.10)

(vii) Performance Improvement Committee (12.11)

(1) Cancer Committee (12.13)

(2) Code/RRT Committee (12.14)

(3) Health Information Management Committee (12.16)

(4) ICU Committee (12.17)

(5) Operating Room Executive Committee (12.19)

(6) Surgical Care Improvement and Tissue Committee (12.23)

(7) Utilization Review Committee (12.24)

(viii) Patient Safety Committee (12.12)

(1) Ethics Committee (12.15)

(2) Infection Prevention and Control Committee (12.18)

(3) Pharmacy and Therapeutics Committee (12.21)

(4) Radiation Safety Committee (12.22).

The Medical Staff may have other peer review standing committees, special committees, and ad hoc committees as created by the President of the Professional Medical Staff or a Department Chair, as deemed appropriate, provided that such committees shall not supersede or serve as a substitute for the Peer Review Committee, and/or its activities, as set forth in Section 12.8. For example, a Department Chair may create a standing Mortality and Morbidity Committee to conduct peer review activities within the department. With respect to required committees, committee names may be modified and committee functions may be combined by the MSEC.

12.1.2 Peer Review Activities. Each Committee of the Medical Staff conducts activities to measure, assess, and improve performance on an organization-wide basis. The Committees and their membership enjoy all confidentiality protections and immunities from liability and all other protections granted by the Pennsylvania Peer Review Protection Act, as amended, MCARE, or by HCQIA, or by any other similar statutes that may be enacted, if such activities are described in any such statute.

12.1.3 TUHS System-Wide Committees. The MSEC may elect to coordinate the activities of some of its Committees with the same subject-matter Committees of its affiliated hospitals within the Temple University Health System to obtain the benefit of the broader base of knowledge, expertise, and unique perspectives, and to enhance the opportunities for system-wide collaboration and coordination.

12.2 GENERAL PROVISIONS

12.2.1 Appointment of Members. Unless otherwise specified,

(a) The Medical Staff Members of all committees will be appointed by and may be removed by the Chair of the Committee, in consultation with the Chair of the MSEC, CMO, and Chair of the applicable Department;

(b) The CEO will appoint all non-Medical Staff members of committees, after consultation with the Chair of the Committee;

(c) Members of the Medical Staff who are appointed to a committee will be voting members of that committee unless otherwise specified in these Bylaws;

(d) Committees may have non-voting members;

(e) The number of voting and non-voting members of a committee will be determined by the Chair of the Committee; and

(f) Committee members other than ex officio members will serve for one year, unless one of the grounds for removal in Bylaws subsection 12.2.4 applies, and their membership will be reevaluated on an Academic Year-by-Academic Year basis. There is no maximum number of terms a committee member may serve.

12.2.2 Committee Chairs. Unless otherwise specified**,**

(a) The MSEC, in consultation with the President of the Professional Medical Staff, will appoint the Chair of every committee, including the MSEC, upon majority vote;

(b) The Chair of every Committee will be a physician member of the Medical Staff in the category of Active Staff;

(c) The Chairs of the MSEC and the eight (8) Core Standing Peer Review Committees will serve for a term of two (2) Academic Years, and may serve three (3) consecutive terms, following which the individual will be eligible to serve again after a period of one Academic Year has elapsed;

(d) The Chairs of the eight (8) Core Standing Peer Review Committees shall appoint Vice Chairs to their respective Committees in consultation with the President of the Professional Medical Staff, CMO, and the Department Chair (of the appointed Vice Chair);

(e) At least six (6) months prior to the end of any Core Standing Peer Review Committee Chair's term, the MSEC Chair may, at her/his discretion, review the performance of the Chair and determine whether to propose a vote by the MSEC to allow that Chair to continue to serve or to be replaced. Otherwise, the MSEC shall review and affirm the continued service of the existing Core Committees' Chair appointments, subject to the term limitations of subsection 12.2.2 (c); and

(f) No one physician member of the Medical Staff shall serve as Chair of more than one of the following committees at the same time: Peer Review, Credentials and Practitioner Review, MSEC, and Graduate Medical Education Committee.

12.2.3 Responsibility. Medical Staff committees will be responsible to the MSEC.

12.2.4 Removal. Committee members may be removed at the end of the designated term for which the committee member was appointed with or without cause by the Officer, person(s) or body that appointed or elected them. Committee members will automatically cease to be Committee members if they cease to qualify for the committee slot to which they were appointed (such as a practitioner who held a slot designated for a Medical Staff Member and ceases to be a member of the Medical Staff) or as otherwise provided in these Bylaws or by contract, and may be removed, for cause, by the MSEC or Board.

12.2.5 Vacancies. Unless otherwise specifically provided, vacancies on any committee will be filled in the same manner in which an original appointment to such committee was made.

12.2.6 Subcommittees.

(a) Each committee may establish one or more subcommittees, including subcommittees at a Satellite Campus, to review such matters and make such recommendations to the committee as set forth in the mandate establishing the subcommittee. The Chair of each committee will notify the standing and core peer review committees of the formation and/or dissolution of a subcommittee.

(b) The Committee Chair will appoint a Subcommittee Chair and other subcommittee members. Each subcommittee must have at least one member who is a voting member of the parent committee, unless otherwise approved by the MSEC. The subcommittee chair, or their designee, shall regularly attend the meetings of the parent committee and report the activities of the subcommittee.

12.3 MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)

12.3.1 Members. The voting members of the MSEC will be composed of the Officers, the Clinical Department Chairs, the Chairs of the Core Standing Peer Review Committees identified in Bylaws section 12.1.1, three (3) Active Medical Staff Members who primarily practice at the Jeanes

Campus, a Medical Staff Member from the ECNC, the Chief Executive Officer of Temple University Health System, the Dean of the Lewis Katz Medical School of Temple University, the CEO and a Graduate Medical Trainee. The CMO and Hospital Chief Nursing Executive will be ex-officio, non-voting members. The MSEC may include other practitioners and any other individuals as determined by the Medical Staff Members. No Medical Staff member in the category of Active Staff who is actively practicing in the Hospital is ineligible for membership on the MSEC solely because of his/her professional discipline or specialty.

12.3.2 Chair. The Chair will be appointed as set forth in Bylaws subsection 12.2.2, and will have primary responsibility for ensuring that the MSEC fulfills its delegated duties and responsibilities as set forth in these Medical Staff Bylaws. If the MSEC Chair does not also serve as the President of the Medical Staff, the MSEC Chair will work in close coordination with the President of the Medical Staff to fulfill this accountability.

12.3.3 Vice Chair. The President of the Professional Medical Staff will serve as either the Chair or the Vice-Chair of the Medical Staff Executive Committee and, if serving as Vice-Chair, will work in close coordination with the Chair in ensuring that the MSEC fulfills its delegated duties and responsibilities under the Medical Staff Bylaws.

12.3.4 Delegated Duties. The duties delegated by the Medical Staff Members to the MSEC include:

(a) Fulfilling the Medical Staff's accountability to the Board for the medical care rendered to the patients of the Hospital;

(b) Working, in conjunction with the Officers of the Medical Staff, for the quality, safety and efficiency of clinical services performed in the Hospital and for the effective assessment and measurement of quality of patient care and professional performance conducted by the Staff,

(c) Implementing and/or approving relevant Medical Staff Bylaws and Rules & Regulations, Medical Staff Policies and Hospital Policies;

(d) Approving, creating or abolishing core or standing peer review committees and advising the Medical Staff at a Medical Staff meeting;

(e) Receiving and acting upon the reports and recommendations of other Medical Staff committees,

clinical Departments and assigned activity groups and communicating such to the Medical Staff;

(f) Empowered to act for the Medical Staff in the intervals between meetings of the Professional Medical Staff within the scope of its responsibilities and duties as defined by the Medical Staff Bylaws;

(g) Making recommendations to the Board and CEO or HCED regarding Hospital operations, procedures, and problems;

(h) Making recommendations to the PAC on matters relating to appointments, reappointments, Medical Staff categorizations or structure, Clinical Privileges, terminations, resignations, and fair hearing procedures;

(i) Coordinating with Hospital Administration and making recommendations to the CMO or HCCMO and CEO or HCED on matters relating to clinical practice and administration;

(j) Taking reasonable steps to ensure ethical professional conduct on the part of all Medical Staff Members and pursuing corrective action when indicated, in accordance with the Medical Staff Bylaws;

(k) Promoting the education of the Medical Staff regarding the status of accreditation and regulatory requirements impacting the provision of care and services; and

(l) Fulfilling such other duties as may be required by law or accreditation standards, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, the PAC or the Board.

12.3.5 Removal of Duties Delegated to the MSEC.

Removal of any duties delegated to the MSEC shall be done in accordance with section 15.1 of the Medical Staff Bylaws.

12.3.6 Meetings.

(a) The MSEC will meet as necessary, but at least ten (10) times per Academic Year;

(b) The Chair of MSEC will submit minutes of each MSEC meeting, or a summary thereof, to the committee of the Board designated to review quality issues promptly upon approval of the minutes; and

(c) A voting MSEC member may be considered present for quorum and voting purposes by acting through another voting MSEC member to whom he/she has given his/her proxy.

12.4 BYLAWS COMMITTEE

12.4.1 Members. The voting members of the Committee will include the President of the Professional Medical Staff, at least two (2) Officers of the Professional Medical Staff, the Chair of the MSEC, at least three (3) Active members of the Medical Staff, one of whom shall primarily practice at the Jeanes Campus, representing a cross-section of the Medical Staff, at least one Graduate Medical Trainee, a representative from Hospital Administration and the Immediate Past-President of the Medical Staff, who will serve as Chair. The CMO and HCCMO will be ex-officio, non-voting members of the Committee. The Committee may invite a member of the Board to participate as an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are deemed appropriate.

12.4.2 Duties. The duties of the Committee include:

(a) Reviewing annually all relevant standards issued by TJC and other pertinent accreditation and regulatory agencies to ensure that the Bylaws comply with such standards and with the Hospital's current practice in the provision of patient care;

(b) Making recommendations to the MSEC regarding changes to the Bylaws as needed; and

(c) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, or the Board.

12.4.3 Meetings. The Bylaws Committee will meet as necessary, but at least once per Academic Year and will report to the Medical Staff Executive Committee.

12.4.4 TUHS System-Wide Coordination of Bylaws Committees. The Bylaws Committees of each TUHS affiliate may coordinate their functions as appropriate to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.5 RESERVED.

12.6 CREDENTIALS AND PRACTITIONER REVIEW COMMITTEE

12.6.1 Members. The voting members of the Committee will include an Officer and at least five (5) Medical Staff Members and one APP, representing a cross-section of the Medical Staff. The CMO will be an ex-officio member of the Committee. The Committee may include such other voting and such non-voting members as are appropriate.

12.6.2 Duties. The duties of the Committee include:

(a) Investigating the professional qualifications and competence of applicants to the Medical Staff;

(b) Receiving and reviewing Practitioners' submitted documentation to ensure that the requirements of subsection 3.2.2 have been met;

(c) Receiving, reviewing and evaluating the reports and recommendations regarding Practitioners' professional performance submitted from any other peer review committee(s) established under Article XII, 12.1.1 of these Bylaws to ensure that Practitioners meet the quality and efficiency of service standards required to attain or maintain membership on the Professional Medical Staff;

(d) Making recommendations to the MSEC for the appointment, reappointment, or modification of Clinical Privileges, including Medical Staff category, of all Medical Staff Members and applicants;

(e) Making recommendations to the MSEC regarding privileging criteria for Medical Staff Members, including working with Department Chairs to establish competency criteria for designated privileges, particularly with respect to new procedures;

(f) Receiving and acting upon the reports and recommendations of the Bylaws Committee and relevant sub-committees;

(g) Reviewing and making recommendations to the MSEC to resolve inter-departmental conflicts with regard to privileges and privilege criteria;

(h) Making recommendations regarding the delegation of the credentialing process to other TJC accredited entities in appropriate cases, such as telemedicine;

(i) Being responsible for the initiation and approval (in consultation with the relevant department chair(s)) of any FPPE and/or OPPE, and making recommendations regarding privileges based upon the results thereof; and

(j) Fulfilling such other duties as may be required by law or accreditation standards, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, the PAC or the Board.

12.6.3 Meetings. The Credentials and Practitioner Review Committee will meet as necessary, but at least ten (10) times per Academic Year and will report to the MSEC.

12.7 GRADUATE MEDICAL EDUCATION COMMITTEE

12.7.1 Members. The voting members of the Committee will include a minimum of ten (10) Program Directors, or their designees. Of these ten (10) members at least one member will be from each of the following groups: (1) hospital based specialties (anesthesiology, emergency medicine, diagnostic radiology, pathology); (2) medically-oriented specialties (internal medicine, physical medicine & rehabilitation, psychiatry, neurology); (3) surgical specialties (neurological surgery, obstetrics & gynecology, orthopedic surgery, ophthalmology, otolaryngology, plastic surgery, surgery, urology); and (4) subspecialty (fellowship) training programs, non-ACGME accredited programs (podiatric specialties, oral-maxillofacial surgery). In addition, the voting members will include the Designated Institutional Official for Graduate Medical Education (DIO), the Dean of the School of Medicine or his/her designee, and four (4) graduate trainee members, selected by their peers. The CMO will be an ex-officio, non-voting member of the Committee. Program Directors or their designees must constitute, at a minimum, sixty percent (60%) of the voting members of the committee. The committee may make such changes in the number and composition of its voting membership as it deems appropriate, provided the composition of the committee is consistent with the minimum membership requirements outlined above, and the composition is approved by the MSEC.

12.7.2 Duties. The duties of the Committee include:

(a) Providing oversight of all graduate medical education programs at Temple University Hospital and Health System to enhance quality and promote excellence;

(b) Regularly reviewing all graduate medical education programs through the process of internal reviews, to ensure compliance with Hospital, ACGME and any other applicable standards;

(c) Providing a written report, at least annually, to the MSEC Hospital Administration and the Board;

(d) Recommending policies to the MSEC with respect to graduate medical education;

(e) Establishing and maintaining appropriate oversight of and liaison with program directors;

(f) Ensuring that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in programs sponsored by the Hospital;

(g) Regularly reviewing all letters of accreditation and monitoring of action plans for the correction of areas of noncompliance;

(h) Assuring that each residency program establishes and implements formal written criteria and processes for the selection, evaluation, promotion and dismissal of residents in compliance with the Institutional and Program Requirements for the specialties and subspecialties of the ACGME, Review and Recognition Committees (RRC) or other accrediting bodies;

(i) Establishing and implementing policies that affect all residency programs regarding the quality of education and the work environment for the residents in each program;

(j) Recommending to the MSEC and the Hospital the appropriate number and distribution of medical residents and fellows and the appropriate funding for resident positions including benefits, salary, and support services;

(k) Establishing and implementing a formal written policies and procedures governing resident duty hours, in compliance with ACGME and other regulatory body requirements, and monitoring compliance by programs with these policies and procedures;

(l) Ensuring that each program provides a curriculum and an evaluation system for residents to ensure that the residents demonstrate competence in the areas described by the Institutional Requirements and Program Requirements;

(m) Ensuring that an education environment is maintained in which residents may raise and resolve issues without fear of intimidation or retaliation;

(n) Receiving reports from and providing reports/direction to the appropriate medical staff committee at any other TUHS hospital that has graduate medical education trainees training at that hospital; and

(o) Fulfilling such other duties as may be required by law, the ACGME or other regulatory or accreditation bodies, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, Hospital Administration, the MSEC, or the Board.

12.7.3 Meetings. The Graduate Medical Education Committee will meet as necessary, but at least quarterly, and will report to the MSEC at least quarterly.

12.7.4 TUHS System-Wide Coordination. The Graduate Medical Education Committees of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.8 PEER REVIEW COMMITTEE

12.8.1 Members. The voting members of the Committee will include at least seven (7) Medical Staff Members, representing a cross-section of appropriate clinical services. Nursing representatives of the Committee shall be voting members of the Committee's Nursing Peer Review Sub-committee. The CMO, and representatives from Performance

Improvement, Risk Management, and Health System Counsel will be ex-officio, non-voting members of the Committee. The Committee may include such other voting and such non-voting members as are deemed appropriate.

12.8.2 Duties. The duties of the Committee include:

(a) Providing an in-depth multi-disciplinary review of the medical care provided, in cases identified for review, according to the Peer Review Policy and Procedures, and FPPE and OPPE Policies, incorporated herein by reference;

(b) Implementing the follow-up and remedial actions provided for in the Peer Review Policy and Procedures;

(c) Providing recommendations to the Department Chairs and other Healthcare Provider supervisors with regard to FPPE;

(d) Evaluating the medical care provided, specifically noting whether documentation supports that an appropriate standard of care was met;

(e) Discussing, assessing, and making recommendations regarding intra- and inter-departmental challenges in quality assessment/quality improvement, patient safety, management, utilization management and credentialing;

(f) Making recommendations for corrective actions as related to care issues identified and discussed;

(g) Developing strategies to address and act upon performance improvement;

(h) Monitoring Medical Staff functions, credentialing, medical record documentation, drug usage evaluation, infection control, blood usage evaluation, utilization reviews and utilization of critical pathways;

(i) Referring findings and recommendations to the appropriate department(s) for review and action; following-up on implementation of recommended actions;

(j) Providing Risk Management and Office of Counsel with committee findings in order for the Office of Counsel to effectively establish and regularly update financial reserves for the professional liability program; and

(k) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, Hospital Administration, the MSEC, the PAC or the Board.

12.8.3 Meetings. The Peer Review Committee will meet as often as necessary, but at least ten (10) times per Academic Year and will report to the MSEC.

12.8.4 Quorum. A quorum for Peer Review Committee meetings shall be met in accordance with the Medical Staff Peer Review Policy.

12.9 PRACTITIONER WELLNESS COMMITTEE

12.9.1 Members. The voting members of the Committee will include at least five (5) Medical Staff Members, one (1) APP, and one (1) representative of the Graduate Medical Education Committee. The CMO and/or HCCMO shall be an ex officio, non-voting member. The Committee may include such other members as are deemed appropriate.

12.9.2 Duties. The duties of the Committee shall be in accordance with Hospital policy.

12.9.3 Meetings. The Practitioner Health Committee will meet at least annually and on an as-needed basis, and will report to the MSEC.

12.10 TUH – JEANES CAMPUS MEDICAL STAFF LEADERSHIP COMMITTEE

12.10.1 Chair. The Committee Chair shall be a medical staff member who performs a majority of her/his clinical practice at the TUH – Jeanes Campus and in the event of vacancy shall be recommended to the MSEC by majority vote of Active medical staff members who perform a majority of their clinical practice at JC. The MSEC, in consultation with the President of the Professional Medical Staff, must approve the recommended Chair of the committee by majority vote. If the MSEC does not approve a Chair recommendation, it shall request that another Chair candidate be recommended in the manner specified above.

12.10.2 Members. All voting members must perform a majority of their clinical practice at JC. The voting members of the Committee will include the

Committee Chair and at least five (5) Active Medical Staff Members, who shall be appointed by the Chair. The JC Executive Director, JC Chief Medical Officer and JC Chief Nursing Officer shall be ex officio, non-voting members of the Committee. The Committee may include such other voting and non-voting members as deemed appropriate by the Committee Chair.

12.10.3 Duties. The duties of the Committee include:

(a) Providing oversight, guidance and leadership for initiatives designed to improve the quality and safety of patient care on the JC;

(b) Acting on and evaluating JC reports from the JC Patient Safety Officer, including making referrals to the Peer Review Committee, when appropriate;

(c) Reviewing and evaluating the results of JC quality and patient safety measures;

(d) Making recommendations to eliminate future serious events and incidents;

(e) Striving to ensure the integration of quality and safety standards into policy and practice across TUH, Inc.;

(f) Reporting its activities to the MSEC; and

(g) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, or the Board.

12.10.4 Meetings. The TUH – Jeanes Campus Medical Staff Leadership Committee shall meet as necessary, but at least four (4) times per Academic Year.

12.11 PERFORMANCE IMPROVEMENT COMMITTEE

12.11.1 Members. The voting members of the Committee will include an Officer, at least five (5) Medical Staff Members, representing a cross-section of the Medical Staff, the Chairs of the relevant reporting committees, a Graduate Medical Trainee, representatives from Nursing, Risk Management, Performance Improvement, and a Medical Staff Member from the ECNC. The CMO and HCCMO will be voting members of the Committee. The Committee may include such other voting and non-voting members as are deemed appropriate.

12.11.2 Duties. The duties of the Committee include:

(a) Providing oversight, guidance and leadership for initiatives designed to improve the quality and safety of patient care;

(b) Establishing the strategic direction for quality initiatives;

(c) Striving to ensure the integration of quality into policy and practice;

(d) Identifying and prioritizing improvements and establishing indicators of success for specific projects;

(e) Receiving and acting upon the reports and recommendations from Medical Staff and Hospital Committees, which include, but are not limited to: the Cancer Committee, Code/RRT Committee, Health Information Management Committee, ICU Committee, Infection Prevention and Control Committee, Operating Room Executive Committee, Utilization Review Committee, Peer Review Committee, and Surgical Care Improvement/Tissue Committee;

(f) Referring matters to the Peer Review Committee, when appropriate; and

(g) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, the PAC or the Board.

12.11.3 Meetings. The Performance Improvement Committee will meet monthly and will report to the MSEC.

12.11.4 TUHS System-Wide Coordination. The Performance Improvement Committee of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.12 PATIENT SAFETY COMMITTEE

12.12.1 Members. The voting members of the Committee will include an Officer, at least five (5) Medical Staff Members, representing a cross-section of the Medical Staff, Patient Safety Officer, the Chairs of the relevant

reporting committees, a Graduate Medical Trainee, representatives from Nursing, Risk Management, Performance Improvement, a Medical Staff Member from the ECNC, other hospital departments, and two (2) members of the community who are not employed by the Hospital. The CMO and HCCMO will be voting members of the Committee. The Committee may include such other voting and non-voting members as are deemed appropriate.

12.12.2 Duties. The duties of the Committee include:

(a) Providing oversight, guidance and leadership for initiatives designed to improve the safety of patient care;

(b) Receiving and acting up on reports from the Patient Safety Officer, including making referrals to the peer review committee, when appropriate;

(c) Evaluating investigations and actions based on Patient Safety Officer reports;

(d) Reviewing and evaluating patient safety measures;

(e) Making recommendations to eliminate future serious/sentinel events and incidents;

(f) Reporting to the MSEC, and, on a quarterly basis, to the Board, the number of serious events and incidents and recommendations to eliminate future serious events and incidents;

(g) Establishing the strategic direction for patient safety initiatives;

(h) Receiving and acting upon the reports and recommendations from Medical Staff and Hospital Committees, which include, but are not limited to: the Ethics Committee, , Infection Prevention and Control Committee, Pharmacy and Therapeutics Committee, Radiation Safety Committee, and Peer Review Committee; and

(i) Referring matters to the Peer Review Committee, when appropriate; and

(j) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the

MSEC, Hospital Administration, the PAC or the Board.

12.12.3 Meetings. The Patient Safety Committee will meet monthly and will report to the MSEC.

12.12.4 TUHS System-Wide Coordination. The Patient Safety Committee of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.13 CANCER COMMITTEE

12.13.1 Members. The voting members of the Committee will include at least one (1) member of the Medical Staff, from each of the diagnostic and treatment services (Diagnostic Radiology, Pathology, Surgery, Medical Oncology, Radiation Oncology and a Cancer Liaison physician from any specialty), a Graduate Medical Trainee, and non-physician members from each of the administrative, clinical and support services (Cancer Program Administrator(s), Oncology Nursing, Social Work, Certified Tumor Registrar and a Palliative Care professional). The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are deemed appropriate.

12.13.2 Duties. The duties of the Committee include:

(a) Setting goals and priorities for cancer programs carried out in the Hospital;

(b) Documenting, assessing and facilitating new approaches in cancer prevention treatment and research;

(c) Maintaining an approved Cancer Registry in accordance with the specifications of the Manual for Cancer Programs as approved by the Commission on Cancer of the American College of Surgeons;

(d) Coordinating a multidisciplinary Tumor Conference;

(e) Working collaboratively with the Cancer Committees of the other TUHS System Hospitals to develop a coordinated system-wide approach to cancer care; and

(f) Fulfilling such other duties as may be required by law, or by Commission on Cancer Program Standards, as they may be revised and updated from time to time, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, the CEO or the Board.

12.13.3 Meetings. The Cancer Committee will meet as necessary, but at least quarterly per Academic Year and will report to the Performance Improvement Committee.

12.13.4 Attendance. All required Committee members, or their respective designees, must attend at least seventy-five percent (75%) of meetings per Academic Year.

12.13.5 TUHS System-Wide Coordination. The Cancer Committees of each TUHS affiliate may coordinate their functions as appropriate to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.14 CODE/RAPID RESPONSE TEAM (RRT) COMMITTEE

12.14.1 Members. The voting members of the Committee will include at least three (3) members of the Medical Staff, including a hospitalist and an emergency medicine physician and anesthesia representation as needed. The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are appropriate.

12.14.2 Duties. The duties of the Committee include:

(a) Recommending policies and monitoring activities related to the provision of cardiopulmonary resuscitation and rapid response team activities in the Hospital;

(b) Reviewing of Codes and RRTs and those medical records necessary to assess the appropriateness of Code/RRT response and operation;

(c) Providing feedback and recommendations to all services that comprise the Code/RRT program;

(d) Reviewing response schedules from each participating discipline to assure adequate and appropriately trained participants;

(e) Educating employees and physicians regarding the appropriate application of criteria and parameters for calling Codes/RRTs; and

(f) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.14.3 Meetings. The Code/RRT Committee will meet as necessary, but at least quarterly and will report to the Performance Improvement Committee.

12.15 ETHICS COMMITTEE

12.15.1 Members. The voting members of the Committee will include at least three (3) members of the Medical Staff, representing a cross-section of the Medical Staff, and a Graduate Medical Trainee. The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee will also include representatives from Hospital Administration, Risk Management, Nursing, Social Work and TUHS Counsel. The Committee may invite community members to participate. The Committee may include such other voting and such non-voting members as are appropriate.

12.15.2 Duties. The duties of the Committee include:

(a) Evaluating ethical issues within the Hospital;

(b) Reviewing the ethical implications of pertinent patient care policies;

(c) Consulting on the ethical implications of specific patient care issues upon request; and

(d) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, or the Board.

12.15.3 Meetings. The Ethics Committee will meet as necessary, but at least six (6) times per Academic Year and will report to the Patient Safety Committee.

12.15.4 TUHS System-Wide Coordination. The Ethics Committees of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.16 HEALTH INFORMATION MANAGEMENT COMMITTEE

12.16.1 Members. The voting members of the Committee will include at least three (3) Medical Staff Members, representing a cross-section of the Medical Staff, a Graduate Medical Trainee and a representative from Medical Records. The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee will also include representatives from Nursing, Risk Management,, Information Systems and Hospital Administration. The Committee may include such other voting and such non-voting members as are appropriate.

12.16.2 Duties. The duties of the Committee include:

(a) Establishing and maintaining a system for the ongoing monitoring and continuous performance of all medical record documentation and processes;

(b) Making recommendations to the Performance Improvement Committee on policies relating to record preparation and maintenance;

(c) Establishing requirements regarding completion of medical records, including a system for disciplinary action for those who do not complete medical records in a timely and legible manner, and making recommendations to the Performance Improvement Committee regarding discipline for Medical Staff Members whose medical record practices fail to conform with necessary record-keeping requirements;

(d) Supervising the maintenance of medical records, including monitoring patient records for completeness to ascertain whether appropriate details are recorded and whether sufficient data are present to evaluate the care of the patient;

(e) Reviewing and developing policies relating to the security of, the access to, and the release of information;

(f) Making recommendations to the Performance Improvement Committee on any changes to the content and format of the medical records;

(g) Promoting TUHS system-wide coordinated use of electronic health records; and

(h) Fulfilling such other duties as may be required by law or accreditation standards, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration, or the Board.

12.16.3 Meetings. The Health Information Management Committee will meet as necessary, but at least four (4) times per Academic Year and will report to the Performance Improvement Committee.

12.16.4 TUHS System-Wide Coordination. The Health Information Management Committees of each TUHS affiliate may coordinate their functions as appropriate to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.17 ICU COMMITTEE

12.17.1 Members. The voting members of the ICU Committee will include the Medical Directors and Nurse Managers of each of the intensive care units. The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may also include such other voting and such non-voting members as are deemed appropriate.

12.17.2 Duties. The duties of the Committee include:

(a) Monitoring, supervising and managing the intensive care units to assure optimal patient care and utilization of facilities;

(b) Monitoring clinical performance and performance improvement initiatives;

(c) Making recommendations to the MSEC on matters related to the provision of critical care services, organization of critical care services and the relationship among the critical care units; and

(d) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.17.3 Meetings. The ICU Committee will meet as necessary, but at least six (6) times per Academic Year and will report to the Performance Improvement Committee.

12.17.4 TUHS System-Wide Coordination. The ICU Committees of each TUHS affiliate may coordinate and share their resources and educational

programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.18 INFECTION PREVENTION AND CONTROL COMMITTEE

12.18.1 Members. The voting members of the Committee will include at least three (3) Medical Staff Members, representing a cross-section of the Medical Staff, a Graduate Medical Trainee, and a physician representative from the Section of Infectious Diseases. The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are appropriate.

12.18.2 Duties. The duties of the Committee include:

(a) Investigating and attempting to control and prevent infection within the Hospital;

(b) Studying hospital infections, recommending precautions against infections that are acquired by patients or personnel, establishing uniform procedures for reporting infections, monitoring resistant organisms, monitoring antibiotic usage, and recommending remedial measures to be taken;

(c) Maintaining and distributing to designated areas an Infection Control Isolation Policy and Procedure Manual; and

(d) Fulfilling such other duties as may be required by law or accreditation standards, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.18.3 Meetings. The Infection Prevention and Control Committee will meet as necessary, but at least six (6) times per Academic Year and will report to the Performance Improvement Committee.

12.18.4 TUHS System-Wide Coordination. The Infection Prevention and Control Committees of each TUHS affiliate may coordinate their functions as appropriate to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.19 OPERATING ROOM EXECUTIVE COMMITTEE

12.19.1 Members. The voting members of the Committee will include the Chairs of Surgery and Anesthesia, six (6) Medical Staff Members representing

Surgery, and two (2) Medical Staff Members representing Anesthesia (each for one Academic Year, renewable term). The CMO and/or HCCMO will be an ex-officio, non-voting member of the Committee. The Committee will also include representatives from Administration, Nursing, Surgical Services, Anesthesia Services, Peri-Operative Services, and Supply and Sterile Processing Services. The Committee may include such other voting and such non-voting members as are appropriate.

12.19.2 Duties. The duties of the Committee include:

(a) Establishing goals and objectives for Surgical Services;

(b) Reviewing policies and guidelines for Surgical Services and making recommendations to the MSEC and Hospital with respect to those policies and guidelines;

(c) Coordinating any enforcement activity with the Department Chairs and Peer Review Committee;

(d) Ensuring compliance with regulatory standards related to surgical services;

(e) Monitoring outcomes associated with care delivery in Surgical Services areas and assisting in the identification of opportunities for improvement;

(f) Serving as a resource for the Hospital with respect to operating room management; and

(g) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.19.3 Meetings. The Operating Room Executive Committee will meet as necessary, but at least six (6) times per Academic Year and will report to the Performance Improvement Committee.

12.19.4 TUHS System-Wide Coordination. The Operating Room Executive Committee of each TUHS affiliate may coordinate their functions, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.20 RESERVED.

12.21 PHARMACY AND THERAPEUTICS COMMITTEE

12.21.1 Members. The voting members of the Committee will include five (5) Medical Staff Members, representing a cross-section of the Medical Staff, two (2) Graduate Medical Trainees and at least two (2) pharmacists and nurses, respectively. The CMO and/or HCCMO will be an ex-officio, non-voting member(s) of the Committee. The Chair of the Committee, in consultation with the MSEC Chair, will appoint such other voting and non-voting members as are deemed appropriate.

12.21.2 Functions and Scope. The functions and scope of the Committee include:

(a) Providing evaluation, educational, and advisory services to the medical staff and hospital administration for all matters related to medication use, including investigational drugs;

(b) Developing a Formulary of drugs accepted for use in the hospital and provide for ongoing maintenance of the Formulary. Inclusion of medications on the hospital Formulary is based on relative therapeutic merits, safety, and cost. Replication of therapeutically equivalent agents is to be minimized;

(c) Developing programs and processes that contribute to safe and effective medication therapy;

(d) Developing programs and processes that contribute to cost effective medication therapy;

(e) Planning appropriate medication related educational programs or materials for the professional staff of the hospital;

(f) Providing ongoing quality improvement and safety, oversight of medication order entry, distribution, storage, administration and use;

(g) Providing oversight of the monitoring and evaluation of adverse medication events, and providing recommendations to prevent occurrence;

(h) Initiating or directing drug utilization evaluations and reviewing results and making appropriate recommendations to optimize medication use;

(i) Serving as advisor to the Department of Pharmacy Services in matters related to medication distribution, and control processes;

(j) Disseminating information on the actions of the Committee to all hospital health-care providers;

(k) Receiving and acting on the reports of any relevant subcommittees; and

(l) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.21.3 Subcommittees. The Pharmacy and Therapeutics Committee may form subcommittees, such as medication practices, IV therapy, formulary, chemotherapy, antimicrobial stewardship, and nutrition, as required or needed.

12.21.4 Meetings. The Pharmacy & Therapeutics Committee will meet as necessary, but at least six (6) times per Academic Year and will report to the Patient Safety Committee.

12.21.5 TUHS System-Wide Coordination. The Pharmacy & Therapeutics Committees of each TUHS affiliate may coordinate their functions as appropriate to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.22 RADIATION SAFETY COMMITTEE

12.22.1 Members. The voting members of the Committee will be appointed as set by the Nuclear Regulatory Commission (NRC) regulations. It will include senior managers (Directors, Chairs) of those departments/sections that are involved in the use of radioactive material or radiation producing equipment and a representative from Hospital leadership.

12.22.2 Duties. The duties of the Committee include:

(a) Assisting in the management of the Radiation Safety program;

(b) Ensuring, with the assistance of the Radiation Safety Officer, that the Radiation Safety Program receives the appropriate level of support and resources;

(c) Ensuring that all radioactive materials and radiation-producing equipment are used in compliance with all

regulatory requirements and institutional policies and procedures;

(d) Ensuring that the use of radioactive material and radiation-producing equipment is consistent with the ALARA philosophy and institutional program;

(e) Reviewing the training and experience of proposed authorized users, Radiation Safety Officer, and teletherapy, brachytherapy, and medical physicists, to ensure that they meet regulatory requirements, and assess whether qualifications are sufficient to enable the individuals to perform their duties safely;

(f) Reviewing and approving or disapproving, with the advice and consent of the Radiation Safety Officer and the representative from management, all radiation safety procedures and changes in the radiation safety program;

(g) Establishing the investigational levels for individual occupational radiation exposures;

(h) Identifying the radiation safety program problems and providing solutions to these problems;

(i) Reviewing all requests for authorization to use radioactive material on the basis of need, safety and the ALARA philosophy; and approve or disapprove the requests with the concurrence of the Radiation Safety Officer;

(j) Periodically reviewing the Radiation Safety Officer's summary report of the occupational radiation exposure records of personnel, paying particular attention to individuals or groups of workers whose occupational exposures appear excessive;

(k) Reviewing annually, with the assistance of the Radiation Safety Officer, the radiation safety program;

(l) Recommending remedial action to correct any deficiencies identified in the radiation safety program audits;

(m) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or

by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.22.3 Meetings. The Radiation Safety Committee will meet at least annually and will report to the Patient Safety Committee.

12.22.4 TUHS System-Wide Coordination. The Radiation Safety Committees of each TUHS affiliate may coordinate their functions, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.23 SURGICAL CARE IMPROVEMENT/ TISSUE COMMITTEE

12.23.1 Members. The voting members of the Committee will include at least three (3) Medical Staff Members, representing a cross-section of appropriate clinical services, and including at a minimum one pathologist and one surgeon, a Graduate Medical Trainee and a representative of Hospital Administration. The CMO and/or the HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are appropriate.

12.23.2 Duties. The duties of the Committee include:

(a) Reviewing and evaluating surgery performed at the Hospital relating to the preoperative, postoperative and pathological diagnoses, including evaluating whether the surgical procedures undertaken were applicable and justified;

(b) Improving surgical care of patients by reviewing documented work;

(c) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or by the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.23.3 Meetings. The Surgical Care Improvement/Tissue Committee will meet monthly and will report to the Performance Improvement Committee.

12.23.4 TUHS System-Wide Coordination. The Surgical Care Improvement/ Tissue Committees of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

12.24 UTILIZATION REVIEW COMMITTEE

12.24.1 Members. The voting members of the Committee will include at least two physicians, the Case Management Director, and a Nursing Representative. The CMO and/or an HCCMO will be an ex-officio, non-voting member of the Committee. The Committee may include such other voting and such non-voting members as are appropriate.

12.24.2 Duties. The duties of the Committee include:

(a) Develop and oversee the implementation of the Utilization Review plan;

(b) Review the results of the concurrent review process, denials, lengths of stay data, admission and observation data;

(c) Oversee the Utilization Management process;

(d) Provide annual reports to medical staff and hospital leadership and the Governing Body on the Utilization Management process; and

(e) Fulfilling such other duties as may be required by law, or as may be assigned pursuant to these Bylaws or the President of the Professional Medical Staff, the MSEC, Hospital Administration or the Board.

12.24.3 Meetings. The Committee will meet at least four times per Academic Year and will report to the Performance Improvement Committee.

12.24.4 TUHS System-Wide Coordination. The Utilization Review Committees of each TUHS affiliate may coordinate and share their resources and educational programs, as appropriate, to enhance the quality and efficiency of medical oversight activities and/or patient care services on a system-wide basis.

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY, PEER REVIEW AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or maintaining Medical Staff membership or applying for, exercising or maintaining Clinical Privileges, a Medical Staff Member, APP, or Applicant:

a) Authorizes representatives of the Hospital and the Professional Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Medical Staff Member's or Applicant's professional ability and qualifications;

b) Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff;

c) Agrees to be bound by the provisions of this Article and by these Bylaws and to waive all legal claims against any representative of the Professional Medical Staff or Hospital who acts in accordance with the provisions of these Bylaws; and

d) Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and the exercise of Clinical Privileges at the Hospital.

13.2 CONFIDENTIALITY OF INFORMATION; BREACH OF CONFIDENTIALITY

Hospital, Medical Staff, and committee minutes, files**,** and records, including information regarding any Medical Staff Member or Applicant to this Medical Staff, will, to the fullest extent permitted by law, be confidential. Dissemination of such information and records may be made only where required by law, or pursuant to Hospital Policies or Medical Staff Policies or with the express approval of the MSEC, the President of the Professional Medical Staff or CEO.

Because effective peer review and consideration of the qualifications of Medical Staff Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of the Hospital, the Professional Medical Staff, or committees, except in conjunction with other Hospital, professional society, licensing authority or regulatory/accrediting agencies, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. It shall be a violation of these Bylaws for any Practitioner to knowingly or recklessly breach the confidentiality protections associated with her/his membership on or participation in any Peer Review Committee or activity. Any determination that such violation has occurred shall be subject to Corrective Action under Article VII.

13.3 IMMUNITY FROM LIABILITY

Each representative of the Professional Medical Staff or the Hospital will be exempt, to the fullest extent permitted by law, from liability to a Medical Staff Member or Applicant for damages or other relief (1) for any action taken or statements or recommendations made within the scope of his/her duties as a representative of the Professional Medical Staff or the Hospital and (2) by reason of providing information, including otherwise privileged or confidential information, to a representative of the Professional Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member of the Medical Staff or who did, or does, exercise Clinical Privileges or provide services at the Hospital.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article will apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:

a) Applications for appointment or reappointment of Professional Medical Staff membership or application, reapplication, granting or delineation of Clinical Privileges; Corrective action, including summary or automatic suspension;

b) Hearings and appellate reviews;

c) Medical care evaluation (e.g. FPPE, OPPE, patient safety data, Peer Review data, quality data, etc.);

d) Utilization reviews;

e) Other Professional Medical Staff or Hospital activities related to monitoring and maintaining quality patient care and appropriate professional conduct, including participation on Professional Medical Staff or Hospital committees; and

f) Reports to peer review organizations, state licensure boards, the National Practitioner Data Bank and similar reports.

The acts, communications, reports, recommendations, and disclosures and other information referred to in this Bylaws section 13.4 may relate to a Medical Staff Member's or Applicant's professional qualifications, clinical competency, judgment, character, mental and emotional stability, physical condition, ethics, ability to work with others, professional liability claims and suits, or any other matter that might directly or indirectly have an effect on patient care or the Practitioner's ability to function effectively in a health care institution or organization.

13.5 PEER REVIEW

The Professional Medical Staff and the Hospital intend that all activities by or in response to the Professional Medical Staff or Board, any committee of the Medical Staff or any committee of the Board, or by or in response to any Medical Staff Member, Board member, or Hospital employee or agent, will enjoy all confidentiality protections and immunities from liability and all other protections granted by the Pennsylvania Peer Review Protection Act, as amended, MCARE, as amended, or by HCQIA, as amended, or by any other similar statutes that may be enacted, if such activities are described in any such statute.

13.6 RELEASES

Each Professional Medical Staff Member and Applicant will, upon request of the Professional Medical Staff or the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases will not be deemed a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws, releases, applications, and other forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to, and not in limitation of, other protections provided by law.

ARTICLE XIV: GENERAL PROVISIONS

14.1 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws.

14.2 AUTHORITY TO ACT

Any Medical Staff Member who acts in the name of this Professional Medical Staff without proper authority will be subject to such disciplinary action as the MSEC may deem appropriate.

14.3 WAIVER OF NOTICE

Whenever any Notice or Special Notice is required to be given to any Professional Medical Staff Member or Applicant under the provisions of these Bylaws, the following circumstances will be deemed equivalent to giving such notice at the time required and in the required manner: (1) the refusal of the Practitioner to accept the notice; (2) the actual receipt by the Practitioner of the information required to be communicated by the notice irrespective of the manner of communication; (3) the appearance of the Practitioner at the meeting to which the required notice related; or (4) a waiver of notice in writing signed by the Practitioner entitled to notice, whether before or after the time stated.

ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS

15.1 ADOPTION AND AMENDMENT OF BYLAWS

These Bylaws may be amended, and new Bylaws may be adopted, as set forth in this section 15.1.

15.1.1 Upon the request of the President of the Professional Medical Staff, the MSEC, the Board, the CEO, the Bylaws Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Professional Medical Staff in good standing who are entitled to vote ("Voting Members"), consideration will be given to amendment of these Bylaws.

15.1.2 These Bylaws may be amended, and new Bylaws may be adopted by review and approval by MSEC, Medical Staff and Board, as follows:

(a) The affirmative vote of a majority of the MSEC members at a meeting at which a quorum is present;

(b) The affirmative vote of the Voting Members of the medical staff which:

(i) Shall be an electronic vote of two-thirds (2/3) of the Voting Members casting a vote, provided that a quorum has been established in accordance with subsection 11.3.1;

(ii) Shall not occur until after the MSEC has given a minimum of ten (10) business days' Notice to the Voting Members of: (1) the proposed amendment(s); and (2) the dates of the voting period;

(iii) Shall be conducted through an electronic link provided to the eligible voting Medical Staff Members that shall remain available for use for ten (10) business days; and

(iv) At the discretion of the MSEC, the voting period may be preceded by an informational meeting of the Voting Members, Notice of which shall be provided by the MSEC to the Voting Members of the medical staff a minimum of ten (10) business days before the meeting.

(c) Approval of the Board.

15.1.3 Neither the Professional Medical Staff nor the Board may unilaterally amend the Bylaws of the Professional Medical Staff. Furthermore,

adoption or amendment of the Bylaws may not be delegated by the MSEC members, the Professional Medical Staff Members, or the Board.

15.1.4 Urgent Amendment. In situations in which there is a need for an urgent amendment to these Bylaws to comply with law, regulation or accreditation standard, the amendment may be provisionally adopted by majority vote of the MSEC and approval of the Board without prior Notice to the Professional Medical Staff. In such cases, the Medical Staff will be notified of the amendment immediately upon its approval by the Board, and may thereafter petition for reconsideration of the amendment through a timely written petition signed by at least ten percent (10%) of the Voting Members. Such reconsideration shall follow the procedures set forth in this section 15.1.2 for routine adoption/amendment.

15.2 NOTICE TO THE MEDICAL STAFF

Following Board Approval of the adoption or amendment of Bylaws, the MSEC will advise all Medical Staff Members of the approval and, if the Bylaw changes or new Bylaws were not previously distributed to all Medical Staff Members, the MSEC will do so upon such approval.

15.3 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

Rules and Regulations ("Rules"), not inconsistent with these Bylaws, may be adopted and amended in the same manner as set forth in this Article XV with respect to these Bylaws, or through the procedures set forth in this section.

15.3.1 Rules may be adopted and amended by the MSEC, with the approval of the CEO and the Board.

15.3.2 Routine Adoption/Amendment. The MSEC will provide the Medical Staff Members at least ten (10) business days advance Notice of any proposed new or revised Rules, and an opportunity to submit written comments for consideration by the MSEC. The MSEC will consider all written comments submitted by Members prior to voting on the proposed new or revised Rules.

15.3.3 Urgent Amendment. In situations in which there is a need for an urgent amendment to a Rule to comply with law, regulation or accreditation standard, the amendment may be provisionally adopted by majority vote of the MSEC and approval of the Board without prior Notice to the Professional Medical Staff. In such cases, the Medical Staff will be notified of the amendment immediately upon its approval by the Board, and may thereafter petition for reconsideration of the amendment through a timely written petition signed by at least ten percent (10%) of the Voting Members. Such reconsideration shall follow the procedures set forth in this section 15.3 for routine adoption/amendment.

15.4 CONFLICTS

Conflicts shall be addressed as set forth in this section.

15.4.1 In the event that there is a conflict between the Hospital Corporate Bylaws and these Bylaws of the Professional Medical Staff, and/or the Rules and Regulations of the Medical Staff,, the Hospital Corporate Bylaws will govern; however, upon identification of such a conflict, an ad hoc Committee of the MSEC and Board will convene to make recommendations for amendments needed to reconcile the conflict, which may be passed following the usual amendment procedures.

15.4.2 Notwithstanding the duties delegated to the MSEC pursuant to section 12.3.4 of the Bylaws, in the event that a conflict arises between the MSEC and the Medical Staff Members on any proposal, including, but not limited to, a proposal to adopt or amend a Bylaw and/or Rule, the conflict shall be resolved by a simple majority vote of the Medical Staff Members at a meeting at which a quorum is present.

APPENDIX I.
SPECIFIED PROFESSIONAL PERSONNEL

1.1 SPECIFIED PROFESSIONAL PERSONNEL

1.1.1 General. Adherence to all rules, regulations and responsibilities as set forth in these Bylaws and other Professional Medical Staff and Hospital Policies is mandatory for all SPP.

Function. SPP shall practice or provide healthcare service in accordance with the Medical Staff SPP Policy.

1.1.2 No Entitlement to Medical Staff Appointment. No individual has a right to serve as SPP at the Hospital or to any specific Clinical Privileges. SPP are not eligible for appointment to the Professional Medical Staff of the Hospital, or entitled to the rights, privileges, and/or prerogatives attendant with Professional Medical Staff Membership.

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APPENDIX II.GRADUATE MEDICAL TRAINEES

2.1 GRADUATE MEDICAL TRAINEES

2.1.1 General. Adherence to all rules, regulations, and responsibilities as set forth in these Bylaws and other Professional Medical Staff and Hospital Policies is mandatory for all Graduate Medical Trainees.

2.1.2 Defined. Graduate Medical Trainees are physicians, podiatrists, dentists and oral surgeons who either (1) meet the qualifications for and are accepted to one of the Hospital's approved residency or fellowship training programs or (2) are rotating at the Hospital from other institutions pursuant to a graduate education affiliation agreement.

2.1.3 Eligibility and Selection. Eligibility and selection guidelines are delineated in the Graduate Medical Education Policy Manual and other Hospital and Professional Medical Staff Policies applicable to Graduate Medical Trainees.

2.1.4 Qualifications. The qualifications for a Graduate Medical Trainee include:

(a) Meet the qualifications for Graduate Medical Trainees set forth in this subsection 2.1.4 and in Hospital and Professional Medical Staff Polices applicable to Graduate Medical Trainees; and

(b) Maintain any legally required graduate license and unrestricted license, if applicable, in the Commonwealth of Pennsylvania.

2.1.5 Hospital Privileges. Graduate Medical Trainees may not be Members of the Medical Staff but may be granted hospital privileges if they are Graduate Medical Trainees who are qualified to Moonlight as Attending physicians in accordance with guidelines delineated in the Graduate Medical Education Policy Manual and other Hospital and Professional Medical Staff Policies applicable to Graduate Medical Trainees.

2.2 RIGHTS AND RESPONSIBILITIES OF GRADUATE MEDICAL TRAINEES

Graduate Medical Trainees whose education and training involve clinical activities have certain rights and responsibilities with respect to their involvement in the care of patients. The Graduate Medical Education Policy Manual, Resident Appointment Agreement and other Hospital and Professional Medical Staff Policies applicable to Trainees describe those rights and responsibilities.

2.3 CORRECTIVE ACTION

2.3.1 Corrective Action. Graduate Medical Trainees may be subject to corrective action as delineated in the Graduate Medical Education Policy Manual, and Resident Appointment Agreement.

2.3.2 Authority. The Chair of the Department to which the Graduate Medical Trainee is assigned and/or Graduate Medical Education (GME) Program Director is responsible for corrective action decisions. Corrective action varies with the seriousness of the offense committed and the standing of the Graduate Medical Trainee involved. Corrective actions are delineated in the Graduate Medical Education Policy Manual, Resident Appointment Agreement, and other Hospital and Professional Medical Staff Policies applicable to Graduate Medical Trainees.

2.4 SUMMARY SUSPENSION

2.4.1 Grounds. Summary suspension of a Graduate Medical Trainee, either participating in one of the Hospitals approved residency or fellowship training programs or rotating at the Hospital from another institution pursuant to a graduate education affiliation agreement, may be imposed if the Graduate Medical Trainee:

(a) Disregards and/or violates these Bylaws, Medical Staff Policies or Hospital Policies in a manner that imminently endangers the health, life or well-being of any patient, prospective patient, or other person in the Hospital;

(b) Engages in conduct, or it is reasonably believed that the Practitioner may engage in conduct, that imminently endangers the health, life or well-being of any patient, prospective patient, other person in the Hospital or to them self;

(c) Engages in conduct that materially disrupts any aspect of the Hospital's operations, so as to create an imminent safety risk;

(d) Exhibits signs of impairment, including but not limited to alcohol or drug use, while providing, or available to provide, patient care; or

(e) Fails without Good Cause to appear at a meeting that the Graduate Medical Trainee is requested to attend and scheduled for the purpose of discussing the Graduate Medical Trainee's practice or conduct or to cooperate fully at such a meeting.

or (5)

2.4.2 Authority. Any one of the following: (1) President of the Professional Medical Staff; (2) the Chair of the Department to which the Graduate Medical Trainee is assigned; or (3) the Graduate Medical Education (GME) Program Director has joint authority with the Designated Institutional Officer and the CEO to summarily suspend all or any portion of the training position of a Graduate Medical Trainee. Unless otherwise stated, such summary suspension or restriction will become effective immediately upon imposition. The summary suspension or restriction may be limited in duration and will remain in effect for the period stated or, if not so limited, will remain in effect until resolved by the procedures specified in the Graduate Medical Education Policy Manual and other Professional Medical Staff and/or Hospital Policies applicable to Graduate Medical Trainees.

2.5 TERMINATION/DISMISSAL

2.5.1 Termination. Appointment as a Graduate Medical Trainee is granted or renewed for a one year period and, if renewed each year, terminates upon completion of the Trainee's training program, or upon resignation or dismissal from such program prior to completion.

2.5.2 Appeal. A Graduate Medical Trainee may be dismissed for any reason whatsoever so long as the dismissal is not based on discrimination that is prohibited by the Non-Discrimination In Provision of Services Policy, as amended. The Department Chair or Graduate Medical Education (GME) Program Director will provide the Graduate Medical Trainee with a written dismissal. The dismissal may be appealed by the Graduate Medical Trainee who is adversely affected in accordance with the guidelines delineated in the Graduate Medical Education Policy Manual, Resident Appointment Agreement and other Professional Medical Staff and/or Hospital Policies applicable to Graduate Medical Trainees.

APPENDIX III.RULES AND REGULATIONS

3.1 GENERAL

Adherence to all rules, regulations, and responsibilities as set forth in these Bylaws and other Professional Medical Staff and Hospital Policies is mandatory for all members of the Professional Medical Staff and APP's. Medical Staff Members may participate in and render care to patients only within the scope delineated in each Medical Staff Member's current Clinical Privileges.

3.1.1 CONFLICTS

The MSEC will work with appropriate hospital representatives to resolve any inconsistencies between the Rules and Regulations and Hospital Policies.

3.2 ADOPTION AND AMENDMENT

These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.

3.3 ATTENDING PHYSICIAN/PODIATRIST/DENTIST/ORAL SURGEON

3.3.1 Defined. All inpatients will be cared for by an Attending physician, podiatrist, dentist or oral surgeon who must be a member of the Professional Medical Staff. The Attending physician, podiatrist, dentist or oral surgeon is responsible to provide for management of the care of his/her patients as delineated in Article VI of these Bylaws.

3.3.2 Admission to the Hospital. Every patient will be admitted to the Hospital based upon medical, dental or podiatric requirements, and may not be discriminated against in violation of the Non-Discrimination In Provision of Services Policy, as amended regardless of sex, race, creed, color, national origin, sexual orientation or other unlawful basis to the service of a physician, podiatrist, dentist or oral surgeon who is a member of the Professional Medical Staff with admitting privileges.

The Attending physician, podiatrist, dentist or oral surgeon to whose service the patient is admitted will be responsible for the medical, dental or podiatric decisions, as applicable, regarding his/her patient.

3.3.3 Provisional diagnosis, initial assessment, history and physical.

(a) Within 24 hours of admission, or in the case of an outpatient prior to any invasive procedure, or non-invasive procedure that requires conscious/moderate sedation, the Attending

physician and/or his/her designee(s) (or, in the case of a patient admitted to the service of a dentist or podiatrist, a physician member of the Active or Associate Medical Staff or his/her designee(s)) will make an initial examination and assessment of the patient, perform a history and physical of the patient, and render a provisional diagnosis. Evidence of the responsibility of the Attending physician (or, in the case of a patient admitted to the service of a dentist or podiatrist, evidence of the responsibility of a physician with admitting privileges in the initial assessment, history and physical, and development of a provisional diagnosis must be evident in the medical record in the form of a written note by the that physician (or in the case of a patient admitted to the service of a dentist or podiatrist, by the physician member of the Active or Associate Staff). The history and physical examination is to be conducted and documented in the patient's medical record in accordance with these Bylaws and Rules & Regulations and Hospital Policies & Procedures.

(b) A history and physical must be completed and documented for each patient no more than thirty (30) days before, or 24 hours after, admission or registration, but prior to surgery or any procedure requiring anesthesia services. The history and physical must be conducted by a Practitioner who is privileged to perform a history and physical. If a history and physical has been completed more than thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services. When the history and physical is conducted within thirty (30) days before admission, an updated examination of the patient, including any changes in the patient's condition, is required. The interval update/day of procedure note must be documented and placed in the medical record prior to the surgery or procedure. The History and Physical should include all conditions known to be present on admission. The minimum content of the H&P should include the following elements: chief complaint, history of present illness, current medications, physical xamination, assessment, allergies, past medical history, past social history (including tobacco, alcohol, drug use), family history, review of systems, and plan of treatment.

(c) Exceptions to Section 3.3.3 may apply, as more specifically set forth in the Hospital's History and Physical Policy.

3.3.4 Involvement of Consulting Services. Consultation is appropriate in cases in which the diagnosis is complex or when doubt exists as to the appropriate diagnostic and therapeutic measures to be utilized. In addition, consultation should be used for specific procedures related to the specialty consulted. In surgical cases, consultations may be requested to evaluate risk and optimal medical condition. The consulting practitioner must be qualified in the field in which advice is sought. The consultation shall include examination of the patient and review of the patient's medical records and a written statement, signed by the consulting practitioner, which shall be made a part of the medical record. When surgical procedures are involved, and a consultation is provided which is relevant to such surgical procedures, the consultation note shall be recorded prior to the procedure or operation, except in cases of emergency surgery. When an Attending physician, podiatrist, dentist or oral surgeon requests a consultation from a medical service other than his/her area of expertise, the Attending physician, podiatrist, dentist or oral surgeon is required to either discuss with the consulting practitioner his/her findings and recommendations, or read the consulting practitioner's progress note summarizing findings and recommendations and incorporate such recommendations as the Attending physician / podiatrist / dentist / oral surgeon deems necessary for the treatment of the patient into the patient care plan. Patients with high risk or complex conditions that require management in an Intensive Care Unit (ICU) shall be managed or co-managed by a physician with the appropriate education, training, experience and demonstrated professional competence in the medical needs of such a patient.

3.3.5 Patient Transfer. A patient remains on the service of the Attending physician/podiatrist/dentist/oral surgeon who admitted him/her unless officially transferred to the service of another physician/podiatrist/dentist/oral surgeon with admitting privileges at the Hospital. Upon transfer of the patient to another Attending physician's/podiatrist's/dentist's/oral surgeon's service, the initial Attending physician/podiatrist/dentist/oral surgeon or his/her designee will (a) enter the transfer order in the patient's record, (b) write a note in the record describing the transfer, (c) ensure that the new Attending physician / podiatrist / dentist / oral surgeon or his/her designee is aware of, and has agreed to accept, the transfer.

3.3.6 Discharge of Hospitalized Patients. The decision to discharge a hospitalized patient is a non-delegable duty of the Attending physician/podiatrist/dentist/oral surgeon. The Attending physician/podiatrist/ dentist/oral surgeon must see the patient prior to discharge or, when medically appropriate, see the patient within 24 hours of discharge and leave specific discharge criteria for the

provider who is to see the patient prior to discharge. The Attending physician / podiatrist/dentist/oral surgeon is responsible for assuring that the patient has appropriate instructions at discharge. The decision to discharge, with any accompanying discharge instructions, must be documented in the medical record by the Attending physician/podiatrist/dentist/oral surgeon or his/her designee.

3.3.7 Autopsies. Attending physicians or their designee will try to obtain consent for autopsies on patients who expire at the Hospital in accordance with Hospital Policy.

3.3.8 Outpatients. Each patient seen on an outpatient basis, whether it is for a visit, a surgical/medical procedure, a radiological procedure, or in the Emergency Department, will be assigned to a Practitioner with Clinical Privileges, who is responsible for the care of the patient. Record of the treatment provided the patient during the outpatient encounter, including a history and physical if appropriate pursuant to these Bylaws, will be documented in the medical record by the Practitioner in the form of a written note. The decision to discharge a patient from the outpatient setting is the responsibility of the Attending physician, podiatrist, dentist, oral surgeon or SPP, who also is responsible for assuring that the patient has appropriate discharge instructions.

3.4 CONSULTING PHYSICIANS / PODIATRISTS / DENTISTS / ORAL SURGEONS

3.4.1 Defined. A consulting physician, podiatrist, dentist or oral surgeon is a member of the Professional Medical Staff from whom a patient's Attending physician requests an evaluation. Typically such evaluations are requested because the medical opinion requested falls outside the area of expertise of the patient's Attending physician, podiatrist, dentist or oral surgeon.

3.4.2 Communication of Finding. Each consulting physician, podiatrist, dentist or oral surgeon must document in writing in the medical record his/her findings and recommendations relative to the reason the Consultant was asked to participate in the care of the patient.

3.5 MEDICAL RECORD RESPONSIBILITIES

3.5.1 General Responsibilities. All treatment provided to patients, including diagnosis, treatment plans, treatment regimens, procedures performed, and discharge instructions, must be documented in accordance with Professional Medical Staff and Hospital Policies by the appropriate care provider. The Practitioner is responsible for documenting the need for continued hospitalization and the plan for

discharge. The documentation must include: (1) a written record of the reason for continued hospitalization; (and (2) a plan for post-hospital care, inclusive of resources offered to the patient such as follow up care, home health, durable medical equipment or other community service. The Practitioner is responsible for maintaining complete medical records on his/her patients, in accordance with Hospital policies.

3.5.2 Timely Completion. Medical records must be completed in accordance with applicable regulations, accreditation standards and Hospital Policy. Procedures developed and approved by the MSEC and Hospital will apply. Such procedures will specify sanctions to be applied to Professional Medical Staff members and APP's who fail to abide by procedures for timely completion of medical records.

4.2 timely Completion. Medical records must be completed in accordance with

3.5.3 Custody. All medical records of patients treated in the Hospital are the property of the Hospital and may not be removed from the Hospital without permission of the Medical Records Department Director or his/her designee, pursuant to Hospital Policy.

3.6 SUPERVISION OF MEDICAL TRAINEES

Medical Students, Residents and Fellows are medical trainees who are at the Hospital to further their education and training. The Professional Medical Staff is directly responsible for overseeing all aspects of patient care, including supervision and education of the medical trainees. With respect to each patient, the Attending physician, podiatrist, dentist or oral surgeon must confer daily with the medical students, residents and fellows regarding the medical management plan for each patient and the specific monitoring and other tasks required of the medical trainees, setting forth possible significant complications and events that might be anticipated and the appropriate response to each, including when the medical student/resident/fellow is to call the Attending physician, podiatrist, dentist or oral surgeon with respect to advice as to each specific patient. When implementation of the patient management plan is to be partially delegated to a medical student, resident or fellow, the Attending physician, podiatrist, dentist or oral surgeon must assure that the delegation is appropriate to the individual's training, experience and competence, and such delegation must be communicated in detail. Documentation in the medical record of oversight of the medical students, residents and fellows by the Attending physician, podiatrist, dentist or oral surgeon must be present in the progress notes.

3.7 PATIENT CARE ORDERS

3.7.1 General. All orders for tests and treatment of patients must be made in writing by physician, podiatrist, dentist, oral surgeon or other health care provider with privileges to do so. Orders in the electronic medical record are considered to be "in writing."

3.7.2 Verbal/Oral Orders.

(a) Verbal/Oral orders may be given only under urgent circumstances, when it is impractical for such orders to be written;

(b) Verbal/Oral orders may be accepted by the following, each within their individual therapy regimens, their legally authorized scopes of practice and hospital privileges:

(1) A practitioner.

(2) A professional nurse.

(3) A licensed practical nurse.

(4) A pharmacist who may transcribe oral orders pertaining to drugs.

(5) A physical therapist who may transcribe oral orders pertaining to physical therapy regimens.

(6) A respiratory therapist who may transcribe oral orders pertaining to respiratory therapy treatments.

(7) A paramedic practicing under § 117.30 (relating to emergency paramedic services);

(8) Radiologic technologists, for medical imaging studies for diagnostic purposes; and

(9) other healthcare providers identified in relevant hospital policy and permitted by law and regulation.

(c) Orders shall be completed, documented and, when applicable, countersigned in accordance with Hospital policy.

3.7.3 Protocols. Protocols may be approved and instituted according to CMS Conditions of Participation.

3.7.4 Standing Orders. Standing orders may be initiated by a nurse if a patient meets certain pre-defined criteria. The criteria and content of standing orders must be approved by MSEC.

3.8 INFORMED CONSENT

Informed consent will be obtained in accordance with the Hospital's administrative policy.

3.9 RULES OF CONDUCT

3.9.1 General. Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital.

3.9.2 Policies. Members of the Medical Staff shall comply with Policies regarding Peer Review, FPPE, OPPE, Practitioner Health, Disruptive Conduct, Sexual Harassment, and any other applicable Policies.

3.10 ADMINISTRATIVE AND CLINICAL POLICIES AND PROCEDURES

Each department/unit/site has policies and procedures that are specific to that area. Hospital administrative and departmental policies and procedures are available on line and can be accessed through the Policies & Key Documents icon on the computer desktop or by logging into Temple University Health System Employee Intranet Site. They may also be accessed using Citrix from outside the organization at **http://access.templehealth.org/citrix** (using TUHS network username and password) under the Online Policies and Key Documents icon.

3.11 ON-CALL LIST OF PHYSICIANS

The hospital maintains a list of on-call physicians developed by each department or section that is available through the Hospital's Employee Intranet Site. The on-call physicians bear the responsibility to respond promptly to any consultation request for in-patients and/or the Emergency Department, Obstetrics, and the Crisis Response Center to provide treatment necessary to stabilize a patient with an emergency medical condition. The attending physician who has personally examined the patient shall determine whether the on-call consulting physician must see the patient emergently.

(Historical amended and approved dates)

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Approved by the Board of Governors: August 10, 2018
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