BYLAWS OF THE MEDICAL STAFF

OF
ADVENTIST REHABILITATION HOSPITAL OF MARYLAND

Rev. June 2007, May 2009, October 2010, October 2012, January 2013, July 2013, July 2014, August 2014, January 16, 2015, August 3, 2015, October 21, 2015

Contents

MEDICAL STAFF BYLAWS

PREAMBLE

Recognizing that the medical staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital's governing body, and that the best interests of the patient are better protected by concerted effort, the practitioners of this hospital are organized in conformity with these bylaws and the medical staff rules and regulations.
These bylaws were prepared for compliance, and are to be construed in conformity with applicable hospital licensing laws, applicable accreditation guidelines and regulatory requirements; they do not constitute an express or implied contract between or among any individual, committee or entity, unless otherwise expressly determined by state law.

DEFINITIONS

The use of the male pronoun (he/his/him) throughout these bylaws is applicable to either male or female.

1. Administrator: the individual appointed by the hospital to act on its behalf in the overall management of the hospital.

2. President of Medical Staff: a member of the active medical staff who is elected in accordance with these bylaws to serve as chief officer of the medical staff of this hospital.

3. Clinical Privilege/Privilege: specified diagnostic and therapeutic services that may be exercised by authorized individuals on approval of the governing body.

4. Completed Application: an application, either for initial appointment or reappointment to the medical staff or for clinical privileges that has been determined by the applicable Credentials Committee, MEC and the governing body to meet the requirements of the medical staff bylaws, rules and regulations.

5. Days: calendar days, unless otherwise noted.

6. Dentist: an individual who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry in this state.

7. Designated Professional Personnel (DPP) a.k.a. Allied Health Professionals: individuals, other than those defined under "Practitioner," who provide direct patient care services in the hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. DPP are not eligible for medical staff membership.

8. Medical Executive Committee/(MEC): the medical executive committee of the medical staff, unless otherwise specified.

9. Ex Officio: service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

10. Good Standing: the term "good standing" means a staff member who, at the time the issue is raised, has met the attendance and committee participation requirements during the previous medical staff year, and has not received a suspension or restriction of membership or privileges in the previous twelve (12) months.

11. Governing Body: the local governing body of the hospital, delegated authority and responsibility and appointed by the Board of Trustees of Adventist HealthCare, Inc.

12. Hospital: **Adventist Rehabilitation Hospital of Maryland, Inc.**

13. Medical Review Committee (MRC): the committee appointed pursuant to these bylaws for the purpose of evaluating the evidence and making findings in a medical staff hearing.

14. Medical Staff/Staff: the formal organization of all physicians (M.D. or D.O.), dentists, psychiatrist, physician assistants, nurse practitioners, and podiatrists who hold an unrestricted license in this state and who are privileged to provide patient care services in this hospital within the scope of their licensure and approved clinical privileges. Only practitioners as defined below can be members of the medical staff.

15. Medical Staff Term: . the period for which each medical staff member is appointed to the medical staff, prior to the next term of reappointment.

16. Medical Staff Year shall be the period January 1 through December 31 of each year, inclusive.

17. Medico-Administrative Practitioner: a practitioner who is under contract, employed by, or otherwise engaged by the hospital on a full or part-time basis, whose responsibilities may be both administrative and, if permitted by state law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such practitioner's direction.

18. Member: a practitioner who has been granted and maintains medical staff membership and (except for honorary staff) clinical privileges and who is in good standing pursuant to these bylaws.

19. Physician: an individual who holds a current, unrestricted license as a M.D. or D.O. in this state.

20. Podiatrist: an individual who has a doctor of podiatric medicine degree and a current, unrestricted license to practice podiatry in this state.

21. Practitioner: a physician, physician assistant, nurse practitioner, dentist or podiatrist as defined in these bylaws with a current, unrestricted license issued by this state.

22. Psychologist: an individual who has a current, unrestricted license to practice psychology in this state, as issued by the Maryland State Board of Examiners in Psychology.

23. Service: a subdivision of either the medical staff or a clinical, grouping members in accordance with their specialty or major practice interest, as specified in these bylaws.

24. State: Maryland

ARTICLE I

NAME

These are the bylaws of the medical staff of Adventist Rehabilitation Hospital of Maryland.

ARTICLE II

PURPOSES AND RESPONSIBILITIES

SECTION 1 - PURPOSES

The purposes of the medical staff are to:

A. provide an organized body through which the benefit of medical staff membership (mutual education, consultation, and professional support) may be obtained by each medical staff member and the obligations of medical staff membership may be fulfilled.

B. serve as the primary means for accountability to the governing body for the quality and appropriateness of the professional performance and ethical conduct of its members as well as of designated professional personnel, and to strive for achievable quality patient care, efficiently delivered and maintained consistent with available resources, to the degree reasonably possible as determined by the state of the healing arts and resources locally available.

C. develop a structure, reflected in medical staff bylaws, rules and regulations, policies, protocols, and other applicable documents, that adequately defines the responsibility and when appropriate the authority and accountability of each medical staff component.

D. provide a means through which the medical staff may provide recommendations to the hospital's policy making and planning process.

SECTION 2 - RESPONSIBILITIES

The responsibilities of the medical staff are to account for the quality and appropriateness of patient care rendered by all practitioners and designated professional personnel authorized to provide patient care services in the hospital by:

A. processing credentials in a manner that matches verified qualifications, performance, and competence with clinical privileges for all medical staff applicants and members, and practice prerogatives for all designated professional personnel.

B. making recommendations to the governing body with respect to medical staff appointments, reappointments, staff category, provisional status, clinical privilege delineation, and as appropriate and corrective actions.

C. participating in the hospital quality/performance management program by conducting objectively all required peer evaluation activities through medical staff and/or service review, specific (committee) monitoring processes, and a comprehensive occurrence screening program.

D. providing an effective utilization review program for allocation of medical services based upon patient-specific determinations of individual medical needs.

E. providing continuing education that is relevant to patient care provided in the hospital as determined, to the degree reasonably possible, from the findings of quality/performance related activities.

F. initiating and pursuing corrective action when indicated.

G. enforcing the medical staff bylaws, rules and regulations uniformly and consistently.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION 1 - MEMBERSHIP AS A PRIVILEGE

A. Membership on the medical staff of this hospital and/or clinical privileges is a privilege that shall only be granted and maintained by those professionally qualified and currently competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws, rules and regulations and the bylaws and policies of the hospital. Appointment to and membership on the medical staff shall confer on the member only such clinical privileges and rights as have been granted by the governing body in accordance with these bylaws.

B. No individual is automatically entitled to initial or continued membership on the medical staff or to the exercise of any clinical privilege in the hospital merely because he is licensed to practice in this or any other state, because he has previously been a member of this medical staff, because he had, or now has membership or privileges at this or another health care facility or another practice setting, because he is a member of any professional organization, or solely because of his certification, fellowship, or membership in a specialty body or society.

C. Medical staff membership does not create an employment or agency relationship between the practitioner and the hospital.

SECTION 2 - GENERAL CRITERIA FOR MEMBERSHIP

Subject to exceptions provided by law or stated herein, medical staff membership and/or clinical privileges shall not be denied on the basis of sex, age, race, religion, creed, color, disability, or national origin, but shall be related to professional ability and judgment, relevant training and experience, health status (subject to any necessary reasonable accommodation to the extent required by law), current competence, and to the hospital's purposes, needs, and nonexclusive capabilities. When the determination is based on the hospital's needs or its nonexclusive ability to provide the facilities, beds, and support staffing/services, consideration will be given, or as otherwise provided by law, to utilization patterns, and actual and planned allocations of physical, financial, and human resources, to general and specialized clinical and support services, and to the hospital's specific goals and objectives as reflected in the hospital's short and long range plans. It is recognized that some patient care services at the hospital may be provided exclusively by a limited number of practitioners selected by the hospital, and who have been properly processed and granted medical staff membership and clinical privileges.

Effective January 16, 2015 all new applicants who have completed residency in the year 2007 or after must comply with re-certification requirements of their Board in their primary area of practice.

SECTION 3 - QUALIFICATIONS AND OBLIGATIONS OF MEMBERSHIP OR PRIVILEGES

A. Qualifications. In addition to the general criteria for membership, only physicians, dentists, podiatrists, physican assistants, and nurse practitioners with a current, unrestricted license to practice in this state who can document their background, professional experience, worthy character, education, relevant training, judgment, and demonstrated current competence; adherence to the ethics of their profession; good reputation; health status (subject to any necessary reasonable accommodation to the extent required by law); the ability to work with others (staff members, members of other health care disciplines, hospital management and employees, visitors, patients, and the community in general); and refrain from disruptive behavior which has or could interfere with patient care or the orderly operation of the hospital; so as to demonstrate to the medical staff and governing body that any patient treated by them in the hospital or in

any of its facilities will be given care of the professional level of quality and efficiency as established by the medical staff and hospital, shall be qualified for membership on the medical staff.

B. Obligations. In addition to the other obligations listed in these bylaws, each applicant, by applying for or being granted membership or clinical privileges (temporary or otherwise), thereby agrees to:

1. adhere to the generally recognized standards of professional ethics of his profession.

2. not participate in fee-splitting or "ghost" surgical or medical care.

3. participate as required in peer evaluation activities.

4. provide continuous care for his patients and delegate the responsibility for diagnosis or care of patients only to a member in good standing who has unrestricted clinical privileges to undertake that responsibility.

5. obtain and document in the patient's medical record appropriate informed consent.

6. abide by the medical staff bylaws, rules and regulations, and applicable hospital policies.

7. complete adequately, and in a timely fashion, the medical and any other required records for all patients he admits or in any way provides care for in the hospital.

8. seek consultation whenever necessary.

9. maintain the required amount of professional liability insurance in an amount and with a carrier approved by the governing body and provide the hospital with a current certificate of insurance for at least $1 million/$3 million in coverage. The insurance must cover the types of privileges requested.

10. reasonably assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations in the areas of professional competence and privileges.

11. reasonably cooperate with the hospital in its efforts to comply with accreditation, reimbursement, and legal or other regulatory requirements.

12. supply requested information and appear for interviews with regard to membership or privileges.

13. immediately notify the administrator of the revocation or suspension of the applicant's professional license or the imposition of terms of probation or limitation of practice by any state licensing agency or the DEA, or of any actions pending with regard to such adverse licensure activity; of the voluntary or involuntary loss of staff membership or clinical privileges at any health care institution; of the cancellation or restriction of professional liability coverage; of any adverse determination by a peer review organization or a third party payor reimbursement program concerning quality of care; of the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or of any state licensing body; of the notice of intent to file or the filing of a claim alleging professional liability; or the filing, entry of a plea, or the conviction of any criminal charges.

14. maintain the confidentiality of all medical staff peer review matters, pursuant to these bylaws and applicable state law.

15. provide patients with care at the professional level of quality and efficiency as defined by the medical staff and governing body.

16. discharge staff, committee and hospital functions for which he is responsible by staff category assignment, appointment, election or otherwise.

17. authorize the hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his competence, skill, character, ethical and other qualifications.

18. consent to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications for the clinical privileges he requests as well as his moral and ethical qualifications for staff membership.

19. release from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with the investigation and evaluation of the applicant and his credentials.

20. release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.

21. consent to the disclosure to other health care entities, medical associations, licensing boards, and other organizations any information regarding his professional or ethical standing that the hospital or medical staff may have, and release the medical staff and hospital from liability to the fullest extent permitted by law.

22. comply with medical staff policies, rules and regulations.

23. comply with the requirement that a medical history and physical examination be completed no more than 30 days before or 24 hours after admission for each patient by a physician, or other qualified individual. This history and physical must be placed in the patient's medical record within 24 hours after admission. When the history and physical are completed within 30 days before admission, the admitting physician shall ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

25. attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest, in accordance with Hospital policy.

SECTION 4 - CONDITIONS AND DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointment and reappointments to the medical staff shall be made by the governing body upon a recommendation from the MEC, and shall be for a period up to, but not to exceed two (2) years. However, in the event of unusual delay or inappropriate recommendation on the part of the MEC, the governing body may act without or contrary to such recommendation on the basis of documented evidence of the applicant's or member's professional and ethical qualifications, obtained from reliable sources but shall give great weight to the recommendation, if any, of the MEC. Prior to taking such action, however, the governing body shall notify the MEC of its intent and shall designate an action date prior to which the MEC may still fulfill its responsibility. Peer input shall be obtained and considered for all applicants for appointment and reappointment. The individual performance profile may serve as the peer input regarding performance required at the time of reappointment.

SECTION 5 - PROCEDURE FOR APPOINTMENT

A-1: Adventist HealthCare, Inc. ("AHC"), and its subsidiaries and related entities, use a common credentialing verification system. By submitting an application for Medical Staff membership and/or clinical privileges, all applicants, Members and Allied Health Professionals consent to their credentialing information being entered into this system, which will cause their credentialing information to be shared among all AHC entities, including but not limited to Shady Grove Adventist Hospital, Washington Adventist Hospital, Adventist Rehabilitation Hospital, and Adventist Behavioral Health. Verification of credentials may be conducted through this common system, although privileges at each facility will be determined by that facility.

A-2. Pre-screening. Upon receipt of a request for an application, the applicant shall be pre-screened by the medical staff office before being sent an initial application. The applicant will be asked to supply documentation of the following threshold requirements:

1. Current, unrestricted license to practice in this state.

2. Current, unrestricted DEA registration and registration with the Maryland CDS.

3. Professional liability insurance which must be of the type, in the amounts of at least $1 million/$3 million, and with a carrier approved by the governing body.

4. Geographic location of office and residence

If the applicant meets all of these requirements, he shall be provided with an application. Failure to meet the above threshold requirements shall not be considered an adverse action, and the applicant shall not be entitled to any hearing and appeal rights under these bylaws. Such action will not result in the filing of report with the state licensing board nor with the National Practitioner Data Bank.

B. Application for Initial Appointment. Each application for appointment to the medical staff shall be in writing, submitted on the prescribed form, and signed by the applicant. When an applicant is provided an application, he shall also be given access to a copy of these bylaws, the medical staff and rules and regulations, and applicable hospital policies.

C. Applicant's Responsibility.
Burden of Producing Information
In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of his or her qualifications and suitability for the clinical privileges and Medical Staff category requested, of resolving any doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for withdrawal of the application. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Credentials Committee or Executive Committee, which may select the examining physician.
The information shall include, but not be limited to:

1. identifying information.

2. undergraduate education.

3. postgraduate education and professional degrees (need source verification).

4. internship (need source verification).

5. residency/fellowship (need source verification).

6. all past and present hospital and other health care entity affiliations (need source verification).

7. memberships in professional associations, societies, academies, colleges, and faculty/training appointments (need source verification).

8. specialty board certification status (need source verification).

9. state licensure(s) with expiration date(s) (need source verification).

10. Drug Enforcement Administration (DEA) and Maryland CDS registration with expiration date (need source verification).

11. professional references consisting of three references from persons other than family or affiliated by marriage who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by law), and the ability to work cooperatively with others.

12. previous practice data.

13. continuing medical education for the past two years.

14. professional liability insurance, including carrier, amount, type, and dates of coverage (need source verification) and past and present professional liability history.

15. responses to questions on the application concerning the applicant's licensing, privilege, malpractice, professional, criminal and federal payor sanction history.

The medical staff and governing body shall inquire, to the extent and in a manner permitted by law, into the physical and mental health status of the applicant so as to determine the practitioner's qualifications to render the privileges requested.

16. a request for staff membership category

17. clinical privileges desired.

18. a specific signed consent for immunity and release from liability for all individuals involved in and performing the credentialing and peer review functions.

19. a small photo for identification purposes only.

20. a signed and dated confidentiality statement.

D. Submission of the Application. The application shall be submitted through the administrator to the medical staff office for the purpose of having all information verified. The hospital shall query the National Practitioner Data Bank (NPDB) and applicable state licensing board, if required, in compliance with existing laws and hospital policy, for all practitioners who are applying for privileges or membership. The applicant must immediately report to the medical staff office any change in the information in the application that occurs after the application has been submitted.

E. Significant Misrepresentations or Omissions. If an applicant supplies information in the application process that contains significant misrepresentations or omissions, this may be grounds for denial of the application, or if membership or privileges have been granted, for corrective action under these bylaws.

F. Incomplete Application/Further Information/Application Withdrawn From Processing. Any committee or individual charged under these bylaws with the responsibility of reviewing an application for appointment, reappointment, or new clinical privileges, may, upon review of the application, deem any such application incomplete. The fact that an application is deemed complete by the medical staff office or a department or committee does not preclude the medical staff office or a committee or department which subsequently reviews the application from deeming it incomplete. If an application is deemed incomplete, it will not be processed. The individual or committee that deems an application incomplete shall request further documentation or clarification from the applicant. Such committee or individual requesting further documentation or clarification shall notify the applicant in writing and shall afford the applicant a set period of time to provide the requested information and clarification. Such period of time shall be as deemed appropriate by the individual or committee requesting the information, but shall not exceed sixty (60) calendar days from receipt of the request to provide the requested information. Failure of an applicant to timely produce all of the requested information, documentation and clarification shall result in the application being deemed incomplete and voluntarily withdrawn. Such action will not result in the filing of a report with the applicable state licensing agency nor with the National Practitioner Data Bank. Any subsequent application submitted by this practitioner shall be processed as an initial application under these bylaws. Notwithstanding any other provision of these bylaws, any practitioner whose application is discontinued from processing pursuant to this section, shall not be entitled to the hearing and appeal rights under these bylaws.

G. Credentials Committee Review. Within ninety (90) days of receipt of the application and recommendation of the departments(s), the Credentials Committee shall make a written recommendation to the MEC as to membership, and, if membership is recommended, as to staff category, privilege delineation and any conditions attached to the appointment.

H. MEC Review and Recommendation. At its next regular meeting after receipt of the recommendations of the Credentials Committee, the MEC shall submit its written recommendation to the governing body relating to membership, and if appointment is recommended, to staff category, clinical privileges, and any special requirements or conditions. The recommendation shall be based on the review of all available information. The MEC may take action by recommending that the governing body either: (a) defer making a recommendation, (b) appoint the applicant to a medical staff category in provisional status and clinical privileges, or (c) reject the applicant's request for membership and/or privileges.

1. The MEC may defer action on a complete application for a period not to exceed forty-five (45) days except for good cause.

2 When the recommendation of the MEC is favorable to the applicant, the administrator will forward it, together with all supporting documentation, to the governing body for consideration at its next scheduled meeting.

3 When the recommendation of the MEC is adverse to the applicant, the administrator shall so inform the applicant within 10 working days advising him of his hearing and appeal rights under these bylaws.

4 Notice of an adverse recommendation shall be forwarded to the governing body for its information, but shall not be acted upon until after the affected individual has exercised or waived the right to a hearing and appeal under these bylaws.

I. Action by the Governing Body.

1 Unless subject to the provisions of Article VII of these bylaws, the governing body or its duly authorized committee shall act on the matter at its next regular meeting following receipt of the recommendation of the MEC.

(a) If the governing body adopts the recommendation of the MEC, it shall become the final action of the hospital.

(b) If the governing body does not adopt the recommendation of the MEC, the governing body may refer the matter back to the MEC with instructions for further review and recommendation and a time frame for responding to the governing body. The MEC shall review the matter and shall forward its recommendation to the governing body. If the governing body adopts the recommendation of the MEC, it shall become the final action of the hospital.

(c) If the action of the governing body is adverse to the applicant, the administrator shall send written notice to the applicant within 10 working days advising the applicant if he is entitled to the hearing and appeal rights under these bylaws.

(d) An adverse decision of the governing body shall not become final until the applicant has exercised or waived his hearing and appeal rights under these bylaws. The fact that such adverse decision is not yet final shall not be deemed to confer membership or privileges when none existed before.

2 At its next regular meeting, after all of the affected individual's hearing and appeal rights under these bylaws have been exhausted or waived, the governing body shall take final action. All decisions to appoint shall include a delineation of clinical privileges, staff category and any applicable conditions and the applicant shall be so notified.

3 Subject to any applicable provisions of Article VII, notice of the governing body's final decision shall be given in writing through the administrator to the applicant within 10 working days of the final decision. The President of Medical Staff shall give notice to the MEC, and the Credentials Committee. In the event a hearing and/or appeal was held, Article VII, Section 6F shall govern notice of the governing body's final decision.

J. Provisional Status. All initial appointments to any category of the medical staff shall be provisional for the first 12 months. Each provisional appointee shall be proctored by one or more appropriate member(s). The care observed shall be relevant to the privileges granted. The purpose of observation is to determine the

individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. The proctor shall complete a proctoring report with comments on the appointee's performance. At the end of the provisional period the appointee must qualify for and be advanced to nonprovisional status, or be extended on provisional status for an additional period not to exceed 12 months, at the end of which time he will be reevaluated for advancement. No member may be on provisional status for a total period longer than 24 months.

K. Previously Denied or Terminated Applicants. Notwithstanding any other provision of these bylaws, if an application is tendered by an applicant who has been previously denied membership and/or privileges, or who has had membership and/or privileges terminated, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. No such application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

SECTION 6 - THE REAPPOINTMENT PROCESS

A-1: Adventist HealthCare, Inc. ("AHC"), and its subsidiaries and related entities, use a common credentialing verification system. By submitting an application for Medical Staff membership and/or clinical privileges, all applicants, Members and Allied Health Professionals consent to their credentialing information being entered into this system, which will cause their credentialing information to be shared among all AHC entities, including but not limited to Shady Grove Adventist Hospital, Washington Adventist Hospital, Adventist Rehabilitation Hospital, and Adventist Behavioral Health. Verification of credentials may be conducted through this common system, although privileges at each facility will be determined by that facility.

A-2. Application. At least 90 days prior to the expiration date of the present Medical Staff appointment of each Member, the Medical Staff Services Department shall provide such Member with an application for reappointment to the Medical Staff. The completed application, supporting documents and payment for the processing fee should be returned to the Medical Staff Coordinator within 30 days. A reminder e-mail will be sent to the member if their reappointment application is not received within 45 days of the date of e-mailing of their application. The member will be charged a late filing fee of $300 and their privileges may be suspended until final Board approval of their reappointment if the review and approval process is not complete by the end of their medical staff term. If a member does not wish to renew their reappointment application, they may submit a letter of voluntary resignation stating the reason and effective date of their resignation. If a member does not return their reappointment application by the end of their medical staff term, their membership and privileges will be recommended as a voluntary resignation.

Data requested on this application will include, but not be limited to: professional qualifications and standing, physical and mental health status, and proof of current clinical competence. When insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations. All Medical Staff reappointment applications must be returned to the Medical Staff Coordinator prior to the expiration of that Member's Medical Staff Term.

1 objective evidence of the individual's clinical competence based on peer review activities.

2 evidence of the individual's support of the medical staff and hospital (e.g., medical record deficiency/delinquency status, meeting attendance, committee service, satisfaction of minimum patient care requirements to maintain staff category, compliance with the bylaws, rules and regulations, and applicable hospital policies).

3 any request or recommendation for change in staff category, clinical privileges, citing the reasons and supporting information.

4 evidence of consideration of the staff member's health status (subject to necessary reasonable accommodation to the extent required by law).

5 information regarding any sanctions imposed by another health care facility, professional organization, or licensing authority.

6 malpractice claims experience since the last reappraisal, including at a minimum, final judgments and settlements against the applicant, identifying the case name, court, date of loss, date of disposition, amount paid in judgment or settlement and a description of the case.

7 evidence of current licensure, DEA, and CDS registration and any pending investigations or complaints regarding same.

8 evidence of professional liability coverage (carrier, type, policy number, amount, expiration date) and any limitations.

9 information regarding previously successful or currently pending challenges to any licensure or registration (DEA) or the voluntary relinquishment of such licensure or registration.

10 information regarding investigation, the voluntary or involuntary termination of membership, or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

11 evidence of a query sent to the National Practitioner Data Bank.

12 information regarding any pending criminal charges or criminal convictions.

B. Failure to Complete Application/Incomplete Application. A practitioner who fails to return the form or to supply all of the required information within ninety (90) days prior to the expiration of the current appointment period or to respond in a timely manner to a request for information shall be deemed to have voluntary resigned his medical staff membership, effective as of the date of the expiration of his current appointment. A practitioner who is deemed to have resigned under this section shall not be entitled to the hearing and appeal rights under these bylaws.

C. Applicant's Responsibility. The applicant shall have the burden of producing adequate information for a proper evaluation of his current competence, character, skill, ethics, health status in terms of his ability to practice in the area in which privileges are sought (subject to necessary reasonable accommodation to the extent required by law), ability to work with others, and other qualifications. By applying for appointment or reappointment to the medical staff, or for clinical privileges, the practitioner agrees to comply with the medical staff bylaws, the medical staff and rules and regulations, and applicable hospital policies.

D. Credentials Committee Review. At least sixty (60) days prior to the final scheduled governing body meeting in the medical staff term, the Credentials Committee shall review all pertinent information and within thirty (30) days make its written recommendation to the MEC concerning the member's reappointment and clinical privilege delineation. The reason for any change shall be documented.

E. MEC Review and Recommendation. At least thirty (30) days prior to the last scheduled governing body meeting in the medical staff term, the MEC shall meet and review all pertinent information and make its written recommendation to the governing body through the administrator concerning each staff member's reappointment and clinical privilege delineation. When any change is recommended, the reason for such recommendation shall be stated and documented. Action by the governing body shall be governed by Section 5J of this Article of these bylaws.

SECTION 7 - CLOSED STAFF; EXCLUSIVE CONTRACTS

A. Exclusive Contracts. The governing body may determine as a matter of policy that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals. These may include, but are not limited to, radiology services, pathology and clinical laboratory services. Applications for initial appointment or for privileges related to those hospital facilities and services specified in such contract(s) will not be accepted for processing unless submitted with confirmation from the administrator that they are from applicants that have an existing or proposed contract with the hospital.

B. Contract Practitioners. A practitioner who is providing contract services pursuant to Section 7A must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category and clinical privileges as any other applicant or member.

C. Termination/Reduction of Privileges. Practice at the hospital is always contingent upon continued staff membership, and is also dependent on the clinical privileges granted. The right of a practitioner who is providing contract services to practice at the hospital is automatically terminated when his staff membership expires or is terminated. Similarly, his right to render services under the contract is automatically limited to the extent that his clinical privileges are reduced, restricted or terminated.

D. Expiration/Termination of Contract. The effect of expiration or other termination of a contract upon a practitioner's staff membership and clinical privileges will be governed solely by the terms of the practitioner's contract. If the contract is silent on the matter, then contract expiration or termination will not affect the practitioner's staff membership or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which the hospital has made exclusive contractual arrangements with another practitioner.

SECTION 8 - MEDICO-ADMINISTRATIVE PRACTITIONERS

Practitioners who have a contract with the hospital, either full-time or part-time, in a medico-administrative position that includes staff clinical responsibilities or functions, must be members of the medical staff. In addition to any applicable terms of the contract, such practitioners shall achieve staff membership and clinical privilege delineation through the same procedure as is required for other medical staff members. The right to the hearing and appeal procedures under these bylaws shall apply if the practitioner's clinical privileges which are independent of the practitioner's contract are also terminated, removed, or suspended. However, the effect of expiration or other termination of a contract upon a practitioner's staff membership and clinical privileges will be governed solely by the terms of the practitioner's contract.

SECTION 9 - LEAVE OF ABSENCE FOR EDUCATIONAL, MEDICAL OR PERSONAL REASONS

A. Request for Leave of Absence. A member may request a voluntary leave of absence from the medical staff by submitting a written request to the administrator who will transmit this request to the Chief Medical Officer, Credentials Committee and the MEC. The request shall state the reason for the request and the specific time period which may not exceed the member's current term of appointment. All leaves must be approved by the MEC and the governing body. By requesting a leave of absence the member understands and agrees that he will be treated as an initial applicant for the purpose of evaluating his qualifications for reinstatement and he shall bear the burden of proof to demonstrate to the satisfaction of the MEC and the governing body that he is qualified for reinstatement. During the period of leave, the member's clinical privileges shall be inactive. While on leave, the member must maintain all required licenses, registrations, and malpractice insurance. Failure to do so shall be deemed voluntary resignation from the medical staff. If the practitioner’s current term of appointment expires during the leave of absence, he shall be deemed to have voluntarily resigned from the medical staff and may reapply as an initial applicant.

B. Request for Reinstatement.

Reinstatement to the Medical Staff may be requested for the following reasons:

a) Due to personal/family illness or injury. A $100 fee may be assessed.
b) Reappointment non-compliance. Fee of $300 will be assessed.
c) Administrative Delay of reappointment. No fee will be assessed.
d) Leave of Absence. No fee will be assessed.
e) Moved out of Area with Reappointment within last twelve months. Fee of $100 will be assessed.
f) When Medicaid or Medicare program exclusion or investigation is cleared, participant may request reinstatement within twelve months and no fee will be assessed.

At least thirty (30) days prior to termination of leave, or at any earlier time, the member may request reinstatement of privileges by submitting a written notice to that effect to the administrator, who will transmit this notice to the Credentials Committee and the MEC. The member must also submit a written summary, detailing his professional and patient care activities during the leave. The Credentials Committee shall evaluate the request and may deem it incomplete if any necessary information is not provided. The MEC, on receipt of the recommendation of the Credentials Committee, may deem the request incomplete, may request further information from the member, may defer action on the request, or may make a recommendation to the governing body concerning the reinstatement of the member's privileges and any conditions that should be attached. Thereafter, the procedure provided in Article III, Section 5 shall apply.

C. Failure to Request Reinstatement. Failure without good cause to request reinstatement, to supply sufficient information for the request to be deemed complete, expiration of current term of appointment during leave of absence, or failure to provide a summary of professional and other activities as above required shall constitute a voluntary resignation from the staff, effective immediately. The MEC shall in its sole discretion, and after giving the practitioner an opportunity to address the MEC, determine whether good cause exists. Such voluntary resignation shall not entitle the practitioner to the hearing and appeal rights under these bylaws. A request for staff membership subsequently received from this practitioner shall be treated and processed as an application for initial appointment.

D. Routine Observation Requirements. In the discretion of the MEC, reinstatement may be made subject to an observation requirement for a period of time during which the practitioner's clinical performance is observed by one (1) or more designated medical staff members. Such routine observation shall not be considered disciplinary action and shall not entitle the practitioner to the hearing and appeal rights under these bylaws.

SECTION 10 - RESIGNATION FROM THE MEDICAL STAFF

Any practitioner who desires to resign from the medical staff must submit a letter of resignation, through the Credentials Committee, to the MEC and the administrator. Such a practitioner's subsequent application for medical staff membership or clinical privileges will not be processed if he has any unfulfilled obligations under these bylaws or the rules and regulations, including, but not limited to, the need to complete delinquent medical records. Subsequent application for staff membership or clinical privileges will not be processed while outstanding obligations remain, and this status will be reported in response to any requests for references.

SECTION 11 - HOSPITAL EMPLOYEES

The hospital may determine as a matter of policy that certain practitioners may be employed in accordance with a written contract between the hospital and the practitioner. An employed practitioner must meet the same membership qualifications, must be processed for appointment, reappointment, and clinical privilege delineation in the same manner, and must fulfill all of the obligations for membership category as any other applicant or member. The termination of the medical staff membership and privileges of an employed practitioner shall be handled in accordance with the provisions of Article VII, Section 11G.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

SECTION 1 - MEDICAL STAFF

The medical staff shall be divided into the following categories: active, and consulting.

SECTION 2 - ACTIVE STAFF

A. Qualifications. The active staff category shall consist of practitioners who regularly admit, or personally provide services other than written consultation, to patients in the hospital and who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance and/or travel time 50 minutes to the hospital in order to provide continuous care to their patients. Active staff members shall admit or provide the above-described services to an average of 25 patients per calendar year, and any less than this shall ordinarily be deemed a request for modification of membership status. Active staff members assume the functions and responsibilities of membership including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments. Members of the active staff shall be eligible to vote; hold staff office; serve on medical staff, and governing body committees; and shall attend not less than the number of medical staff, and committee meetings required by these bylaws. Active staff members shall participate in the quality/ performance management activities required of the medical staff and shall serve, when qualified and required to do so, as proctors for other practitioners during any period of temporary privileges pending membership processing or during the initial membership provisional status period.

B. Failure to Meet Qualifications. An active staff member who provides the above services for less than **25** patients per year in the hospital shall be automatically transferred to the consultant staff at the time of the next reappointment, unless the practitioner does not meet the qualifications for membership in either staff category, in which case his medical staff membership shall automatically expire, without the hearing and appeal rights under these bylaws.

SECTION 3 - CONSULTANT STAFF

The staff category shall consist of practitioners who are located (primary or satellite office and temporary or permanent residence) within a reasonable travel time of 50 minutes to the hospital to provide continuous care for their patients but who do not admit or provide services other than written consultation. Consultant staff members shall be members of the active or associate staff of another hospital in which their regular participation in quality\performance management activities is documented and their performance is evaluated. Consultant Staff membership shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation if less than 10 Patients encounter per calendar year. Consultant Staff members are eligible to vote on medical staff matters and hold medical staff office. They may serve as voting members of designated hospital committees in which they may participate. They shall be required to attend medical staff meetings.

ARTICLE V

CLINICAL PRIVILEGES

SECTION 1 - EXERCISE OF PRIVILEGES

Every practitioner providing direct clinical services at this hospital, by virtue of membership or otherwise, shall, in connection with such practice and except as provided in Sections 3 and 4 below, be entitled to exercise only those privileges specifically granted to him by the governing body. The privileges must be within the scope of the license authorizing the practitioner to practice in this state. Regardless of the privileges granted, each practitioner must obtain consultation when necessary for the safety of his patients or when required by these bylaws, the medical staff and departmental rules and regulations and other policies of the medical staff and the hospital.

SECTION 2 - DELINEATION OF CLINICAL PRIVILEGES

A. Application. Clinical privileges may be granted only upon formal request on forms provided by the hospital with subsequent processing and approval. Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a practitioner for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request.

B. Basis for Privilege Determination. Requests for clinical privileges shall be evaluated on the basis of the practitioner's training; experience; education; demonstrated current competence; any required references; and other relevant information, and health status (subject to necessary reasonable accommodation to the extent required by law). In granting privileges, consideration must be given to objective information received from sources outside the hospital, to the need for an adequate ongoing successful experience to maintain proficiency, to the hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in determining clinical privileges.

C. Procedure. All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article III for medical staff membership.

D. Special Conditions for Clinical Privileges.

Requests for clinical privileges for dentists and podiatrists shall be processed in the manner specified in this Article for other practitioners, and shall be based on their training, experience, education, health status in terms of the applicant's ability to practice in the area in which privileges are sought, demonstrated current competence, and the need for their services in the hospital. The dentist or podiatrist shall be responsible for completing the part of the consult related to any dental or podiatric problem.

E. Unavailable Clinical Privileges. Notwithstanding any other provisions of these bylaws, to the extent that any requested clinical privilege is not available at the hospital (whether because of exclusive contract, lack of facilities, policy decision of the governing body, or otherwise), the request shall be rejected without the necessity of processing pursuant to Section 2C above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the hearing and appeal rights under these bylaws.

SECTION 3 - TEMPORARY PRIVILEGES

A. Temporary Privileges: Temporary privileges may be granted for the following:

A. To fulfill an important patient care, treatment, and service need;

Temporary privileges under section ‘A’ may be granted on a case by case basis for a period not to exceed 30 days by the Hospital President as a representative of the Hospital Board upon recommendation of the applicable Chief Medical Officer provided there is verification of current licensure and current competence. An urgent patient care need, treatment and service is defined as one where we do not have any physicians on staff with the necessary scope of privileges to perform the necessary treatment and any delay may cause harm to the patient.

Temporary privileges under section ‘A’ may be granted for a specified period of time necessary to care for the urgent patient need (usually a one-time surgery or consult) by the Hospital Preside or designee a representative of the Hospital board upon recommendation from the Chief Medical Officer. The following Information/documents must be provided by the applicant: Current State of Maryland License, DEA and CDS Certificates; Letter of Introduction from the requesting physician; Reference from most recent Chief of Services (Confidential evaluation form) and a Peer reference letter; Current Malpractice Insurance Certificate and Endorsements; Evidence of Board Certification; Current Curriculum Vitae (CV) and a Signed consent and release form to allow queries for NPDB/FSMB/AMA/Certifacts/AIM.

B. When a new application is complete that raises no concern is pending review and recommendation by the Medical Executive Committee, and approval by the Hospital Board;

Temporary privileges under section ‘B’ may be granted for a period not to exceed 120 days by the Hospital President or designee as a representative of the Hospital Board upon recommendation of the

Credentials Committee Chair and Chief Medical Officer provided: there is verification of current licensure, relevant training or experience, current clinical competence and the ability to perform requested privileges, other criteria required by the Medical Staff Bylaws, the results of the National Practitioner Data Bank query have been obtained and evaluated. The applicant has: a complete application, no current or previously successful challenge to licensure or registration, not been subject to involuntary termination of medical staff membership at another organization; not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

C. Participant in a Medical Review Committee. In the rare situation where there are no qualified members of the medical staff to act as a member of a Medical Review Committee, temporary privileges may be granted to a qualified individual for the limited purpose of participating as a member of a Medical Review Committee as defined under Article VII of these bylaws.

D. Participate as a Consultant on Peer Review Matters. In those cases where a peer review committee or it necessary to obtain a review of a practitioner's practice by an outside consultant who is not a member of the medical staff, the outside consultant may be granted temporary privileges for the limited purpose of conducting the review, reporting to the peer review committee/department, and for testifying at a hearing or appeal with regard to that review.

E. Denial, Termination or Restriction of Temporary Privileges.

1. At any time, temporary privileges may be terminated by the Hospital's President with the concurrence of the Chair of the department (or their designees), subject to prompt review by the Executive Committee. In such cases, the appropriate department Chair or, in the Chair's absence, the President of the Medical Staff shall assign a Member of the Medical Staff to assume responsibility for the care of such Member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Physician.

2. A person shall not be entitled to the procedural rights afforded by Article VII of the Bylaws because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended or expire.

3. All persons requesting or receiving temporary privileges shall be bound by the terms of the Bylaws.

SECTION 4 - EMERGENCY PRIVILEGES

A. Privileges. In an emergency, any practitioner to the degree permitted by his license shall be permitted to do everything he deems reasonably necessary and appropriate to save the life or limb of a patient. The administrator shall be notified promptly in such cases.

B. Conclusion of Emergency. When the emergency no longer exists, the practitioner must request the privileges necessary to continue to treat the patient if he so desires. In the event such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff.

C. Definition of Emergency. For the purpose of this Section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life or limb of a patient is in immediate danger and any delay in administering treatment would add to that danger.

SECTION 5 - CHANGE IN MEMBERSHIP, PRIVILEGES OR STAFF CATEGORY

A staff member may, at any time, request a change of staff category, department affiliation, or privileges by submitting a written application to the medical staff office on the approved form. Such application shall be processed in substantially the same manner as an initial appointment application.

ARTICLE VI

CORRECTIVE ACTIONS

SECTION 1 - ALTERNATIVES TO CORRECTIVE ACTION

Under certain circumstances, routine monitoring and education of a practitioner in accordance with departmental procedures as described in Article IX, Section 2, may be an appropriate alternative to corrective action.

SECTION 2 - CORRECTIVE ACTION

A. Grounds; Initiation. Whenever the conduct of any medical staff member ("affected practitioner") is considered to be lower than the standards of the medical staff; or to be disruptive to the operations of the hospital; or to constitute fraud or abuse; or to be detrimental to the quality of patient care at the hospital; or to be detrimental to the hospital's licensure or accreditation; or to be detrimental to hospital or medical staff efforts to comply with any professional review organization, third-party payor (private or governmental), or utilization review requirements; or to be in violation of the medical staff bylaws, rules and regulations, or policies of the hospital, medical staff or any department or committee thereof; or to be in violation of the ethics of their profession; or if any affected practitioner is believed to have engaged in criminal conduct, corrective action may be requested against such practitioner by the requesting party who may be any member of the medical staff or the governing body, or the administrator. All requests for corrective action shall be in writing, shall be submitted to the MEC through its President, and shall set forth the specific conduct constituting the basis for the request.

B. Investigation. The MEC, before taking action on the request, shall conduct such investigation as it deems necessary, which may, in its discretion, include informal interviews with the requesting party and the affected practitioner (each out of the presence of the other), informal interviews with or reports from other persons, any required or requested and chart reviews, if applicable. Neither the investigation nor any other activities of the MEC in acting upon a request for corrective action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these bylaws shall apply.

C. Time for Taking Action; Notice; Right to Hearing. Within sixty (60) days after receipt by the MEC of a request for corrective action, or within such reasonable additional time as the MEC deems necessary, the MEC shall take action upon the request. Within 10 days after taking action, the MEC shall give written notice to the affected practitioner and the governing body stating which of the actions set forth in this Section the MEC has taken or recommended. If the action is of a type requiring notice as described Article VII, Section 2, the notice shall comply with the applicable Sections of Article VII. In no event shall the practitioner be entitled to the rights under Article VII when the only action of the MEC was to issue a letter of admonition or reprimand.

D. Possible Actions. The action of the MEC on a request for corrective action may be to: (1) reject the request; (2) issue a letter of admonition or reprimand; (3) impose terms of probation or require proctoring, co-admitting, or consultation; (4) recommend reduction, suspension, proctoring, co-admitting, consultation, or revocation of clinical privileges; (5) recommend that an already imposed summary suspension of membership or clinical privileges be terminated, modified, or sustained; (6) recommend that the practitioner's membership be suspended or revoked; or (7) take or recommend other actions deemed appropriate by the MEC.

E. Notice to Administrator. The President of the MEC shall promptly notify the administrator in writing of each request for corrective action received by the MEC and the date of its receipt, and shall keep the administrator fully informed of all communications, meetings, and actions in connection with each request.

F. Governing Body Action. At any time that it believes corrective action to be warranted, the governing body, or its designee, may initiate it. Before initiating such corrective action, the governing body, or its designee, shall consult with the President. Thereafter the governing body, or its designee, may direct the MEC to conduct an investigation or otherwise initiate corrective action. In the event the MEC fails to take action in response to a direction from the governing body, or its designee, the governing body, or its designee, may

conduct an investigation or otherwise initiate corrective action proceedings. If applicable, such proceedings shall afford the affected practitioner the hearing and appeal rights described in these bylaws.

G. Use of Membership/Privileges. The affected practitioner shall retain the use of his membership and privileges pending final action by the governing body unless such membership and/or privileges are otherwise suspended as provided in this Article. If the practitioner's current term of appointment expires during the pendency of corrective action, the practitioner's application for reappointment may be subject to the proposed corrective action; provided, however, that no additional rights to hearing and appeal shall arise from such related corrective action(s).

SECTION 3 - SUMMARY SUSPENSION OR SUMMARY RESTRICTION

A. Grounds; Authority. All or any portion of a practitioner's clinical privileges may be summarily suspended or restricted where the failure to take summary action may result in imminent danger to the health of any individual. The following persons are authorized by the medical staff to take summary action: the President, the MEC or the administrator. Suspension or restriction pursuant to this paragraph shall be temporary and effective only until further action is taken by the MEC pursuant to Section 3D. When no person or committee referenced above is available to impose a summary suspension or restrict clinical privileges, the governing body, or its designee, may take such action if a failure to do so would be likely to result in an imminent danger to the health of any individual.

B. Effective Date; Notice. A summary suspension or restriction shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension or restriction to the suspended practitioner, stating by whom it was imposed and the reasons for same. The notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended practitioner, whichever occurs first. The notice, or a written confirmation of it, shall inform the suspended practitioner: (1) of his right to an informal interview upon his written request under Section 3C; and (2) if the summary suspension or restriction could be reportable to the National Practitioner Data Bank and to any state licensing agency; and (3) that unless the suspension or restriction is terminated when the MEC takes further action under 3D, the practitioner will be entitled to the hearing and appeal rights under these bylaws. In the event that the suspension or restriction is terminated when the MEC takes further action, the practitioner shall be entitled to a hearing and appeal under these bylaws; however, the sole issue shall be whether there was probable cause for the summary suspension or restriction. A copy of the notice shall promptly be delivered to the administrator, the MEC, and the governing body.

C. Investigation. The MEC, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one meeting of the MEC; and may include an informal interview with the suspending party. An informal interview with the affected practitioner (out of the presence of the suspending party, if other than the MEC) may be held if the affected practitioner delivers a request for an informal interview in writing within seven (7) days after notice of the suspension was given to him. The MEC's investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant committees. Neither the investigation nor any other activities of the MEC in taking its further action shall constitute a hearing; they shall be informal, and none of the hearing and appeal rights under these bylaws shall apply.

D. Further Action; Time. Within fourteen (14) days after the date of the suspension, the MEC shall take further action with respect to the suspension, and may modify, continue for a definite or indefinite period, or terminate the summary suspension or restriction. Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. If the MEC upholds a summary suspension, it shall also decide if the affected practitioner's medical staff membership and clinical privileges should be terminated. The MEC shall promptly give written notice of its further action to the suspended practitioner, the administrator and the person or body who imposed the suspension or restriction (if other than the MEC).

E. Rights to Hearing. Following the decision of the MEC regarding further action, the provisions of Article VII shall govern the hearing and appeal rights under these bylaws.

F. Alternate Patient Coverage. Immediately upon the imposition of a summary suspension or restriction, the Chief Medical Officer shall provide for alternate medical coverage by a member of the medical staff for the patients of the suspended practitioner remaining in the hospital at the time of such suspension, if the privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternate coverage.

SECTION 4 - AUTOMATIC SUSPENSION; TERMINATION

The following shall result in the automatic suspension and possible termination of medical staff membership and/or clinical privileges and shall not entitle the affected practitioner to the hearing and appeal rights specified in these bylaws, unless otherwise expressly provided:

A. Medical Records; Suspension. Practitioners must complete their patients' medical records within thirty (30) days of each patient's discharge, or within such time as the governing body requires. Medical records that the practitioner fails to complete within the required period will be considered delinquent. The HIM Director shall send a written notice to a practitioner who has incomplete medical records near delinquent status. This notice be sent by either personal delivery or by certified mail, return receipt requested, and shall remind the practitioner that his clinical privileges will be automatically suspended if such records are not completed within five (5) work days after the date of the notice. If the practitioner completes the records within the time allotted, the HIM Director shall notify the Chief Medical Officer. If the practitioner does not complete the medical records within the time provided, then a temporary suspension of all privileges shall be automatically imposed by the administrator and will notify the Chief Medical Officer and President. Such suspension shall be effective as of the first day after the expiration of the prescribed time period and shall continue until the medical records in issue are satisfactorily completed. The suspension may be terminated by the joint action of the administrator and the President if they, or their designees, determine that failure to timely complete the records was justified (e.g., illness or other circumstances beyond the control of the affected practitioner) or, upon the request of the suspended practitioner, the President may temporarily lift the suspension only if the President, as the designee of the MEC, determines that an emergency exists in which the health and safety of any patient will be jeopardized by failure to allow the practitioner to treat that patient. With the exception of emergency care for which only the practitioner is qualified and available and the care of patients already hospitalized at the time of the suspension, such temporary suspension shall include all admitting and clinical privileges, Failure to complete the medical records within three (3) months of suspension shall be deemed a voluntary resignation from the medical staff and the voluntary relinquishment of all clinical privileges. Practitioners whose clinical privileges are automatically suspended or who have been deemed to have voluntarily resigned from the staff pursuant to this Section shall not be entitled to the hearing and appeal rights under these bylaws. Suspension for Medical Record delinquency is not reportable outside entities.

B. Licensure. It is the responsibility whenever a practitioner's license to practice in this state is revoked, not renewed, restricted, suspended, or voluntarily relinquished, the practitioner's staff membership and clinical privileges shall automatically terminate upon receipt by the hospital of notice thereof. If a practitioner's license to practice is made subject to probationary terms by the licensing agency, the practitioner's privileges and membership shall automatically become subject to the terms of probation, subject to review by the MEC and approval by the governing body. Action automatically imposed under this Section does not entitle the practitioner to the hearing and appeal rights provided under Article VII of these bylaws.

C. Drugs/Medication. A temporary automatic suspension of a practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall be immediately imposed by the administrator upon the receipt by the hospital of notice that such practitioner's right or license to prescribe or obtain controlled substances or medications has been suspended, revoked or otherwise restricted by the applicable governmental agency. It is the responsibility of the Practitioner to notify the hospital of such action. The matter shall be forwarded to the MEC for review at their next meetings. The MEC may decide to lift or continue that automatic suspension and may interview the practitioner if it so chooses. If a practitioner's right or license to prescribe or obtain controlled substances or medications is subject to an order of probation, the practitioner's privileges to prescribe or obtain controlled substances or other medications at or through the hospital or any of its facilities shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation. An affected practitioner shall not be permitted to prescribe medications under the hospital's DEA number. Action imposed under this Section does not entitle the practitioner to the hearing and appeal rights under these bylaws.

D. Loss of Malpractice Insurance. It is the responsibility, if a practitioner fails to maintain professional liability insurance as required by the governing body, or fails to provide evidence of such coverage, the practitioner's membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the MEC that he has secured the required professional liability coverage. Failure to provide such evidence within three (3) months after the date the automatic suspension became effective shall be deemed a voluntary resignation from the medical staff. A practitioner whose clinical privileges are automatically suspended or who has been deemed to have voluntarily resigned from the medical staff pursuant to this Section may request a meeting to discuss the matter informally with the MEC or its designee, but the practitioner shall not be entitled to the hearing and appeal rights under these bylaws.

E. Dues; Suspension. The annual dues of the medical staff shall be fixed by the MEC during July, to be effective for the following year. Medical staff members shall be billed at the time of reappointment. Failure to pay these dues will halt the reappointment process, and will be taken as a voluntary resignation from the medical staff.

F. Felony Conviction. A practitioner who has been convicted, who receives probation before judgment, or who has pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction shall be automatically suspended. Such suspension shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect unless and until the matter is resolved by subsequent recommendation by the MEC and action by the governing body or through corrective action, if necessary.

G. Quality/Performance Management and Peer Review Inquiries. Practitioners have an obligation to timely and satisfactorily respond to inquiries from medical staff committees and their designees on issues relating to the practitioner's qualifications, character, behavior, ethics, health status in terms of the practitioner's ability to practice in the area in which privileges are sought or have been granted, case management, and the practitioner's compliance with the bylaws, rules and regulations, and policies of the medical staff and hospital. Unless provided otherwise in these bylaws, the Credentialing or committee chairman shall send a letter to the practitioner requesting a response within thirty (30) days. If the practitioner fails to timely respond, the Chief Medical Officer shall send a notice advising that failure to comply within seven (7) days shall result in an automatic ten (10) days suspension of membership and all privileges. Such suspension shall continue until the inquiring person or body confirms that a satisfactory response has been received. With the exception of *bona fide* emergency care which only the practitioner is qualified and available to render, and the care of patients already hospitalized at the time of the suspension, such suspension shall include all admitting and clinical privileges. Unverified emergency admissions shall not be used to bypass such restriction. Failure to satisfactorily comply three (3) months of the date of the suspension, shall be deemed a voluntary resignation and relinquishment of all privileges. Action taken pursuant to this Section shall not entitle the affected practitioner to the hearing and appeal rights of these bylaws.

H. Notice. Unless otherwise specified in this Section, the administrator shall immediately notify the affected practitioner and the Chief Medical Officer and President in writing, either by personal delivery or mail, of any suspension or termination under this Section. Such notice shall set forth the effective date and the reason for the suspension or termination.

I. Application to Medical Staff After Termination. Unless reinstated by the MEC and the governing body, any practitioner who is terminated from membership or who has clinical privileges terminated and who desires to be admitted to the medical staff or granted clinical privileges shall be required to apply for membership and privileges and such application shall be processed as for an initial applicant. Notwithstanding the foregoing statement, no such application shall be made or processed within twenty-four (24) months after the effective date of the practitioner's termination, unless the practitioner makes a written request for consideration by the MEC and can demonstrate to the MEC good cause for why he should be permitted to apply at an earlier time.

SECTION 5 - OTHER INVESTIGATIONS

Notwithstanding anything in these bylaws to the contrary, the MEC in its sole discretion may investigate any matter or any practitioner brought to its attention by anyone and may take any action it deems appropriate, subject to review by the governing body. Such investigation shall not be deemed a hearing and may be substantially as described in Section 1B above. The MEC shall act with reasonable promptness and shall given notice of any action thus taken or recommend within five (5) days there from, to any affected practitioner and the administrator. The practitioner shall only have a right to request a hearing if the action or recommendation falls into one or more of the grounds for a hearing specifically set forth in Article VII; in such cases, the notice to the affected practitioner shall comply with the notice requirements of Article VII.

ARTICLE VII

HEARING AND APPELLATE REVIEW PROCEDURES

SECTION 1 - GENERAL PROVISIONS; DEFINITIONS; SETTLEMENT

A. Duty to Exhaust Remedies. The purpose of this Article is to permit the medical staff and hospital to resolve issues related to professional practice and qualifications for medical staff membership and clinical privileges fairly, expeditiously and with due regard for both the need to protect patients and the interest of practitioners. Each applicant and member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing and appeal under this Article. The absence of an interlocutory appeal process for reviewing any alleged violation of the bylaws or the affected practitioner's fair procedure rights does not warrant judicial intervention.

B. For the purposes of this Article, the following definitions shall apply:

40 Affected Practitioner: means the medical staff member or applicant for membership with respect to whom any of the actions specified in Section 2B below have been taken or recommended, and whose membership or privileges may be affected thereby.

41. Body Whose Decision Prompted the Hearing: means the person, committee, or body (which will generally be the MEC) that, pursuant to these bylaws, took the action or made the recommendation that resulted in a hearing being requested.

42. Notice: means a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his address as it appears in the records of the hospital. Copies shall be as effective as the original for the purpose of giving notice. Any such notice shall be deemed effective on the date it was first received or five (5) working days after it was mailed first-class postage prepaid, whichever occurs first.

43. Parties or party: means, unless clearly indicated otherwise by particular context, collectively or individually as the case may be, the affected practitioner, the MEC, and/or the body whose decision prompted the hearing (if other than the MEC).

C. Settlements. At any time following receipt of notice of a recommendation or action which would entitle a practitioner to request a hearing under this Article, the practitioner may ask the body whose decision prompted the hearing to discuss voluntary settlement or resolution of the matter. Upon such request and subject to the practitioner's waiver of time requirements in order to allow such discussions to proceed, the MEC may authorize one or more of its members to conduct confidential discussions with the practitioner; provided, that the MEC shall not be obligated to conduct such discussions if it concludes that the request is interposed primarily for delay or that a settlement is not feasible.

If the practitioner and the body whose decision prompted the hearing reach a written agreement which could settle the matter, the body whose decision prompted the hearing shall promptly notify the administrator and the governing body. Any such written settlement agreement should include an acknowledgment by the practitioner that he voluntarily waives his hearing and appeal rights under these bylaws, that the settlement is entered into voluntarily and that he will waive all claims relating in any way to the matter against all medical staff and hospital personnel. Any such proposed settlement shall be subject to governing body approval.

SECTION 2 - THE HEARING PROCESS

A. Notice of Adverse Action or Recommended Action; Request for Hearing. Whenever any of the actions constituting grounds for a hearing as set forth in Section 2B below has been taken or recommended, the person, committee, or body causing same to occur shall give notice to the affected practitioner.

The notice shall:

1. describe what action has been taken or recommended.

2. state the reasons for the action (a statement of charges will be provided in the event a hearing is properly requested).

3. advise that the practitioner has the right to request a hearing and, that such request must be in writing and received by the administrator within thirty (30) days after the affected practitioner's receipt of the Notice of Adverse Action or Recommendation.

4. contain a summary of the practitioner's rights in the hearing.

5. state that the action, if finally adopted, will be reported to the appropriate licensing entity and to the National Practitioner Data Bank (NPDB).

Whenever the MEC has given notice of action that constitutes grounds for a hearing as described in Section 2B below, the affected practitioner shall have thirty (30) days following the date such notice was given within which to request a hearing. A request for a hearing must be in writing and delivered to the administrator within the applicable time period set forth above. Failure of the affected practitioner to request a hearing within the time and in the manner set forth in this subsection shall be deemed an acceptance by the practitioner of such action or recommendation and a waiver by such party of all hearing and appeal rights under these bylaws. The matter shall thereupon be forwarded to the governing body for its final decision in accordance with Article VII, Section 6F. The administrator shall give notice to all parties of any such waiver and acceptance.

B. Grounds for Hearing. Except as otherwise provided in these bylaws, the taking or recommending of any one or more of the following actions when based on the member's professional conduct or competence, unless taken in compliance with a policy decision of the hospital (e.g., closing a service or physical plant changes), shall constitute grounds for a hearing pursuant to this Article:

1. denial of initial appointment to the medical staff.

2. denial of staff reappointment.

3. suspension of staff membership or clinical privileges for more than thirty (30) days.

4. termination of staff membership.

5. denial or termination of clinical privileges.

6. reduction in clinical privileges.

7. summary suspension of clinical privileges for more than thirty (30) days.

8. significant consultation or co-admitting requirements other than in compliance with the medical staff bylaws, rules and regulations.

C. Notice of Hearing.

1. Upon receipt of a proper request for hearing, the administrator shall deliver the request to the MEC, stating the date it was received by an administrator, then

2. the MEC shall, within thirty (30) days after receipt by the administrator of the request, schedule a date for a hearing

3. the MEC shall, not less than thirty (30) days prior to the date of the hearing, give notice to the parties of the time, place, and date thereof, and shall deliver to the practitioner a copy of these bylaws, a Statement of Charges as provided in the following paragraph, and a list of witnesses expected to testify at the hearing in the case in chief on behalf of the body that made the adverse recommendation. Unless otherwise agreed with the practitioner, the date of commencement of the hearing shall not be less than thirty (30) days from the date of the notice of hearing nor more than sixty (60) days from the date of receipt of the request for a hearing by the administrator, except that when the request is received from a member who is under suspension, the hearing shall commence as soon as reasonably practicable, but not later than forty (40) days from the date of receipt by the administrator of the request for hearing. In such instances, the notice of hearing shall be provided at least 30 days prior to the date of commencement. The parties and the medical review committee shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

D. Statement of Charges. As a part of, or together with, the Notice of Hearing referred to in the previous paragraph of these bylaws, the MEC shall state the acts or omissions with which the affected practitioner is charged, including, if applicable, a list of chart numbers under question, if any, and the reasons for the action or recommendation. Amendments to the statement of charges may be made from time to time, but not later than the close of the case by the medical staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the affected practitioner, the hearing officer, and each party. If the affected practitioner promptly gives written request to the medical review committee, he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The medical review committee shall give prompt notice to the parties of each such postponement.

E. Medical Review Committee (MRC) or Arbitrator; Appointment, Removal, and Qualifications. Promptly after a hearing has been properly requested, the President as a designee of the MEC shall determine if the hearing shall be held before: (1) an arbitrator or arbitrators selected by a process mutually acceptable to the practitioner and the MEC; or (2) before a panel referred to as a medical review committee ("MRC"). Should the President as a designee of the MEC determine that a medical review hearing committee shall be used, he shall promptly appoint such an MRC and its chairman to act as the peer review group in the hearing. The MRC shall consist of not less than three nor more than seven members, at least the majority of whom shall be physicians who shall be licensed to practice medicine but need not be members of the medical staff. When feasible, the MRC shall include at least one individual practicing in the same specialty as the affected practitioner, so long as he/she is not in direct economic competition with the affected practitioner, to the extent that can be reasonably ascertained. The MRC members may have knowledge of the matters to be heard, but each shall be willing to hear the matters objectively and without prejudgment. They shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with the same matter; shall gain no direct financial benefit from the outcome; and shall not be in direct economic competition with the affected practitioner to the extent that can be reasonably ascertained at the time of their selection.

F. Hearing Officer; Chairman of MRC. The administrator may appoint a hearing officer to conduct the hearing. The hearing officer may be a member of the state bar and should be familiar with the law applicable to hospital administrative proceedings. The hearing officer shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. The hearing officer shall gain no direct financial benefit from the outcome of the hearing and shall not act as a prosecuting officer or advocate. The hearing officer shall act as advisor to the MRC as to procedural matters, including the drafting of its decision and report, but he shall not be entitled to vote. In the alternative, the administrator, after consulting the MEC, may appoint a medical hearing officer to conduct the hearing. The medical hearing officer may be a member of the medical staff but may not be in direct economic competition with the affected practitioner. He should be familiar with the applicable medical issues and with medical staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. He shall decide all procedural matters. All references to the "hearing officer" shall refer to the medical hearing officer if one is appointed. If a hearing officer is not appointed, the chairman of the MRC shall conduct the hearing and rule on procedural matters, and all references to the "hearing officer" shall be deemed to refer to the chairman of the MRC or the arbitrator, as appropriate.

G. Postponements and Extensions. After the appointment of the MRC and before the commencement of the hearing, postponements beyond the times required by these bylaws may be requested by any of the parties, and shall be granted upon agreement of the parties or by the arbitrator or hearing officer on a showing of good cause. The MRC shall promptly give notice to the parties of each such postponement.

H. Medical Staff Representative. After a hearing has been properly requested, the President shall promptly appoint a medical staff member ("medical staff representative") to present the case on behalf of, and otherwise represent, the body whose decision prompted the hearing. The President may, in its sole discretion, remove or replace the medical staff representative at any time. The President may also choose to use attorney(s) to present the case.

SECTION 3 - HEARING PROCEDURE

A. General. It shall be the duty of the practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such prehearing decisions shall be raised on the record at the hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

B. Witness Lists. At the request of either party, the parties must exchange at least ten (10) days before the hearing: (1) lists of witnesses expected to testify at the hearing during each party's case in chief; and (2) copies of all documents expected to be introduced at the hearing during that party's case in chief. Failure of a party to produce these materials, or to update them, at least ten (10) days before the commencement of the hearing, shall constitute good cause for the hearing officer to grant a continuance, or to bar or otherwise limit the introduction of any documents not provided to the other party or testimony from witnesses not identified pursuant to this provision. Such requirements shall not apply to witnesses and documents used in rebuttal or cross-examination.

C. Failure to Appear. Failure of the affected practitioner to appear at the hearing shall be deemed to constitute the affected practitioner's voluntary acceptance of the recommendation or action and waiver of all hearing and appeal rights under these bylaws, unless the MRC finds good cause for such failure, based upon written request by the affected practitioner or his representative.

D. Representation. The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on conduct or professional competency. Accordingly, neither the affected practitioner nor the body whose decision prompted the hearing shall be represented in any phase of the hearing by an attorney at law, unless the MEC, in its discretion, permits each to be represented by legal counsel or if required by state law. Any request for legal representation by the practitioner shall be made at the time the hearing request is made. The affected practitioner shall be entitled to be accompanied by and represented at the hearing by a physician licensed to practice in this state and who is not also an attorney at law and who preferably, is a member in good standing of the medical staff. The body whose decision prompted the hearing shall appoint a representative from the medical staff to present the evidence in

support of the recommendation or actions. Any party may obtain legal counsel at their expense for the purpose of preparing for the hearing. A representative may also be a witness.

E. Record of the Hearing. The MRC proceedings shall be taken and transcribed by a court reporter, and a copy of the transcript of each session shall be available for purchase by either party. Each party shall be responsible for payment of all costs and charges associated with any transcript that it requests.

F. Oath of Witness. The MRC may, in its discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.

G. Organization and Conduct of Hearing Process. Unless otherwise expressly provided in these bylaws, the hearing shall be conducted as follows:

1. The parties shall have a reasonable opportunity to voir dire the MRC members and the hearing officer, and the right to challenge the appointment of any MRC member or the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

2. The medical staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove.

3. The medical staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the written evidence to support the case. He may call any person or opposing party, who is present, in support of the case.

4. At the close of the medical staff representative's case, unless the MRC believes that the action or recommendation being reviewed was clearly not supported by the medical staff representative's presentation (in which case the hearing may terminate by such a ruling at this point), the affected practitioner or his representative shall make an opening statement and shall make a case presentation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case.

5. Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the hearing officer as to order, time, relevance, and repetition.

6. Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitation by the hearing officer, to submit a written statement and give closing statements and argument.

7. Upon the close of all presentations, rebuttals, statements, and argument, the hearing officer shall declare the hearing finally adjourned, and all persons other than the MRC and hearing officer shall thereupon leave the hearing. The MRC shall thereafter, at the convenience of its members but subject to the provisions of Section 4 below, deliberate in order to reach its decision.

8. Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the hearing officer after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only.

9. No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the hearing officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the hearing officer, leave the hearing. Unless directed otherwise for good cause by the hearing officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the affected practitioner or a witness, he shall have the right to submit to the MRC, not later than ten (10) days after such exclusion

(unless extended by the hearing officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.

10. Except as otherwise provided in these bylaws and subject to reasonable restriction by the hearing officer, the following shall be permitted to attend the entire hearing in addition to the MRC, the hearing officer, court reporter, counsel, and parties, the administrator or his designee, one (1) person designated by the administrator (or designee), the medical staff coordinator or assistant, one (1) key consultant for each party, and one (1) or more representatives of the entity that owns the hospital.

H. Burden of Proof. The affected practitioner shall have the burden of proving, by clear and convincing evidence, that the action or recommendation of the body whose decision prompted the hearing, which is the subject matter of the hearing, is arbitrary, capricious or unreasonable.

I. Admissible Evidence and General Procedures. Except as otherwise provided in these bylaws, the following rules shall apply in the hearing:

1. The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law. The MRC shall have the discretion to recognize any matters, either technical or scientific, including statistical data, relating to the issues under consideration, which are common knowledge in the general medical community and/or any medical specialty.

2. Parties or their representatives shall have the right to:

(a) a reasonable opportunity to voir dire the MRC members and the hearing officer, and the right to challenge the impartiality of any MRC member or the hearing officer. Such challenges shall be ruled upon by the hearing officer.

(b) be provided with all information made available to the MRC that is relevant to the hearing.

(c) call and examine witnesses on relevant evidence and to cross-examine witnesses.
evidence.

(e) present evidence that tends to impeach any witness on relevant matters, provided that, to prevent abuse of this right, the hearing officer may, in his discretion, require a prior offer of proof summarizing such evidence and may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justifies such rejection.

(f) submit a written statement at the close of the presentation of evidence.

3. Evidence of relevant activities or practices at any location or facility shall be admissible unless limitations are imposed by the hearing officer upon a showing of good cause.

4. The MRC may receive and consider any brief or memorandum presented by any party.

5. Any relevant material contained in medical staff files regarding the affected practitioner is admissible, including but not limited to applications, references, and accompanying documents.

SECTION 4 - DECISION AND REPORT OF MRC; NOTICE

After adjournment of the final session of the hearing, the MRC shall begin its deliberations. Within thirty (30) days after closure of the deliberations of the MRC, the MRC shall render and deliver to the administrator a written report and decision. The MRC may recommend that the governing body affirm, terminate or modify the action or recommendation that prompted the hearing. If the recommendation is to modify, the MRC must identify the modifications recommended. The decision and report shall be based on evidence produced at the hearing, including any recognized matters and reasonable inferences that may be drawn. The decision and report shall include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. It shall include sufficient detail to enable the parties and the governing body to determine the basis for the

MRC's decision on each issue contained in the statement of charges. It shall also contain a description of the appellate rights provided under these bylaws. The administrator, within five (5) working days after receiving the decision and report, shall send a copy of them to the parties.

SECTION 5 - GOVERNING BODY ACTION AFTER MRC DECISION

The governing body shall take no action regarding the underlying matter or the decision and report of the MRC, until after the expiration of the time for requesting appellate review under Section 6, provided that if an appellate review is properly requested under Section 6, the governing body shall take no action except in compliance with the procedures and provisions of this Article. If an appellate review is not timely requested, the governing body shall make its final decision in accordance with Section 6.

SECTION 6 - APPEAL TO GOVERNING BODY

A. Time for Requesting Appeal. Within thirty (30) days after receipt of notice of the decision of the MRC, either the affected practitioner or the body whose decision prompted the hearing, may request an appellate review by the governing body. The request shall be in writing and must be received by the administrator within the applicable time period set forth above. The administrator shall immediately deliver copies of the request to the governing body and to the other parties. The request shall set forth the ground(s) for appeal as noted under Section 6C. If an appellate review is not requested as set forth in this paragraph, all parties shall be deemed to have waived all rights to appeal.

B. Nature and Effect of Appellate Review. The appellate review shall be by the governing body or a committee thereof and all references to the "governing body" shall include such committees. Appellate review shall consist of a review of the prior proceedings and decision in the matter being reviewed, an appellate review meeting, deliberations, review of any further recommendations, and a final decision. In its final decision the governing body may affirm, modify or reverse the decision of the MRC. No person or entity that participated in bringing the charges or in officially reviewing the matter shall participate in the appellate review process, even if such removal leaves the governing body with less than a quorum.

C. Grounds for Appeal. The grounds for appeal are limited to: substantial and prejudicial failure of the MRC or the MEC to comply with these bylaws or to afford due process or a fair hearing; the action or recommendation that prompted the hearing, or any substantial part was arbitrary or capricious; the MRC's decision or any substantial part was clearly contrary to the weight of the evidence; or that a medical staff bylaw, rule or regulation relied on by the MRC in reaching its decision lacked substantive rationality.

D. Notice of Time, Date, Place of Appellate Review Meeting. The governing body shall, within thirty (30) days after receipt by the administrator of a timely request for appeal, schedule a date for an appellate review meeting. The governing body shall, not less than ten (10) days prior to the date of the appellate review meeting, give the parties written notice of the time, place, and date. The date thereof shall be not less than ten (10) days, nor more than sixty (60) days, from the date of receipt by the administrator of the request for appellate review, except that when a request for appellate review is from a member who is then under suspension, the appellate review meeting shall be held as soon as reasonably practicable but not later than forty (40) days from the date of receipt of the request. The date for the appellate review meeting may be extended by the chairman of the governing body for good cause.

E. Appellate Review Proceedings. The appellate review shall be conducted as follows:

1. The governing body shall limit its review to the record of the hearing before the MRC, the MRC decision and report, and any written briefs submitted by the parties. The governing body may, however, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided for MRC hearings. Such acceptance of additional issues or evidence may be based on the governing body's own motion, or upon the request of a party if, not less than seven (7) days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes written request to the governing body to do so, specifying the nature and relevance of the issues or evidence, and gives notice of such request to all other parties. The governing body shall give notice of its decision in such matters to all parties as soon as reasonably possible.

2. The governing body may, in its sole discretion, appoint a hearing officer to conduct the appellate review meeting, rule on procedural matters, act as advisor to the governing body as to procedural matters, and without voting rights, participate in its deliberations and assist in the preparation of its decision.

3. Each party shall have the right to submit a written brief in support of his position on appeal, provided that copies of such brief shall be given to all other parties at such time as may be directed by the governing body.

4. The governing body, in its sole discretion, has the option to allow each party or party's representative to appear personally and make oral argument at the appellate review hearing, provided that such party shall make written application therefor to the governing body not less than seven (7) days prior to the date of the appellate review meeting. The governing body shall give notice of its response to such applications to all parties as soon as reasonably possible. If personal appearance is allowed, the affected practitioner, if present, and all other parties and representatives present, shall answer any questions posed by any member of the governing body.

5. The governing body may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it decides, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter. The governing body shall give notice to the parties of any such date and time, unless the parties were present when such date and time were announced by the governing body.

6. At the conclusion of the appellate review meeting, including oral argument, if held, the governing body shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, in order to determine whether to affirm, modify, or reverse the decision of the MRC.

7. The governing body shall, in its sole discretion, decide the order of procedures to be followed in the appellate review, as well as answers to questions not otherwise addressed in these bylaws, to the end that the appellate review, including the appellate review meeting, shall be thorough, orderly, efficient, and fair.

8. No person shall disrupt any appellate review proceeding. Any person in attendance (whether a party or any other person) who disrupts an appellate review meeting after being warned by the chairman of the governing body (or his designee or the hearing officer) to cease such disruption on penalty of indefinite exclusion, shall, at the direction of such chairman (or designee or the hearing officer), leave the meeting. Unless directed otherwise for good cause by the chairman (or designee or the hearing officer), the appellate review meeting shall proceed in the absence of such excluded person. Any party may enforce the provisions of this Section by court order upon injunctive or other appropriate relief.

F. Final Decision; Effective Date. The appellate review process shall conclude with the governing body's final decision in the matter which shall be made in accordance with the following rules:

1. Within thirty (30) days after either the waiver of appellate rights or the conclusion of the appellate review meeting, the governing body shall render its final decision, unless it refers the matter to the MRC for further review and recommendation. The governing body, however, may exercise its independent judgment in determining whether the hearing procedures in these bylaws were followed.

2. If the governing body refers the matter to the MRC for further review and recommendation, such referral may include instructions such as that the MRC arrange for further hearings on specific issues. The governing body shall give notice of such referral to the parties. The MRC shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the governing body within forty-five (45) days after the receipt of the referral from the governing body. Within forty-five (45) days after receipt of such recommendation, the governing body shall render its final decision.

3. The governing body's final decision shall be in writing and shall include a statement of the governing body's basis for its decision. The decision shall be effective immediately and not subject

to further hearing or appeal. As soon as the final decision is effective, a copy of it shall be delivered to the affected practitioner, the administrator, and each party, in person or by mail.

SECTION 7 - RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

No party shall be entitled to more than one (1) evidentiary hearing and one appellate review on any matter that may be the subject of a MRC hearing or appeal.

SECTION 8 - INFORMAL INTERVIEWS

Nothing in these bylaws shall be deemed to prevent any committee, or person contemplating any action or recommendation set forth in Section 2B, from, at its sole discretion, inviting the affected practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article.

SECTION 9 - RESIGNATION OR WITHDRAWAL OF APPLICATION

Notwithstanding any other provision of these bylaws, whenever the affected practitioner unconditionally: (a) resigns from the medical staff; (b) resigns and relinquishes the privileges that are the subject matter of a hearing; (c) withdraws the application that is the subject matter of hearing; (d) amends an application or request with regard to the items that are the subject matter of the hearing; or (e) consents in writing to the action or recommendation that prompted the hearing, and there are no other issues before the hearing, all hearing and appellate review proceedings with respect to the practitioner, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the governing body, after receiving a written request from, or giving notice to, the affected practitioner, and determining that good cause exists for such reopening.

SECTION 10 - CONFIDENTIALITY

In addition to the provisions provided in Article XII of these bylaws, all medical staff applicants and members, committee members and committee guests, peer review consultants, persons involved in any peer review activity at this hospital, as well as parties, participants, and attendees at a medical staff peer review hearing, shall keep all peer review investigations as well as all hearing and appellate review proceedings and the contents thereof confidential. No one shall disclose or release any information from or about the proceedings to any person or the public, except as allowed or required by applicable law.

SECTION 11 - EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these bylaws, the hearing and appeal rights under these bylaws are not applicable under the following circumstances:

A. Closed Departments/Exclusive Contracts. The hearing and appeal rights under these bylaws do not apply to a practitioner whose application for medical staff membership and privileges was denied on the basis that the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy.

B. Medico-Administrative Practitioner. The hearing and appeal rights under these bylaws do not apply to those persons serving the hospital in a medico-administrative capacity. Termination of such persons' rights to practice in the hospital shall instead be governed by the terms of their individual contract with the hospital. However, the hearing and appeal rights of these bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

C. Automatic Suspension or Termination of Privileges. The hearing and appeal rights under these bylaws are not granted if a member's medical staff membership or clinical privileges are automatically suspended or terminated in accordance with these bylaws.

D. Hospital Policy Decision. The hearing and appeal rights of these bylaws are not available if the hospital makes a policy decision (e.g., closing a department or service or physical plant changes) that adversely affects the staff membership or clinical privileges of any member or applicant.

E. Termination of Hospital Employed Practitioners. The privileges and staff membership of any practitioner employed by the hospital shall be subject to termination in accordance with the terms of the practitioner's contract. Such practitioner shall not be entitled to the hearing and appeal rights under these bylaws, except to the extent that the practitioner's staff membership or privileges which would otherwise exist independent of the contract are to be limited or terminated, or unless otherwise provided in the practitioner's contract.

ARTICLE VIII

OFFICERS OF THE MEDICAL STAFF

SECTION 1 - OFFICERS

Officers of the medical staff shall be the:

A. President

B. President Elect

C. Immediate Past President

D. Secretary-Treasurer.

E. Member at Large - Rockville

F. Member at Large - Takoma Park

SECTION 2 - QUALIFICATIONS

Officers must be members of the active or consultant staff at the time of their nomination and election and must remain in good professional and ethical standing during their term of office. Because of the peer responsibilities of their offices, the President and President Elect shall be physicians, with demonstrated competence in their fields of practice and ability to direct the medico-administrative aspects of medical staff activities. Officers must have demonstrated good interpersonal relationships with medical staff members and hospital staff, and have indicated a willingness to accept the responsibilities of the office.

SECTION 3 - NOMINATION AND ELECTION OF OFFICERS

A. Officers shall be elected for a two (2) year term by the medical staff members. Election shall be by written ballot. The candidate must be elected by a majority vote of the medical staff returning ballots. When three (3) or more candidates are running and a majority is not obtained, the candidate with the least votes will be eliminated each time until a candidate receives a majority vote.

B. Nominations may be made in the following ways, provided that written consent to serve is obtained from the proposed nominee prior to placing the nominee's name into nomination:

1. By a nominating committee. The nominating committee shall consist of five (5) members of the approval of the MEC. The nominating committee shall convene and shall submit to the medical staff coordinator one (1) or more qualified nominees for each This shall be done six (6) months before the end of the MEC term The nominees shall be for the offices of President Elect, Secretary Treasurer, Member at Large - Rockville, and Member at Large - Takoma Park ;

2. By petition. Nominating by petition requires the signature of at least ten medical staff members of the active staff members and must be filed with the medical staff coordinator at least ten (10) days prior to the final MEC. The medical staff shall be notified of these additional nominees at the time of this meeting;

3. From the floor. Nominating may be done from the floor at the time of the 3rd MEC meeting of the term .

SECTION 4 - TERM OF OFFICE/VACANCIES

A. Term of Office. Each officer shall serve a two-year term, beginning the first day of the medical staff term following their election. Each officer shall serve until the end of his term or until a successor is elected, unless he shall sooner resign or be removed from office.

B. Vacancies in Office. Vacancies in office during the medical staff term, except for the President, shall be filled by the medical staff MEC. If there is a vacancy in the office of President, the President Elect shall serve out the remaining term. A vacancy in the office of immediate past President will not be filled

SECTION 5 - REMOVAL OF ELECTED OFFICERS FROM OFFICE

A. Removal. Removal of a medical staff officer for cause may be initiated by a two-thirds (2/3) majority vote of the active medical staff. Removal shall also require approval of the MEC and the governing body. The governing body may remove any officer for cause as described in Section 5B, below.

B. Grounds for Removal. Each of the following conditions in itself constitutes cause for removal of a staff officer from office:

1. Revocation of professional license by the authorizing state agency.

2. Suspension from the medical staff.

3. Failure to perform the required duties of the office.

4. Failure to adhere to professional ethics.

5. Failure to comply with or support enforcement of the hospital and medical staff bylaws, rules and regulations, and policies.

6. Failure to maintain adequate professional liability insurance.

7. Failure to maintain medical staff membership.

SECTION 6 - RESPONSIBILITIES, DUTIES, AND AUTHORITY OF OFFICERS

A. President. The responsibilities, duties, and authority of the President are to:

1. call, preside at, and determine the agenda of all general and special meetings of the medical staff.

2. serve as chairman of the MEC, with tie-breaking vote prerogative only, and as ex officio member of all other medical staff committees without vote.

3. enforce medical staff bylaws, rules and regulations and appropriate hospital rules and policies; implement sanctions when they are indicated; and enforce the medical staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a practitioner.

4. appoint the chairman and all medical staff members of medical staff standing and ad hoc committees, except the MEC; appoint the medical staff members of hospital and governing body committees when these are not designated by position or by specific direction of the governing body.

5. represent the views, policies, concerns, needs, and grievances of the medical staff to the governing body and administration; serve ex officio as a voting member of the governing body.

6. advise the governing body on the effectiveness of the quality/performance management program and the overall quality of patient care in the hospital.

7. advise the governing body, administration, and the MEC on matters that impact on patient care and clinical services, including the need for new or modified programs/ services, for recruitment and training of professional and support staff personnel, and for staffing patterns.

8. serve as spokesman for the medical staff in its external professional and public relations.

B. President Elect. The responsibilities, duties, and authority of the President Elect are to:

1. assume the responsibilities, duties, and authority of the President during the latter's absence whether the absence is temporary or permanent.

2. serve as an ex officio voting member of the MEC.

3. serve as chairman of the Quality/Performance Management Committee.

C. Immediate Past President The responsibilities, duties, and authority of the Immediate Past President are to:

1. serve as an ex officio voting member of the MEC.

2. advise the President and MEC on matters concerning the medical staff.

3. perform other functions at the request of the President.

4. assume the responsibilities, duties, and authority of the President when both the latter and the President Elect are temporarily absent.

D. Secretary-Treasurer. The responsibilities, duties, and authority of the Secretary-Treasurer are to:

1. serve as an ex officio voting member of the MEC .

2. maintain accurate and complete minutes of all medical staff meetings.

3. take steps so that an answer is rendered to all official medical staff correspondence.

4. maintain a record of medical staff dues, collections, and accounts, and sign checks for medical staff fund expenditures pursuant to his authority.

ARTICLE IX

COMMITTEES AND FUNCTIONS

SECTION 1 - GENERAL CONSIDERATIONS

A. Standing and Special Committees. There shall be standing and special (ad hoc) committees of the medical staff. Unless stated otherwise in these bylaws, the committees of this Article shall be standing committees of the Medical Staff. Special/ad hoc committees may be created by the MEC to perform specified tasks.

B. Appointment and Removal. Unless otherwise specified, the chairman and members (except the MEC and its chairman) of all committees shall be appointed and may be removed by the President after consultation with and approval of the MEC.

C. Minutes. Unless stated otherwise in these bylaws, each committee shall submit a copy of its minutes to the MEC, and shall maintain a permanent record of its proceedings, including pertinent discussion and any conclusions, recommendations, and actions.

D. Participation of Non-Medical Staff Members. Persons who participate/attend committees/functions who are not medical staff members shall be selected by the administrator with the concurrence of the committee chairman or President Non-medical staff members shall not be entitled to vote, but may participate if invited in discussions.

E. Ex officio members. Ex officio committee members shall serve vote, committee meetings as designated by MEC, but not MEC

F. Performance of Functions. Whenever these bylaws require that a function be performed by:

1. a medical staff committee but no committee has been specified, the MEC shall perform the function or designate a subcommittee to perform it.

2. the MEC but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

G. Vacancies. Unless stated otherwise in these bylaws, vacancies on any committee shall be filled in the manner of original appointment to the committee; provided, however, that if an individual obtains membership by virtue of these bylaws and is removed for cause, a successor may be selected by the MEC.

H. Confidentiality. All committee participants/attendees, including members and invited guests, are required as a condition of attending/participating in a medical staff peer review committee, to sign and date a medical staff peer review confidentiality statement acknowledging that each agrees to maintain the confidentiality of committee matters.

SECTION 2 - MEDICAL EXECUTIVE COMMITTEE (MEC)

A. Composition. The MEC shall be a standing committee of the medical staff and shall consist of the officers of the staff, two (2) members elected by the medical staff, 2 members at large, secretary, the most recent ex-chief of staff, Pharmacy and Therapeutics and Credentialing committees, and the administrator of the hospital, who shall be an ex officio member without vote. The President shall be chairman of the committee. Each voting MEC member, regardless of staff, department, or other committee position held shall have only one (1) vote.

B. Responsibilities, Duties, and Authority. The MEC shall:

1. represent and act on behalf of the medical staff, subject to such limitation as may be imposed by these bylaws.

2. recommend to the governing body on all matters relating to appointments, reappointments, clinical privileges, staff category and corrective action. When designated professional personnel provide or are recommended to provide services in the hospital, the committee shall make recommendations to the governing body on their qualifications to provide those services and on the degree of supervision required.

3. receive and act upon reports and recommendations from medical staff committees, and staff officers concerning quality/performance management activities and the discharge of their delegated administrative responsibilities.

4. cause, through evaluation by this committee or the Quality/Performance Management Committee, each medical staff peer evaluation and quality/performance assessment and improvement activity to be performed effectively.

5. coordinate the activities of, and policies adopted by, the staff, and committees.

6. fulfill the medical staff's accountability to the governing body for the medical care rendered to patients in the hospital.

7. initiate and pursue corrective action, when warranted, in accordance with these bylaws.

8. take all reasonable steps to help provide for professional ethical conduct, competence, and clinical performance on the part of all staff members.

9. make recommendations to the governing body on medico-administrative and hospital management matters as requested, particularly as they relate to patient care, through the administrator and President

10. submit recommendations to the governing body for changes in the medical staff bylaws, rules and regulations and other organization documents pertaining to the medical staff.

11. provide and promote effective liaison among the medical staff, administration, and the governing body.

12. participate in identifying community health needs and in setting hospital goals and implementation of programs to meet those needs.

13. actively promulgate effective medical staff participation in the hospital's occurrence screening program.

14. promote in house medical staff continuing education activities that are relevant to the care and services provided in the hospital and, in particular, to the findings of medical staff peer evaluation and quality/performance management activities.

C. Meetings. The MEC shall meet as often as necessary to accomplish its functions, but at least four (4) times per year.

SECTION 3 - CREDENTIALS COMMITTEE

A. Composition. The Credentials Committee shall be a standing committee of the medical staff and shall consist of two 2 or more members of the active staff, with ex officio representation from administration who shall not vote. The chairman of the committee shall be an active member of the medical staff elected. The chairman shall elect members of the active staff.

B. Responsibilities, Duties and Authority. The committee shall:

1. review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment, and for clinical privileges.

2. review each application prior to processing to determine if it is complete for processing and shall not process any application for membership or privileges that is incomplete.

3. review and evaluate the qualifications of designated professional personnel to provide specific patient care services in the hospital and to obtain and consider the recommendations of the appropriate department.

4. submit a report, in accordance with these bylaws, to the MEC on the qualifications of each applicant for staff membership or clinical privileges, and of each designated professional personnel, to provide specific patient care services. Such report shall include recommendations for medical staff applicants as to appointment, staff category assignment, and clinical privileges, and, for designated professional personnel the specific services to be performed. In either case, any special conditions will be recommended at the same time.

5. submit quarterly reports to the MEC on the status of pending applications, including the specific reasons for any unusual delay in processing an application or request.

6. monitor activities implemented for evaluation of the performance of patient care, such as for practitioners in provisional status or who have been granted temporary privileges pending medical staff appointment.

7. initiate, investigate, review, and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any practitioners assigned or referred by the President, the chairman of the Quality/Performance Management Committee, the MEC, or the governing body.

8. provide that a separate credentials file is maintained for each staff member, each practitioner with clinical privileges, and each designated professional personnel, including reports from quality/performance assessment and improvement activities and of corrective actions of any degree.

C. Meetings. The Credentials Committee shall meet as often as necessary to accomplish its functions, but at least ten (10) times per year.

SECTION 4 - PHARMACY AND THERAPEUTICS COMMITTEE/FUNCTION

A. Composition. The Pharmacy and Therapeutics Committee is a standing committee of the medical staff and shall consist of five (5) physicians from the active and consultants categories of the medical staff, a pharmacist from the hospital's pharmacy service, and a representative from administration and from nursing services and when indicated, a clinical dietitian The chairman shall be elected if indicated. The chairman shall select the medical staff committee members

B. Responsibilities, Duties, and Authority. The committee shall:

1. cause an objective evaluation over time of the clinical use of drugs (particularly high risk, problem-prone and investigative drugs) in the hospital, establishing priorities for specific drug or drug category reviews, and using measurable criteria in the review process. After any required peer review, the findings will be entered into the appropriate practitioner performance profiles.

2. cause a well controlled or closed formulary to be established and implemented to help control drug use in the hospital. The committee will evaluate and make recommendations to the MEC as to which drugs should be added to and deleted from the formulary. Requests for formulary changes from individual medical staff members must be submitted to the committee in writing and include the rationale for the change. The committee's action shall be transmitted to the requesting practitioner by the committee chairman.

3. define and evaluate all significant untoward reactions to drugs. In addition, the committee shall strive for adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic inservice training for nursing personnel and other appropriate hospital personnel.

4. define and evaluate all significant medication errors.

5. evaluate initially, or when changes are made, and at least annually, standing and routine orders in use and minimize the use of personal standing orders

6. assist in the formulation of and approve all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the hospital.

7. assist in providing for the centralized function and adequacy of intravenous admixtures, total parenteral nutrition, and admixture of chemotherapeutic agents.

8. make recommendations to the MEC on protocols proposed for the use of high-risk and drug categories for use in the hospital.

C. Meetings. The P & T Committee shall meet as often as necessary to accomplish its functions but alt least 4 times per year

ARTICLE X

MEETINGS

SECTION 1 - GENERAL STAFF MEETINGS

A. Regular Meetings. Regular meetings of the medical staff shall be held **[specify the interval at which regular meetings of the medical staff shall be held]**. ***[NOTE: Failure to permit the MEC to act for the staff, while requiring the whole medical staff to act on certain issues (e.g., recommending to the governing body medical staff membership and privilege delineation for new applicants) can result in many extra medical staff meetings and/or unjustified delays in completing required critical business.]*** The annual meeting every other year general medical staff meeting shall be the last meeting before the end of the designated medical staff term. The agenda of such meetings shall include cumulative reports by staff officers and by committee and department chairman of the review and evaluation of the work done. The President shall preside at all general meetings of the medical staff.

B. Order of Business and Agenda. The order of business and agenda of a general staff meeting will be determined by the President. The peer review and evaluation of patient care and clinical performance will be last on the agenda following the reading and acceptance of the minutes of the last meeting and the consideration of any old business to be completed. Except under the provisions of new business, no additional agenda items will be permitted unless they have been requested in writing with justification at least five (5) days prior to the meeting and approved by the President

C. Special Meetings. Special meetings of the medical staff may be called at any time by the President and shall be called at the written request of the administrator, governing body, the MEC, or at least one-fourth (1/4) of the active staff members. The President shall call a special meeting within seven (14) days of his receipt of written request for same.

1. Written or printed notices stating the place, day, and hour of any special meetings of the medical staff shall be delivered, either personally or by mail, electronic, or fax, to each member of the active staff not less than five (5) nor more than ten (10) days before the date of such meetings, by or at the direction of the President If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his address as it appears in the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting.

2. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION 2 - COMMITTEE AND DEPARTMENT/CLINICAL SERVICE MEETINGS

A. Medical staff committees, may by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. Committees shall meet as required by these bylaws.

B. A special meeting of any committee may be called by or at the request of the chairman, by the President, or by one-third (1/3) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C. Notice of Meetings (Committee).

1. Notice of regular meetings may be given orally.

2. For any special meeting or any regular meeting not held pursuant to resolution, written or oral notice stating the place, day, and hour of the meeting shall be given to each member not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital, with postage prepaid.

D. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 3 - QUORUM

A. General Staff Meetings (Regular or Special).

1. The presence of one-fifth (1/5) of the voting members of the medical staff at any regular or special meeting shall constitute a quorum for the purpose of amendment to these bylaws, rules and regulations and the election of staff officers; and the presence of twenty-five (25%) percent of such members shall constitute a quorum for the transaction of all other business.

2. In the event that a quorum is not present at any regular or special meeting, those members present may meet as a subcommittee of the whole. Any action taken by those present, acting as a subcommittee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

B. Committee,.

Fifty (50%) percent of the voting members of a committee, , shall constitute a quorum at any meeting.

SECTION 4 - MANNER OF ACTION

A. Except as otherwise specified in these bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group.

B. Action may be taken without a meeting of a committee, by a writing setting forth the action so taken and signed and dated by a majority of the members entitled to vote thereat.

SECTION 5 - MEETING MINUTES

Minutes of all meetings shall be prepared by the secretary of the meetings and shall include a record of attendance and the vote taken on each matter. The minutes shall record a brief discussion of all problems discussed, indicating any recommendations made and forwarded, conclusions reached, and actions taken. The minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC and the quality/performance management committee. A permanent file of the minutes of each meeting (and the actions taken without an actual meeting) shall be maintained.

SECTION 6 - ATTENDANCE REQUIREMENTS

A. Regular Attendance. Each member of the active and consultant staff shall be required to attend the following:

1. At least fifty (50%) percent of all meetings of any committee of which he is a member. If less than 4 members more than 50% need to be present.

B. Absence from Meetings.

1. The meeting attendance record of each practitioner shall be maintained and made a part of the performance profile section of his credentials file.

2. A practitioner may have no more than twenty five percent (25%) excused absences in a medical staff year from required committee except for extenuating circumstances, dismissed from committee

C. Special Attendance Requirements

1. A practitioner whose patient's clinical course of treatment is scheduled for discussion at a general medical staff, committee meeting shall be so notified in writing by the chairman of the meeting at least ten (10) days prior to the meeting. The notification shall indicate the time and place of the meeting, a statement of the issue(s) involved and, whenever apparent or suspect deviation from standard clinical practice is involved, the fact that the practitioner's appearance is mandatory.

2. Failure of a practitioner to attend any meeting with respect to which he was given notice that his attendance was mandatory, shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct pursuant to Article VI of these bylaws. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC or of the governing body, if necessary, pursuant to Article VI. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate excuse that his absence will be unavoidable, such presentation may be postponed by the President, or by the MEC if the President is involved, until not later than the next regular staff, committee, department, or clinical service meeting; otherwise the pertinent clinical information available shall be presented and discussed as scheduled.

SECTION 7 - NONVOTING EX OFFICIO MEMBERS

Individuals serving under these bylaws as nonvoting ex officio members of a committee shall, unless otherwise specified, have all other rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum.

SECTION 8 - MEETING AS A COMMITTEE-OF-THE-WHOLE

Notwithstanding any other provision of these bylaws, whenever the medical staff it shall be considered to be meeting as a committee of the whole medical staff respectively.

SECTION 9 - CONDUCT OF MEETINGS

All meetings shall follow an acceptable form of parliamentary procedure, such as Robert's Rules of Order, in the conduct of meeting business.

ARTICLE XI

CONFIDENTIALITY/IMMUNITY FROM LIABILITY

SECTION 1 - CONFIDENTIALITY OF INFORMATION

A. General. Records and proceedings of all medical staff committees having the responsibility of the evaluation and improvement of quality of care and performance in this hospital, and including information regarding any member or applicant to the medical staff or for clinical privileges or practice prerogatives, shall be confidential, subject to release only in accordance with policies of the medical staff and privileged to the fullest extent permitted by law.

B. Agreement to maintain confidentiality. All individuals participating or attending such committees or entitled to access such information shall keep all of the proceedings, minutes, discussions and documents related to any peer review, clinical performance or quality management matter confidential and subject to disclosure only in accordance with policies of the medical staff or as permitted or required by applicable law.

C. Breach of confidentiality. Inasmuch as effective peer review, credentialing and quality/performance management activities must be based on free and candid discussions, any unauthorized breach of confidentiality of the discussions, deliberations or records of any medical staff meeting is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operation of the hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach may subject the individual to disciplinary action under the medical staff bylaws, rules and regulations and applicable hospital policies; any individual, committee or entity which may be damaged by such violation may seek enforcement by a court order for injunctive or other appropriate relief.

SECTION 2 - PRIVILEGES/IMMUNITY

A. Privileges. Any act, communication, report, recommendation, or disclosure with respect to any applicant or member of the medical staff, committee member, or practice prerogatives performed or made for the purpose of assessing patient care or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

B. Application. Such privileges shall extend to all individuals participating in the process of assessing patient care or achieving and maintaining quality patient care and practitioner performance including, but not limited to, members of the medical staff or governing body, designated professional personnel, the administrator and designees and to third parties who supply information to any of the individuals or committees authorized to receive, release or act upon such information. For the purpose of this Article the term "third parties" means both individuals and organizations from which information has been requested and/or received by an authorized representative of a health care facility, its governing body, the medical staff, or any committee or component thereof.

C. Immunity. Immunity from civil liability for any act, communication, report, recommendation or disclosure shall be to the fullest extent permitted by law.

SECTION 3 - RELEASES

All applicants and members of the medical staff shall execute a release of liability and of confidential information pursuant to these bylaws.

ARTICLE XII

AMENDMENT AND ADOPTION OF BYLAWS

SECTION 1 - MEDICAL STAFF RESPONSIBILITY

The medical staff (through its bylaws committee and the MEC) shall have the initial responsibility to formulate, adopt and recommend to the governing body, medical staff bylaws and amendments thereto which shall be effective when approved by the governing body. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the governing body and with the community.

SECTION 2 - METHODOLOGY

Medical staff bylaws must be adopted, amended, or repealed by the following process:

A. the affirmative vote of the Bylaws, Rules and Regulations Committee;

B. the affirmative vote of the MEC;

C. the affirmative vote of the medical staff members eligible to vote on this matter by written ballot or by action at a meeting at which a quorum is present, requiring a two-third vote; and

D. the approval of the governing body, which shall not be unreasonably withheld.

However, in the event that the medical staff shall fail to exercise its responsibility as required by Section 1, and after notice from the governing body to such effect including a reasonable period of time for response, the governing body may resort to its own initiative in formulating or amending medical staff bylaws that are necessary to comply with existing laws, rules, regulations or accreditation, reimbursement or licensing and certification requirements. In such event, medical staff recommendations and views shall be carefully considered by the governing body during its deliberations and in its actions.

ARTICLE XIII

RULES AND REGULATIONS

SECTION 1 - MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. The rules and regulations shall relate to the proper conduct of medical staff organizational activities and will embody the specific standards and level of practice that are required of each medical staff member and other designated individuals who exercise clinical privileges or provide designated patient care services in the hospital. Such rules and regulations may be amended or repealed at any regular MEC at which a quorum is present, and without previous notice or at a special meeting of the medical staff with notice. All such changes in the rules and regulations shall not become effective until approved by the governing body.

SECTION 2 - RELATIONSHIP TO BYLAWS

In the event there is a discrepancy between the bylaws and any rules and regulations, the bylaws shall supersede the rules and regulations.

These Medical Staff bylaws are:

Adopted by the Medical Staff

By: _____ Date:_____

Approved by the Governing Body

By: _____ Date:_____

RULES AND REGULATIONS OF THE MEDICAL STAFF OF ADVENTIST REHABILITATION HOSPITAL OF MARYLAND

1. The meetings of the Medical Staff shall be held as provided in ARTICLE XII of the Bylaws.

2. No patient shall be admitted to the Hospital without a provisional diagnosis.

3. Attending physicians assigned to individual patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to secure protection of the patients from self harm.

4. No patient may be considered for inpatient admission unless pertinent medical information is provided at the time of referral and/or a pre-admission examination is performed by an Attending Staff physician.

5. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his/her own name. Telephone orders are strongly encouraged to be authenticated within 48 hours or no later than 30 days by the original person who dictated the order, by an associate or by a cross-covering physician.

6. Drugs used shall be those listed in the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, with the exception of drugs for bona fide clinical investigations.

7. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include: identification data, chief complaints, personal history, family history, history of present illness, physical examination (at minimum: Heart/ Lungs exams and exams pertinent to chief complaint) and review of systems; special reports such as: consultation, clinical laboratory, x-ray, and others; provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, follow-up and autopsy report when available.
No medical record shall be filed until it is complete, except on order of the Medical Records Committee. Failure of a Medical Staff member to complete medical records on a timely basis, that is, within the time limits established by Medical Staff Rules and Regulations and Hospital policies, will be grounds for disciplinary action.

8. A complete history and physical examination shall in all cases be prepared within twenty-four (24) hours after admission of the patient.

9. All entries in the record shall be dated, timed and signed in the timeframe as defined by hospital policy. Symbols and abbreviations may be used only when they have been approved by the Medical Staff, and when there is a legend to explain. Final diagnoses should be recorded in full and without the use of either symbols or abbreviations.

10. It is the duty of the Hospital to see that members of the staff do not fail in the matter of calling consultants as needed. The consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. He/she must have clinical privileges. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. All consultations will be called for at the discretion of the attending physician.

11. Patients shall be discharged only on written order of the attending or covering physician. Following discharge, the attending physician shall see that the record in complete, state his/her final diagnosis, and sign the record.

12. All patient charts shall be completed no later than 30 days following discharge of the patient.

13. The Hospital shall admit patients suffering from physical handicaps who will benefit from the services afforded through the restoration program. Patients may be treated only by practitioners holding unlimited licenses, duly licensed dentists, and podiatrists licensed to practice in the State of Maryland, who have submitted proper credentials and have been duly appointed to membership on the Medical Staff.

14. Medical Staff Disaster Assignments: All physicians shall be assigned to posts in the Hospital and it is their responsibility to report to their assigned stations in the case of disasters or disaster drills. No physician will perform any duties other than those assigned. Please refer to the Code Yellow Policy, EOC.210, and Privileges for Volunteer Licensed Independent Practitioners During Disaster Response, ADM-199. The Chief Medical Officer (CMO) and the Administrator will work as a team to coordinate activities and directions. In cases of evacuation from Hospital premises, the CMO will authorize the movement of patients by direction of the Administrator. All policies concerning patient care will be a joint responsibility of the CMO and the Administrator, and in their absence, the CMO's designee and alternate in administration are next in line of authority, respectively.

15. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical record of their patients covering all periods during which they attended such patients in the Hospital.

16. All drug orders for narcotic and other Class II drugs (administered orally or parenterally) shall be automatically discontinued after forty-eight (48) hours unless the attending physician reorders the medication or indicates otherwise.

17. No medical records pertaining to the care and treatment of any patient at the Adventist Rehabilitation Hospital of Maryland shall be removed from the Hospital without a subpoena or court order.

18. All standing orders and instruction sheets shall be approved by the Medical Staff. Standing orders will be transferred to the Physician's Order Sheet and countersigned within 24 hours.

19. Members of the registered nursing staff who have completed the necessary educational requirements for certification may start an intravenous procedure upon order of the attending physician.

20. Guidelines for Consultations: (a) when the diagnosis(es) remains unclear after ordinary diagnostic procedures have been completed; (b) when there are significant differences of opinion as to appropriate diagnosis(es) and/or the best choice of therapy(ies); (c) in situations where specific skills of other practitioners may be helpful; (d) when specifically requested by the patient or his family and with concurrence of the attending physician; and (e) for all patients who have attempted suicide or who have had self-administered chemical overdoses, psychiatric consultation will be provided.

21. A complete medical history and physical examination shall be part of the record for those patients seen for out-patient physician services.

22. Members of the Consulting Staff are only eligible to admit patients to the service of an active member of the medical staff.

23. Active medical staff who are not physiatrists will have a physiatrist as the attending physician for their patient.

24. In the event of patient death, refer to Administrative Policy No. ADM 195, Autopsy Criteriea

25. IMPAIRED PRACTITIONER PROGRAM

Please refer to ADM Policy No. 196, Impaired Professional Policy.

IMPAIRED PRACTITIONER - DEFINITION

For the purpose of these Bylaws an impaired physician or licensed independent practitioner (LIP) is defined as a "physician or LIP whose professional performance has been impaired as a consequence of alcohol abuse, the abuse of drugs other than alcohol, mental or emotional illness, dementia or a physical disability severe enough to impact on professional performance."

PHYSICIANS' HEALTH TEAM

The Medical Director, in consultation with the Administrator, shall appoint two qualified members of the Medical Staff to serve as a Physicians' Health Team.

REFERRALS TO THE PHYSICIANS' HEALTH TEAM

All questions, complaints or inquiries that arise concerning the professional performance of any staff member, when the issue of "impairment" is a consideration, shall be referred to this team.

DOCUMENTATION

Upon a referral, the Physicians' Health Team shall promptly investigate the allegations and attempt to document the facts of the individual case. Investigations, assessments, and evaluations shall be confidential except as limited by regulation, ethical obligation, Hospital bylaws and/or threat to patient safety.

TREATMENT

Constructive intervention to resolve health problems and impairments will be made available. If the physician involved requires formal treatment, a referral will be made to an impaired practitioner program. The process for addressing impaired performance related to health issues will be separate from the discipline functions for practitioners and will be aimed at assistance and rehabilitation. In order to maintain privileges, the practitioner must attend and complete the program.

COMPLIANCE WITH THE MEDICAL PRACTICE ACT

In all the actions concerning these cases, the state Medical Practice Act and other applicable law will be followed.

26. DISRUPTIVE PHYSICIAN POLICY

All practitioners who are members of or are affiliated with the medical staff shall conduct themselves in a professional manner and shall not engage in disruptive behavior. Please refer to ADM Policy No. 197, Disruptive Physician Policy

27. DICTATIONS AND ELECTRONIC SIGNATURES

History and Physical, Consultation, Discharge Summaries and Transfer Summaries must be dictated into the ARHM system. In the event of electronic failure, a manual system will be put in place until it is resolved.

All practitioners must sign all dictations electronically within 30 days of discharge. Written signatures will not be accepted

28. The following professionals can write specific orders in the patient's record as noted below and physicians will date, time and sign in the timeframe as defined by hospital policy.

- Registered Nurses – Telephone Orders
- Speech Therapist– Diet consistency changes
- Pharmacist – Formulary substitution protocol, telephone orders, and anticoagulation protocol
- Wound Care Specialist– Wound dressing changes

29. All newly admitted patients to ARHM will have a CBC and CMP drawn within the first 24 hrs of admission unless the attending documents a clearly the rationale for not executing the order.

30. Quality/Performance Management data collected quarterly and which is available to practitioner upon request, see Attachment A and B

Human Subjects Research Review

The Institutional Review Board(s) ("IRB") at Adventist HealthCare ("Adventist") is charged with protecting the rights and welfare of human subjects recruited to participate in research activities at Adventist facilities. The responsibility of assuring that research is conducted in an ethical manner is shared by Adventist, the IRB, Adventist committees, the investigators who conduct the research and their research staff, as well as the individuals who enroll in the research process.

The IRB maintains a cooperative and coordinating relationship with the Medical Executive Committee on protocols conducted at Adventist Rehabilitation Hospital of Maryland.

A. Responsibilities and Authority of the IRB. The responsibilities and authority of the IRB shall be to:

1. Protect the rights and welfare of human subjects recruited to participate in research activities at Adventist Rehabilitation Hospital of Maryland by reviewing and approving human research in a manner consistent with federal regulation, state and local laws, and institutional guidelines and policies;

2. Routinely update the Medical Executive Committee regarding the status of research projects involving human subjects being conducted at Adventist Rehabilitation Hospital of Maryland through the timely distribution of monthly IRB meeting minutes and relevant IRB correspondence, once approved by the IRB;

3. Conduct initial and continuing review of research, approve, require modification to, or disapprove proposed human subject research, and has the responsibility and authority to suspend or revoke its approval of ongoing research, if necessary. While research that has been reviewed and approved by the IRB may be subject to review and disapproval by officials at Adventist Rehabilitation Hospital of Maryland, those officials may not approve research that has been disapproved by the IRB.

B. Responsibilities of Medical Executive Committee. The responsibilities and duties of the MEC shall be to:

1. Aid in IRB membership recruitment, as requested by IRB Staff and Institutional Officials;

2. Take all reasonable steps to help assure professional ethical conduct, competence, and clinical performance on the part of all Medical staff members who serve as research team members;

3. Aid in evaluating complaints and allegations of research noncompliance and determine, after a preliminary analysis, if allegations have merit;

4. Initiate and pursue corrective action, when requested by IRB Staff and Institutional Officials;

5. Promote continuing education activities that are relevant to research ethics and human research protections provided at Adventist;

6. Aid in the development of needed joint policy/ procedures that pertain to the human research protection program at Adventist;

7. Aid IRB Staff in review and evaluation of the qualifications of Medical Staff personnel to perform patient care services necessary for research protocol conduct.

ARTICLE XIX

GENERAL PROVISIONS

Section 1. Conflict Resolution:

A. CONFLICTS BETWEEN THE GOVERNING BOARD AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Staff, in partnership with the Governing Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Governing Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Governing Board, or a designated committee of the Governing Board and Hospital Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President or the Chair of the Governing Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chair, Vice-Chair, and Secretary of the Board or other designees of the Governing Board
- The Hospital President or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Governing Board within 30 days of the initial meeting, the Medical Staff and the Governing Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Governing Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Governing Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Governing Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Governing Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Governing Board cannot resolve the conflict in a manner agreeable to all parties, the Governing Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Governing Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Governing Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chair of the Governing Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Governing Board, or the Hospital Administration.

B. CONFLICTS BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the perceived wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President, the representatives of the Medical Staff or the Chair of the Governing Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- Three voting members of the Medical Staff selected by the Medical Staff members who signed the written petition
- The Chair of the Governing Board
- The Hospital President or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Governing Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Governing Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Governing Board determines, in its sole discretion, that action must be taken

related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Governing Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chair of the Governing Board or the Medical Staff President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Governing Board, or the Hospital Administration.