BYLAWS OF THE MEDICAL STAFF
OF
FORT WASHINGTON MEDICAL CENTER

Board Approved November 1, 2021

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OF
FORT WASHINGTON MEDICAL CENTER

TABLE OF CONTENTS

Addendums to MS Bylaws

- Credentialing Manual
- Medical Staff Rules and Regulations
-
-
-

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OF
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PREAMBLE

WHEREAS, Fort Washington Medical Center is a corporation organized under the laws of the State of Maryland; and

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

WHEREAS, it is recognized that the Board of Directors has delegated to the Medical Staff the responsibility for the quality of patient care in the Hospital, that the Medical Staff's performance of this responsibility is subject to the legal authority inherent in the Board, and that the cooperative efforts of the Medical Staff, the President and the Board are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the Physicians, dentists, podiatrists, allied health providers, advanced practice practitioners, and other approved Practitioners practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and in accordance with all applicable State and Federal laws.

DEFINITIONS

Whenever each of the following terms shall occur in these Bylaws, it shall have the meaning specified below:

1. "Administration": The Executive members of the Hospital staff, including the Hospital President, Chief Operating Officer, Director of Finance, Chief Nursing Officer, and Chief Medical Officer.

2. "Adverse Action": An action that adversely affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction or termination of clinical privileges.

3. "Advanced Practice Practitioners" (APPs) – Licensed health care professionals who are not physicians, dentists, podiatrists, or otherwise described in the bylaws, including but may not be limited to, physician assistants, nurse midwives, nurse anesthetists, advanced practice nurses, clinical psychologists, and other individuals who may be licensed or certified by the State of Maryland as a health care professional. APPs are members of the Medical Staff and are designated by the Board to be credentialed through the medical staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. The APPs are under the scope of both hospital and medical staff policies and procedures, including the Advanced Practice Practitioner Credentialing/Privileging Policy and the Advanced Practice Practitioner Grievance Procedure, which are deemed to be part of these Bylaws. These policies/procedures will be duly approved and adopted by the Medical Staff and the Board of Directors, and may be amended from time to time, which among other matters describes the process whereby APPs attain Appointment or Reappointment; are granted Clinical

Privileges at the Hospital; and are governed by the APP Grievance Procedure.

4. "Applicant": A Practitioner who has submitted a complete application for Medical Staff Appointment or Reappointment and/or for delineated Clinical Privileges at the Hospital.

5. "Appointment" and "Reappointment": The process by which an Applicant acquires and retains Medical Staff membership and assignment to a Medical Staff category and Department(s).

6. "Board" or "Board of Directors": The Board of Directors of Fort Washington Medical Center.

7. "Board Certified" or "Board Certification": A designation for a physician who has completed an approved educational training program and an evaluation process, including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty. Board certification shall be from an American Board of Medical Specialties ("ABMS"), the American Dental Association ("ADA"), the American Board of Podiatric Surgery ("ABPS"), the American Board of Oral/Maxillofacial Surgeons (ABOMS), the American Board of Osteopathic Specialists (AOA) or such other boards or associations as may be appropriate and as designated by the Board of Directors.

8. "Bylaws": The Medical Staff Bylaws set forth herein, including the Credentialing Manual, as such shall be amended from time to time, which amendments are incorporated by reference into these Bylaws.

9. "Certification" The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

10. "Clinical Privileges" or "Privileges": The scope of patient care services that a physician member or allied health practitioner may provide at the Hospital, as granted and authorized by the Board or the Board's designated representative(s), including but not limited to the admission of patients to the Hospital and the provision of specific diagnostic, consultative, therapeutic, medical, dental, podiatric or surgical services.

11. "Complete Application" An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee (MEC) and/or the Board to meet the requirements of these Bylaws and Credentialing Manual. To be complete the application must be submitted in writing on a form approved by the MEC and the Board and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for teaching of the privileges requested.

12. "Contract Practitioner": A Practitioner providing care or services to Hospital patients through a contract or other arrangement with the Hospital.

13. "Core Privileges" or "Core": A defined grouping of privileges for a specialty or subspecialty

that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Executive Committee and Board to require closely related skills and experience.

14. "Credentialing and Privileging Manual": The manual, as duly approved and adopted by the Medical Staff and the Board of Directors, and as may be amended from time to time, which among other matters describes the process whereby Practitioners attain Appointment or Reappointment to the Medical Staff; are granted Clinical Privileges at the Hospital; conduct investigations; and recommend corrective action. The Credentialing and Privileging Manual is by reference incorporated herein and made a part of these Bylaws.

15. "Criminal Conviction": Conviction of, or a plea of guilty or nolo contendere for, any felony or misdemeanor by a trial court, even if the matter is still on appeal.

16. "Data Bank": The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA (The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. 11101 et seq.)

17. "Days": Calendar days, unless otherwise noted.

18. "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.

19. "Department": A general clinical area of medical practice composed of the Medical Staff Members that practice in that general clinical area. The departments are Medicine and Surgery.

20. "Divisions": A clinical area of specialty practice of a Department composed of medical staff who practice in specialty clinical areas.

21. "Disruptive Conduct": Conduct that adversely impacts the operations of the Hospital, affects the ability of others to do their jobs, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual's own ability to practice competently.

22. "Electronic Medical Record" (EMR): The clinical patient care system used to electronically document patient care.

23. "Ex-Officio" - Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided in these Bylaws, without voting rights.

24. "Federal Health Care Program": Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal healthcare programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FED), Tricare, and the Veterans programs.

25. "Good Standing": Applies to staff members who, during the current term of appointment, has maintained qualifications for Medical Staff membership and assigned staff category, has met

attendance and participation requirements, is not in arrears in dues payment (if applicable) or the completion of the medical records, and has not received a suspension or restriction of membership or privileges.

26. "HCQIA": The Health Care Quality Improvement Act of 1986, 42 U.S.C.A. Sec. 11101et.seq.

27. "He": Whatever gender is appropriate.

28. "Healthcare Professional": An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health to provide health care to patients

29. "Hospital": Adventist HealthCare Fort Washington Medical Center, Inc.

30. "Impaired Practitioner": A Practitioner whose ability to practice his profession with reasonable skill and safety is compromised because of a physical or mental illness, including, without limitation, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs, including alcohol.

31. "Independent Healthcare Professional": An individual who is permitted by the applicable state law and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.

32. "Ineligible Person": An individual who (1) is currently excluded, suspended, debarred or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment or ineligibility.

33. "License": An official or a legal permission granted by a state professional board to a healthcare professional.

34. "License Status": The status of the practitioner's professional license, as issued by the state licensing board. The most common status categories are:

    a. Active--full and unrestricted license to practice
    b. Inactive--practitioner is not practicing, but reserves the right to activate the license in the future
    c. Expired—no longer valid for use due to nonrenewal
    d. Revoked—disciplinary action prohibits the practice
    e. Restricted—licensing board imposed limitation on the practice

35. "Licensure": A legal right that is granted by a governmental agency in compliance with statute governing the activities of a profession.

36. "Licensed Independent Practitioner":- An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services independently, without direction or supervision, within the scope of the individual's license and in accordance with

individually granted clinical privileges.

37. "Medical Executive Committee" or "MEC": The executive committee of the Medical Staff, which shall constitute the Board of Directors of the Medical Staff as described in the Bylaws.

38. "Medical Staff" or "Staff": The formal organization of all categories of Practitioners designated by the Board to be eligible for Medical Staff membership. The Board has determined that the categories of Practitioners eligible for medical staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD or DDS), dentists (DDS), podiatrists (DPMs), and Advanced Practice Professionals (APPs).

39. "Medical Staff Credentialing Office": The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and request for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Credentialing Office responsibilities are assigned by Hospital Administration or Hospital President. The documents maintained by the Medical Staff Credentialing Office are the property of the Hospital.

40. "Medical Staff Information": All records and proceedings of meetings of the Medical Staff, Departments and committees thereof, and all records, communications and deliberations concerning Medical Staff matters, including but not limited to performance improvement activities, Appointment, Reappointment, delineation of Clinical Privileges, OPPE, FPPE, Letters of notification or Letters of Recommendation filed in the physician's credentialing file and/or quality profile, Practitioner health information, investigations, recommendations for corrective action, and fair hearings.

41. "Medical Staff Year": The period that commences on the first (1st) day of January and ends on the thirty-first (31st) day of December of that year.

42. "Member": Any Practitioner who currently holds an Appointment or Reappointment to the Medical Staff, including on a temporary basis, as determined by the Board of Directors or its designated representatives, whose membership is in good standing pursuant to these Bylaws.

43. "Membership": The approval granted by the Board to a qualified Practitioner to be a member of the Medical Staff of the Hospital.

44. "Non-Privileged Practitioner" Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges with this Hospital (e.g., outside physicians ordering outpatient tests at Fort Washington Medical Center)-Must conduct GSA and OIG sanction check and online licensure verification check prior to any procedure or test being conducted. Proof of this check must be kept on file)

45. "OIG Sanction Report":-The Health and Human Services Office of Inspector General List of Excluded Individuals or Entities.

46. "Oral and maxillofacial Surgeon, Qualified": A individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education.

47. "Patient Contact": Includes but is not limited to a documented admission or participation in an admission in conjunction with another Practitioner, consultation, diagnostic procedure, or Hospital outpatient visit.

48. "Peer": An individual from the same professional discipline (e.g., Physician and Physician, dentist and dentist) with essentially equal qualifications.

49. "Peer Review": The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures

50. "Physician": An individual who possesses an M.D. or D.O. degree or its equivalent. In this context, "equivalent" shall mean any degree recognized by the Maryland State Board of Physicians as qualifying the individual to practice medicine.

51. "Podiatrist": An individual who holds a current license as a Doctor of Podiatric Medicine (DPM).

52. "Practitioner": An individual who provides direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently.

53. "President of the Hospital" or "President": The individual appointed by the Hospital Board to be President of Fort Washington Medical Center. (i.e., Chief Executive Officer).

54. "President of the Medical Staff" or "Chief of Staff": The individual elected by the Voting Members of the Medical Staff to serve as the chief administrative officer of the Medical Staff, and who also serves as Chair of the MEC.

55. "Psychologist": An individual who has completed a doctoral degree program in an appropriately related specialty area of psychology that is approved by the American Psychological Association and who is licensed by the State Board of Examiners of Psychology.

56. "Qualified Medical Person/Personnel" (QMP): A person designated by Hospital policy to perform a Medical Screening Examination in the Emergency Room. Individuals in the following professional categories who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Physicians, Physician Assistants or Advanced Nurse Practitioners.

57. "Proctor/Proctoring": Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

58. "Rules and Regulations": Those rules and regulations established by the MEC and Board that further define the conduct of certain functions set forth herein and may be amended from time to time and are made part of these Bylaws.

59. "Special Notice": Unless otherwise provided in these Bylaws, a written communication

delivered personally to the addressee, sent by email or other electronic means, or sent by United States Postal Service, first class postage prepaid, certified or registered mail, return receipt requested, addressed to the addressee at his address as it appears in the records of the Hospital.

60. "Special Privileges": privileges that fall outside of the core privileges for a given specialty and that require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.

61. "Supervising Physician": the supervision of an allied health professional by a Supervising/Collaborating Physician, that may or may not require the actual presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the physician be readily available for consultation. The requisite level of supervision will be determined at the time each allied health professional is credentialed and will be consistent with any applicable written supervision/collaboration agreement.

62. "Staff": Unless otherwise specifically stated, the Medical Staff of this Hospital.

63. "State": the State of Maryland unless the context indicates otherwise.

64. "Telemedicine/Telehealth": The treatment of a Hospital patient through audiovisual forms of communication. This includes any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient.

65. "Voting": For all purposes that require votes of any Medical Staff member, voting shall be validly conducted in person, by electronic means (e.g., email, electronic tabulation, or conference call), mail, or proxy, unless the chair of the applicable body announces otherwise before the meeting is called to order.

66. "Voting Member" – A Member of a category of the Medical Staff with voting prerogatives, as defined in the Credentialing Manual and other medical staff documents/policies.

ARTICLE 1

NAME

The name of this organization shall be the "Medical Staff of Adventist HealthCare Fort Washington Medical Center." This organization is an integral part of the Hospital and shall not be deemed to be a legal entity separate and distinct from the Hospital.

ARTICLE 2

PURPOSE

The purpose of this organization shall be:

2.1. To ensure and oversee that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive quality care provided by practitioners privileged by the medical staff for the duration of the length of care/treatment and services provided, including assuring designated practitioners perform oversight activities;

2.2. To establish and maintain Rules and Regulations, policies, and procedures for self-governance of the Medical Staff;

2.3. To serve as the primary means by which the Medical Staff are accountable to the Board of Directors for the professional performance and ethical conduct of each Medical Staff Member;

2.4. To serve as the formal organizational structure through which the roles and responsibilities of Medical Staff Members may be fulfilled;

2.5 To recommend Appointment and Reappointment of individual Practitioners to the Medical Staff;

2.6. To encourage a high level of professional performance of all Medical Staff Members through the appropriate delineation of Clinical Privileges that each Member may exercise in the Hospital, and through the ongoing review and evaluation of each Member's performance in the Hospital;

2.7. To preserve and protect the rights and prerogatives of individual Medical Staff Members;

2.8. To provide a means of effective communication among the Medical Staff, the Board of Directors, and the administration of the Hospital;

2.9. To foster the active participation and professional leadership of Medical Staff Members in measuring, assessing, and improving the quality of care rendered at the Hospital;

2.10. To provide education and to maintain educational standards that will promote the continuous advancement of professional knowledge and skill among the Medical Staff;

2.11. To provide leadership in patient safety;

2.12. To provide oversight in processes of analyzing and improving patient satisfaction;

2.13. To provide leadership in measuring, assessing and improving processes that primarily depend on the activities of one or more practitioners, and other credentialed individuals;

2.14. To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regards to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance;

2.15. To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals;

2.16. To design a credentials program, including mechanisms for granting and renewing membership and the matching of clinical privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated competence of the applicant or Medical Staff member;

2.17. To recommend to the Board action with respect to membership, staff category and department assignments and clinical privileges relative to competence and conduct;

2.18. To recommend to the Board programs for the establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of healthcare within the hospital;

2.19. To develop, administer, recommend amendments to and seek compliance with the Bylaws and the Rules and Regulations of the Medical Staff;

2.20. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet these needs;

2.21. To provide a means for communication and conflict resolutions with regard to issues of mutual concern to the Medical Staff, Administration and Board;

2.22. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted;

2.23. To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities by monitoring and enforcing compliance with these Bylaws, Rules and Regulations and Hospital Policies; and

2.24. To maintain compliance of the Medical Staff with regard to applicable accreditation requirement and applicable federal, state and local laws and regulations

2.25 PRIVACY PRACTICES

Each member of the Medical Staff will be deemed part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. 164.501 (commonly known as the "HIPAA Privacy Regulations") as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff members and Hospital employees.

ARTICLE 3

ORGANIZATION OF THE MEDICAL STAFF

3.1. CURRENT DEPARTMENTS AND DIVISIONS

3.1.1. The current Departments of the Medical Staff are the Department of Medicine and the Department of Surgery.

3.1.2. The Department of Medicine shall include the following Divisions: Acute Care and Emergency Medicine. The Department of Medicine shall include subspecialties such as Cardiology, Critical Care, Dermatology, Family Practice, Gastroenterology, General Internal Medicine, Hematology/Oncology, Nephrology, Neurology, Psychiatry, Pulmonology, and Rehabilitation Medicine.

3.1.3. The Department of Surgery shall include the Divisions of Anesthesiology, Pathology, and Radiology. It will also include subspecialties in General Surgery, Gynecology, Maxillo-facial Surgery, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic Surgery, Otorhinolaryngology, Plastic Surgery, Podiatry, Thoracic Surgery, Urologic Surgery, and Vascular Surgery. .

3.2. CHANGES TO DEPARTMENTS AND DIVISIONS

With the approval of the MEC and the Board, the Voting Members may establish additional Departments or Divisions or may eliminate, modify, or combine existing Departments or Divisions. The Voting Members may also establish Sections within Divisions, with the approval of the MEC and the Board.

3.3. ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each Member shall be assigned to at least one Department. A Member may be assigned to more than one Department in accordance with that Member's delineation of Clinical Privileges. The exercise of clinical privileges within any department shall be subject to the rules and regulations of the Department and the authority of the Department Chairpersons

3.3.1 EXCLUSIVE CONTRACT; MORATORIUM ON APPLICATION; RESTRICTION ON MEMBERSHIP.

The Board of Directors shall have the sole authority to (a) grant an exclusive contract to a Physician or group of Physicians for a Department, Division, or part of a Department or Division, or (b) declare a moratorium on Medical Staff appointments or clinical privileges in a particular Department, Division, or part of a Department or Division, or (c) restrict membership in any Department or Division to Physicians who are employed by or under contract with the Hospital. Such an exclusive contract may be granted, such a moratorium declared, or such a restriction imposed, by the Board of Directors upon its own authority or upon a recommendation by the MEC. Before making a final decision to grant such an exclusive contract, declare such a moratorium, or impose such a restriction, the Board of Directors will obtain input from the MEC. In the event that the Board of Directors grants an exclusive contract as described in (a) above, and so long as such exclusive contract or successor thereto remains in effect, no application for Appointment, Reappointment, or Clinical Privileges to or in the affected Department, Division, or part of a Department or Division shall be accepted from any individual unless the individual is employed by or under contract with the holder of the exclusive contract and the holder of the exclusive contract has requested the Hospital to provide the application to the individual. In the event that the Board of Directors declares a moratorium as described in (b) above, and for

so long as such moratorium remains in effect, no applications for Appointment or Reappointment to or for clinical privileges in the affected Department or Division shall be accepted while the moratorium is in effect. In the event that the Board of Directors imposes a restriction as described in (c) above, and so long as such restriction remains in effect, no applications for Appointment, Reappointment, or Clinical Privileges to or in the affected Department, Division, or part of a Department or Division shall be accepted from any individual unless the individual is employed by or under contract with the Hospital.

3.4. FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each Department is to implement and conduct specific quality, effectiveness, and efficiency of patient care provided by Members of the Department. In order to fulfill this responsibility, each Department shall:

3.4.1. Participate and provide leadership in the performance improvement activities of the Hospital.

3.4.2. Conduct or participate in and make recommendations concerning the need for orientation and continuing education programs related to advances in clinical care and performance improvement activities of all persons in the department.

3.4.3. Establish standards for the granting of Clinical Privileges within the Department.

3.4.4. Evaluate and make appropriate recommendations concerning the qualifications of Applicants seeking Appointment or Reappointment and Clinical Privileges within the Department, in accordance with the procedures set forth in the Credentialing Manual.

3.4.5. Monitor, on a continuous and concurrent basis, Departmental adherence to:

3.4.5.1. Medical Staff and Hospital rules, regulations, policies and procedures;

3.4.5.2. Sound principles of clinical practice; and

3.4.5.3. Other standards designed to promote patient welfare.

3.4.6. Coordinate and integrate patient care and services provided by Members of the Department with nursing, ancillary patient care services, administrative support services, interdepartmental services, and intradepartmental services.

3.4.7. Foster professionalism among its Members.

3.4.8. Establish such committees or other mechanisms as may be necessary and desirable to properly perform the functions delegated to the Department.

3.4.9. Take appropriate action when potential problems in clinical performance are identified, in accordance with the processes outlined in these Bylaws.

3.4.10. Recommend to the President of the Hospital or the President's designee a sufficient number of qualified and competent persons and sufficient space and other resources necessary for the provision of high quality, effective, and efficient patient care.

3.4.11. Assess and recommend to the President of the Hospital or the President's designee, external resources for necessary patient care services not provided by the Department of the Hospital.

3.4.12. Account to the MEC for all Medical Staff professional and administrative activities within the Department.

3.4.13. Develop and implement policies and procedures that guide and support the provision of services including formulating recommendations for Rules and Regulations necessary or desirable for the proper discharge of the Department's responsibilities, subject to the approval of the MEC and the Board.

3.4.14 Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

3.4.15 Recommend space and other resources needed by the department or service.

3.5. DEPARTMENT CHAIRS AND VICE-CHAIRS

3.5.1. Qualifications

3.5.1.1. At the time of election, whether nominated by committee or from the floor, each Department Chair shall be a Member in good standing of the Active Medical Staff. Department chairpersons (and any Vice Chairs) will be certified by the appropriate specialty board or affirmatively establish comparable competency through the Medical Staff Credentialing process. The Department Chair may select a Vice Chair who is appropriately qualified.

3.5.2. Selection

3.5.2.1. Department Chairs shall be elected by secret ballot of a majority of Voting Members of the Department present at a duly convened meeting of the Department, so long as a quorum is present, or by a majority written vote. The results of such elections will be subject to ratification by the MEC and approval by the Board. In-person and electronic voting are considered valid methodologies for voting.

3.5.2.2. For the purpose of this election, a committee of the Medical Staff appointed by the Department Chair for such purpose and chaired by the immediate past Chair of the Department (the "Nominating Committee") shall recommend one or more nominees for Chair, after obtaining the consent of such nominees. The Nominating Committee shall circulate a report its nominees to the Department members at least 30 days prior to the election. Nominations may also be made from the floor at such meeting, provided that the nominee is present and consents to the nomination. Nominations shall be closed immediately following such meeting. Meetings may be held in person or by video communications platform. The President of the Medical Staff may not simultaneously hold office as a Department chair.

3.5.2.3. In the event of the resignation or removal of a Department Chair, the President of the Medical Staff shall select a temporary replacement to serve as acting Chair until the election of a successor to complete the term of office at a regularly scheduled meeting of the Department within 120 days of such resignation or removal. If qualified in all respects, the Department Vice-Chair may, at his option, serve as Acting Chair.

3.5.3. Term of Office

3.5.3.1. Each Department Chair shall be elected to serve a two year term, which shall commence on the first (1st) day of the Medical Staff Year following his election.

3.5.3.2. Each Department Chair and any Vice-Chair shall serve until the end of his term, or until a successor is elected, whichever is later, unless he shall sooner resign or be removed from office.

3.5.3.3. Department Chairs may be re-elected for not more than two (2) consecutive terms. The MEC and the Board of Directors may waive this term limit.

3.5.4. Removal

3.5.4.1. A Department Chair or Vice-Chair shall be automatically removed from office upon suspension or termination of his Medical Staff membership or Clinical Privileges within the Department; provided that a suspension for incomplete medical records will not count for this purpose unless the suspension continues for longer than 90 days.

3.5.4.2. A Department Chair or Vice-Chair may be removed during his term of office for valid cause by a two-thirds (2/3) vote of all Active Medical Staff Members of the Department, provided that such vote is ratified by the MEC and by the Board of Directors. Valid cause includes, but is not limited to, continued gross or willful neglect of the Department Chair's or Vice-Chair's duties and responsibilities under these Bylaws; failure to attend at least fifty percent (50%) of Department meetings; gross misfeasance in office; a final adverse action affecting the Department Chair's or Vice-Chair's Clinical Privileges; or conviction of a crime.

3.5.5. Duties and Responsibilities

3.5.5.1 Each Department Chair shall be responsible for the function of and clinical care rendered by his respective Department, all administratively related activities of the Department unless otherwise provided by the hospital, and for the review, educational and evaluation activities that contribute to the preservation and improvement of the quality, effectiveness, and efficiency of patient care provided by Members of the Department. The Department Chair is responsible for ensuring that the Department effectively performs each of the Department functions enumerated in these Bylaws. In addition, the Department Chair is responsible for:

3.5.5.1.1 Determining the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care services;

3.5.5.1.2 Maintaining quality control programs;

3.5.5.1.3 The continuous assessment and improvement of the quality of care and services provided; and

3.5.5.1.4 Integrating the Department or service into the primary functions of the organization.

3.5.5.2 Each Department Vice-Chair shall assume the duties and responsibilities of the

Department Chair in the Chair's absence, and shall carry out such duties as delegated by the Department Chair.

ARTICLE 4

OFFICERS OF THE MEDICAL STAFF

4.1. IDENTIFICATION

There shall be the following four officers of the Medical Staff: President, President-Elect, Secretary and Treasurer.

4.2. QUALIFICATIONS

The officers of the Medical Staff shall:

4.2.1. Be Members in good standing of the Active Medical Staff at the time of nomination and election.

4.2.2. Have demonstrated interest in maintaining and improving quality medical care at the Hospital and have constructively participated in Medical Staff affairs, such as performance improvement activities.

4.2.3. Possess and have demonstrated the ability for harmonious interpersonal relationships.

4.2.4. Possess and have demonstrated effective leadership skills.

4.2.5. Be willing to faithfully discharge the duties and responsibilities of the position to which the Member is elected or appointed.

4.3. NOMINATING COMMITTEE AND ELECTION OF MEDICAL STAFF OFFICERS

4.3.1. Officers of the Medical Staff shall be elected by secret ballot (hard copy or electronic ballot) of a majority of a quorum of the Active Medical Staff Members present at a duly convened meeting (in-person or remote attendance). Officers so elected are subject to approval by the Board.

4.3.2. For the purpose of this election, a committee of the Medical Staff appointed by the President of the Medical Staff for such purpose (the "Nominating Committee for Medical Staff Officers") shall recommend to the Medical Staff one or more nominees for each office of President of the Medical Staff, President-Elect of the Medical Staff, the Secretary of the Medical Staff and Treasurer, upon due consideration of the qualifications for officers of the Medical Staff as set forth in these Bylaws, and after obtaining the consent of such nominee(s). The Nominating Committee for Medical Staff Officers shall recommend only the current President-Elect for the office of President, unless the President-Elect no longer satisfies all qualifications to serve as an officer of the Medical Staff, in which case the Nominating Committee for Medical Staff Officers shall nominate one or more other persons for the office of President of the Medical Staff who satisfy such qualifications. The President of the Medical Staff shall automatically become Immediate Past-President of the Medical Staff upon the expiration of his term of office, unless the President of the Medical Staff no longer satisfies all qualifications to serve as an officer of the Medical Staff. The Nominating Committee shall report its recommendations to the Medical Staff at a meeting of the Medical Staff at least 30 days prior to the voting meeting of the Medical Staff. Nominations may also be made from the floor of the meeting at which the Nominating Committee for Medical Staff Officers recommendations, provided that the nominee is present and consents to the nomination. Nominations shall be closed immediately

following such meeting of the Medical Staff.

4.4. TERM OF OFFICE

4.4.1. Each officer of the Medical Staff shall be elected to serve a two-year term, commencing on the first day of the Medical Staff Year following his election.

4.4.2. Each officer shall serve in his respective office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office.

4.4.3. The officers of the Medical Staff may not serve more than one term in the same office in succession.

4.5. REMOVAL

4.5.1. An officer of the Medical Staff shall be automatically removed from office upon suspension or termination of his Medical Staff membership or Clinical Privileges; provided that suspensions for less than 60 days that resulted from incomplete medical records will not be counted for this purpose.

4.5.2. An officer of the Medical Staff may be removed during his term of office for valid cause by a two-thirds (2/3) vote of all Active Medical Staff Members, provided that such vote is ratified by the Board of Directors. Valid cause includes, but is not limited to continued gross or willful neglect of the officer's duties and responsibilities under these Bylaws; failure to attend at least fifty percent (50%) of MEC meetings; gross misfeasance in office; a final adverse action affecting the officer's Clinical Privileges; or conviction of a crime.

4.6. DUTIES AND RESPONSIBILITIES

4.6.1. President of the Medical Staff. The President of the Medical Staff shall serve as chief elected official of the Medical Staff, and in such capacity shall:

4.6.1.1. Be accountable to the Board, in conjunction with the Medical Executive Committee ("MEC"), for the quality, efficiency and effectiveness of clinical care provided at the Hospital.

4.6.1.2. Act in coordination and cooperation with the President of the Hospital in the enforcement of Hospital policies and bylaws and in all matters of the Medical Staff's mutual concern with the Hospital.

4.6.1.3. Be responsible for the enforcement of these Bylaws and all other governing documents of the Medical Staff.

4.6.1.4. Aid in coordinating the activities and concerns of the Hospital administration, nursing, and other patient care services with those of the Medical Staff.

4.6.1.5. Communicate and represent the opinions, policies, concerns, needs, grievances, and recommendations of the Medical Staff to the Board and to the administration of the Hospital.

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

4.6.1.7. Serve as Chair of the MEC.

4.6.1.8. Serve as an Ex-Officio member of any or all other Medical Staff committees if he so desires.

4.6.1.9. Appoint Members to all standing committees of the Medical Staff and to special committees established by the MEC as provided in these Bylaws.

4.6.1.10. Be responsible for the continuing education activities of the Medical Staff.

4.6.1.11. Serve as the spokesperson for the Medical Staff in its external professional and public relations.

4.6.1.12. Grant temporary Privileges in accordance with the provisions set forth in the Credentialing Manual.

4.6.1.13 Represent Medical Staff at Board of Director meetings.

4.6.2. President-Elect of the Medical Staff. The President-Elect of the Medical Staff shall:

4.6.2.1. Perform such duties as may be assigned to him by the President of the Medical Staff, and, in the absence of the President of the Medical Staff, assume all of the duties and authority of the President of the Medical Staff.

4.6.2.2. Serve as Vice-Chair of the MEC.

4.6.3. Secretary of the Medical Staff. The Secretary of the Medical Staff shall:

4.6.3.1. Perform such duties as may be assigned to him by the President of the Medical Staff, and, in the absence of the President of the Medical Staff and the President-Elect of the Medical Staff, assume all of the duties and authority of the President of the Medical Staff.

4.6.3.2. Call meetings of the Medical Staff on the order of the President of the Medical Staff.

4.6.3.3. Ensure that full and accurate minutes and records are kept of all meetings of the Medical Staff.

4.6.4. Treasurer of the Medical Staff. With appropriate assistance of the Medical Staff, Office, the Treasurer of the Medical Staff shall:

4.6.4.1. Have custody or control of all Medical Staff funds and render a monthly account of such funds to the MEC.

4.6.4.2. Prepare and submit an annual financial report at a meeting of the Medical Staff.

4.6.4.3. Serve as a member or as chair of other committees of the Medical Staff at the request of the President of the Medical Staff.

ARTICLE 5

COMMITTEES OF THE MEDICAL STAFF

5.1. IDENTIFICATION

5.1.1. The Committees of the Medical Staff shall consist of standing committees and special committees, the latter appointed on an ad hoc basis and all reporting to the MEC. Some standing and special committees of the Medical Staff may be multi-disciplinary committees reporting to both the President of the Hospital and the MEC. Notwithstanding any other provision of these Bylaws, the nature, composition, duties and responsibilities, meetings, and quorum requirements of the committees of the Medical Staff may be amended on behalf of the Medical Staff by the MEC, with the approval of the Board of Directors.

5.1.2. The standing committees of the Medical Staff shall include but shall not be limited to:

5.1.2.1. Medical Executive Committee (MEC);
5.1.2.2. Performance Improvement Committee;
5.1.2.3. Credentials Committee, which may include a subcommittee to be known as the Physician Health Committee; and
5.1.2.4. Nominating Committee

5.1.3. The MEC may establish or dissolve such other standing committees of the Medical Staff as the MEC deems necessary or desirable for the fulfillment of Medical Staff purposes, functions, or responsibilities.

5.1.4. The MEC may from time to time establish special committees for such purposes as it shall determine. Special committees shall confine their efforts to the projects for which they are created and shall report their findings and recommendations to the MEC.

5.2. MEMBERSHIP

5.2.1. The President of the Medical Staff or his designee shall be an Ex-Officio member of all committees unless otherwise so designated.

5.2.2. The President of the Medical Staff shall appoint Members to all committees with the exception of the MEC. The President of the Medical Staff and the President of the Hospital shall confer on the appointment of Hospital employee committee members.

5.2.3. Voting members of Medical Staff committees shall be Physician members. Voting members of multi-disciplinary committees shall be all members unless otherwise specified in these Bylaws.

5.2.4. Members of the Medical Staff who are not members of a given Medical Staff committee may only attend meetings of that committee as provided in these Bylaws or by invitation of the committee chair.

5.2.5. Each Medical Staff committee member's term of appointment shall be for two (2) years. Committee members may serve successive terms, unless otherwise specified in these Bylaws.

5.3. MEETINGS AND MINUTES

5.3.1. Committees of the Medical Staff shall hold and conduct meetings in accordance with these Bylaws.

5.3.2. Minutes of all committee meetings shall be taken and maintained in accordance with these Bylaws.

5.4. MEDICAL EXECUTIVE COMMITTEE

5.4.1. Composition: The MEC shall consist of the following membership with certain voting and non-voting members, and shall regularly invite certain non-voting guests to its meetings.

5.4.1.1. Voting members of the MEC shall consist of: the President of the Medical Staff (Chairperson), Medical Staff Department Chairs, Medical Staff Division Chairs, President-Elect, Secretary, Treasurer, the immediate Past-President and two (2) at-large members.

5.4.1.2. The Hospital President or his/her designees may attend each MEC meeting on an ex-officio basis, without vote.

5.4.1.3. All members of the Medical Staff, of any discipline or specialty, are eligible for membership on the MEC so long as they meet the qualifications stated in 5.4.4.

5.4.2. Officers: The President, President-Elect, Secretary and Treasurer of the Medical Staff shall serve as the Chair, Vice-Chair, Secretary and Treasurer of the MEC, respectively.

5.4.3. At-Large Elections: The two at-large members of the MEC shall be elected by secret ballot of a majority of a quorum of the Active Medical Staff Members present at a duly convened meeting. MEC members so elected are subject to approval by the Board. For the purpose of this election, the Nominating Committee shall recommend to the Medical Staff one or more nominees for each at-large position on the MEC, upon due consideration of the qualifications for MEC members as set forth in these Bylaws. The Committee shall report its recommendations to the Medical Staff at a meeting of the Medical Staff at least 30 days prior to the voting meeting of the Medical Staff. Nominations may also be made from the floor at the meeting at which the Nominating Committee reports its recommendations, provided that the nominee is present and consents to the nomination. Nominations shall be closed immediately following such meeting of the Medical Staff.

5.4.4. Qualifications: Members of the MEC shall satisfy the following qualifications:

5.4.4.1. Be Members in good standing of the Active Medical Staff;

5.4.4.2. Have demonstrated interest in maintaining and improving quality medical care at the Hospital and have constructively participated in Medical Staff affairs, such as performance improvement activities;

5.4.4.3. Possess and have demonstrated effective leadership skills; and

5.4.4.4. Be willing to faithfully discharge the duties and responsibilities of a MEC member.

5.4.5. Replacement: In the event of the resignation or removal of an officer or any member of the MEC during his term of office, the President of the Medical Staff shall select a temporary replacement until the election of a successor to complete the term of office at a duly convened meeting of the Medical Staff, except that if the President of the Medical Staff resigns or is removed, the President-Elect will automatically serve in his stead. The election of a successor shall take place within 120 days of the officer or MEC member's resignation or removal.

5.4.6. Term of Office: Each at-large member of the MEC shall be elected to serve a two year term, commencing on the first (1st) day of the Medical Staff Year following his election. An at-large member of the MEC may not serve more than one consecutive term on the MEC in the capacity of an at-large member.

5.4.7. Removal: A member of the MEC shall be automatically removed from office upon suspension or termination of his Medical Staff membership or Clinical Privileges; provided that suspension of less than 60 days for incomplete medical records will not count for this purpose. The MEC, by 2/3 vote, may remove a member of the MEC during his term of office for valid cause. Valid cause includes, but is not limited to continued gross or willful neglect of the MEC's duties and responsibilities under these Bylaws; failure to attend at least fifty percent (50%) of MEC meetings; gross misfeasance in office; a final adverse action affecting the MEC member's Clinical Privileges; or conviction of a crime.

5.4.8. Duties and Responsibilities: The duties and responsibilities of the MEC, delegated by the Medical Staff, shall be:

5.4.8.1. To represent and act on behalf of the Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws and within the scope of its responsibilities defined by these Bylaws;

5.4.8.2. To make recommendations to the Board on behalf of the Medical Staff on matters concerning but not limited to:

5.4.8.2.1. The organization of the Medical Staff;

5.4.8.2.2. The mechanism by which Applicants' credentials are reviewed and Clinical Privileges are delineated;

5.4.8.2.3. Recommendation of individual Applicants for Medical Staff membership;

5.4.8.2.4. Recommendation of delineated Clinical Privileges for individual Applicants;

5.4.8.2.5. The Medical Staff's participation and leadership in Hospital performance improvement activities;

5.4.8.2.6. The mechanism by which Medical Staff membership may be terminated; and

5.4.8.2.7. Procedures for investigations, corrective actions and fair hearings.

5.4.8.3. To implement and enforce the Bylaws, Rules and Regulations, and policies and procedures of the Medical Staff.

5.4.8.4. To consider and act upon the reports and recommendations of Departments and committees of the Medical Staff.

5.4.8.5. To review the recommendations of Department Chairs regarding Applicants for Appointment, Reappointment, changes in Medical Staff category, delineation of Clinical Privileges and/or assignments to Departments, and to make recommendations to the Board of Directors for acceptance, deferral or rejection of such applications.

5.4.8.6. To coordinate, approve, and recommend approval of the activities and policies adopted by the Medical Staff and Departments and committees of the Medical Staff.

5.4.8.7. To take all reasonable steps to ensure professional and ethical conduct on the part of all Members of the Medical Staff.

5.4.8.8. To initiate and pursue investigations and to enforce corrective action in accordance with the Credentialing Manual.

5.4.8.9. To act as a liaison among the Medical Staff, the President of the Hospital and the Board of Directors.

5.4.8.10. To recommend action to the President of the Hospital concerning medico-administrative and Hospital management matters.

5.4.8.11. To participate in identifying community health needs and to provide leadership in establishing Hospital goals and programs designed to meet those needs.

5.4.8.12. To account to the Board of Directors for the quality of the medical care rendered to the patients in the Hospital.

5.4.8.13. To account to the Board of Directors for the Medical Staff's performance improvement activities, and the mechanisms designed to conduct, evaluate and revise such activities.

5.4.8.14. To inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.

5.4.8.15. To report to the Medical Staff at the annual Medical Staff meeting.

5.4.8.17 Requesting evaluations of practitioner privileges through medical staff processes if there is doubt about the applicant's ability to perform privileges requested,

including all issues with APPs.

5.4.8.18 Adoption of associated details which supplement the Medical Staff Bylaws.

5.4.9. Meetings and Minutes: The MEC shall generally meet at least every other month, maintain minutes of its proceedings and actions, and report its findings and recommendations to the Board of Directors.

5.4.10. Quorum/Manner of Action: A quorum of the MEC shall consist of fifty percent (50%) or more of the voting members of the Committee. Decisions shall be made by a majority vote of those Committee members voting in the presence of a quorum. The Chair of the MEC shall not vote unless the vote of those Committee members voting in the presence of a quorum results in a tie. In the event of a tie, the Chair of the MEC shall cast the deciding vote.

5.4.11. How the Medical Staff Delegates Authority to the MEC: The Medical Staff delegates its authority to the MEC by electing MEC members, taking action at meetings of the Medical Staff, and approving the Medical Staff Bylaws and related documents as set forth below, including appropriate amendments to such documents. Such authority may be revised or removed by the same methods.

5.5. CREDENTIALS COMMITTEE:

5.5.1. Composition: The Credentials Committee is appointed by the President of the Medical Staff. There will be at least three members: one representative each from the Departments of Medicine and Surgery, and the Immediate Past President of the Medical Staff, who will serve as Chair. The Credentials Committee may function as the Physician Health Committee, as needed.

5.5.2. Duties and Responsibilities: The Credentials Committee will review all applications for Medical Staff membership and clinical privileges, whether for initial applicants or reappointment, and shall make recommendations to the Medical Executive Committee as to the applicant's qualifications for membership and privileges. The Credentials Committee may interview applicants and make other reasonable inquiries as to the applicant's qualifications.

5.5.3. Meetings: The Credentials Committee will generally meet every two months or more often if needed, maintain a record of its proceedings and actions, and report its findings and recommendations, as appropriate, to the MEC for action.

5.5.4. Quorum/Manner of Action: A quorum shall consist of fifty percent (50%) of the Committee members. Decisions shall be made by a majority vote of those Committee members voting in the presence of a quorum. Notwithstanding any other provision of this subsection, performance improvement activities conducted for the purpose of collecting data to measure, evaluate, and improve the quality of care rendered to patients by Members of the Departments of the Medical Staff may be conducted in the absence of a quorum.

5.6. PERFORMANCE IMPROVEMENT COMMITTEE

5.6.1. Composition: The President of the Medical Staff shall appoint the members if the Performance Improvement Committee and designate one member as Chair. There will be at least three members: one representative each from the Departments of Medicine and Surgery, and the President-Elect of the Medical Staff.

5.6.2. Duties and Responsibilities: The duties and responsibilities of the Performance Improvement Committee shall be:

5.6.2.1. To review data in order to ensure high quality, effective, and efficient patient care within the Departments of the Medical Staff.

5.6.2.2. To review and act upon recommendations from the President of the Medical Staff, the Chairs of the Departments of the Medical Staff, the MEC, or other committees of the Medical Staff in order to ensure high quality, effective, and efficient patient care within the Departments of the Medical Staff.

5.6.2.3. To act in fulfillment of the Medical Staff's responsibility to conduct performance improvement activities for the purpose of measuring, evaluating, and improving the quality of care rendered to patients by Members of the respective Departments, in accordance with the performance improvement plan of the Hospital.

5.6.2.4. To participate, provide leadership and refer matters to the Hospital-wide Patient Safety/Performance Improvement Committee.

5.6.2.5. To study the correlation among pre-operative, post-operative and pathological diagnosis as well as other matters related to the quality and acceptability of surgical procedures performed in the Hospital.

5.6.2.6. To recommend proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components, and to evaluate the appropriateness of blood transfusions.

5.6.2.7. To supervise, suggest, and recommend policies pertaining to statistical records, charts, and other records related to the professional care of inpatients and outpatients; to review records of both inpatients as well as discharged patients of Fort Washington Medical Center to determine deficiencies or delinquencies in standards of clinical pertinence.

5.6.2.8. To review the medical propriety of hospital admission, length of stay, utilization of Hospital facilities (which includes availability of Hospital facilities and services), all of these to be consistent with the maintenance of high quality patient care.

5.6.2.9. To review the procurement, disposition and inventory of whole blood and blood components, and to consider, when necessary, modification and correction of clinical and laboratory practices and procedures related thereto.

5.6.2.10. To review all Code Blue situations; to review patient care delivery in the critical care units for appropriateness and quality; and to review, maintain and develop policies and procedures governing critical care and monitored bed routines and services.

5.6.2.11. To provide confidential and privileged peer review of medical and surgical cases using the Just Culture philosophy and pursuant to the peer review policy.

5.6.3. Meetings: The Performance Improvement Committee will generally meet every two months or more often if needed, maintain a record of its proceedings and actions, and report its findings and recommendations, as appropriate, to the President of the Medical Staff, the Chairs of the Departments of the Medical Staff, the MEC and the Hospital-wide Patient Safety/Performance Improvement Committee for action.

5.6.4. Quorum/Manner of Action: A quorum shall consist of fifty percent (50%) of the Committee members. Decisions shall be made by a majority vote of those Committee members voting in the presence of a quorum. Notwithstanding any other provision of this subsection, certain performance improvement activities conducted for the purpose of collecting data to measure, evaluate, and improve the quality of care rendered to patients by Members of the Departments of the Medical Staff may be conducted in the absence of a quorum..

5.7. NOMINATING COMMITTEE FOR OFFICERS OF THE MEDICAL STAFF

5.7.1. Composition: The Nominating Committee for Officers of the Medical Staff will consist of a minimum of three members of the Active Medical Staff selected by the President of the Medical Staff. At least one member will be from the Department of Surgery or designee, one member from the Department of Medicine or designee, and the Immediate Past President of the Medical Staff, who will serve as chair.

5.7.2. Duties and Responsibilities: The Nominating Committee will prepare a slate of nominees for President, President-Elect, Secretary, Treasurer and the two At-Large Members of the Executive Committee. A quorum shall consist of all members of the Nominating Committee, and decisions shall be made by a majority of Nominating Committee members.

ARTICLE 6

MEDICAL STAFF MEETINGS

6.1. GENERAL STAFF MEETINGS

The general meetings of the Medical Staff shall be held semi-annually or at such other time as the President of the Medical Staff shall deem appropriate. At the last meeting of the Medical Staff Year (the "annual meeting") during each odd-numbered year, the officers of the Medical Staff and the two at-large members of the MEC shall be elected for the ensuing two-year period.

6.2. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called for a specific agenda at any time by the President of the Medical Staff or at the request of 10% of the Voting Members of the Medical Staff. In the event that a special meeting is called, Voting Members shall be notified by phone call or other electronic means at least three days in advance of the meeting, and notices shall be conspicuously posted in the Hospital in areas frequented by Medical Staff members. If time permits, written notice will be provided by First Class United States Mail, postage prepaid, to all Members of the Medical Staff at least 15 days in advance of the meeting. Only such business as is published in the notice of a special meeting may be transacted at such meeting. The attendance of a Member at a special meeting of the Medical Staff shall constitute waiver of notice of such meeting.

6.3. QUORUM – GENERAL AND SPECIAL STAFF MEETINGS

6.3.1. Ten percent (10%) of the total membership of the Voting Members of the Medical Staff shall constitute a quorum for the transaction of any and all business.

6.3.2. Once a quorum is established, a majority affirmative vote by Voting Members present shall be required to approve any ordinary business. In the event that a Voting Member is unable to attend a general or special meeting of the Medical Staff at which voting upon an ordinary business matter is to occur, such Voting Member may submit his vote to the Medical Staff President, President-Elect, or their designee at least 24 hours in advance of such meeting. The absent Voting Member's vote so submitted may be counted as if the Voting Member were present. However, the absent Voting Member may not be included for purposes of establishing a quorum.

6.3.3. If a quorum is not present for the transaction of business, such business to have been transacted may be submitted to the Voting Members of the Medical Staff by First Class United States Mail, postage prepaid, or by electronic means, with each Voting Member to cast his vote by return ballot.

6.4. DEPARTMENT MEETINGS

Departments of the Medical Staff shall hold meetings in accordance with the Rules and Regulations for the respective Department.

6.5. QUORUM – DEPARTMENT MEETINGS

Meetings of Departments of the Medical Staff shall have the same quorum requirements as those set forth in this section.

6.6. RULES OF ORDER

The most recent edition of Robert's Rules of Order shall serve as a guide for the conduct of all meetings of the Medical Staff and the Departments and committees unless otherwise provided in these Bylaws. Technical departures from Robert's Rules of Order shall not be grounds for invalidating the business transacted at such meetings.

ARTICLE 7

SPECIAL APPEARANCE

7.1. At the discretion of the chair or presiding officer, when a Member's practice or conduct is scheduled for discussion at a Department or committee meeting, the Member may be required to appear at the meeting.

7.2. The Member shall be provided with Special Notice of a request for special appearance at such meeting at least three calendar days prior to the requested appearance. Such Special Notice shall include a general statement of the issue involved and the time, date, and location of the meeting.

7.3. Failure of any Member to comply with such request for a special appearance, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action in accordance with the provisions set forth in these Bylaws.

ARTICLE 8

ATTENDANCE REQUIREMENTS

8.1. COMMITTEE MEETINGS

8.1.1. Medical Staff Members who have accepted appointment to a standing or special committee of the Medical Staff are required to attend thirty percent (30%) of the committee's meetings during the course of the Medical Staff Year, unless an excused absence has been granted in accordance with these Bylaws.

8.1.2. A Medical Staff Member's failure to comply with this committee meeting attendance requirement may result in revocation of the Member's committee appointment.

8.2. EXCUSED ABSENCE

8.2.1. An excused absence may be granted for reasons that include but are not limited to illness and medical or personal emergency.

8.2.2. The Committee Chair may grant an excused absence from a meeting of a standing or special committee of the Medical Staff.

ARTICLE 9

CONFIDENTIALITY AND IMMUNITY

9.1. CONFIDENTIALITY

9.1.1. All Medical Staff Information shall be considered confidential. The Medical Staff shall preserve the confidentiality of Medical Staff Information and shall disclose such information only as required to fulfill the purposes, prerogatives, duties, and responsibilities of the Medical Staff as set forth in these Bylaws and in Hospital governing documents or as required or permitted by law.

9.1.2. Inasmuch as Medical Staff Members participate in effective performance improvement; utilization review; risk management; appointment, reappointment, and clinical privileges delineation activities; investigations and recommendations for corrective action; fair hearing processes; and other Medical Staff functions in reliance upon the preservation of confidentiality, any breach of the confidentiality of Medical Staff Information constitutes a failure to meet the professional and ethical standards of the Medical Staff, constitutes a disruption of the operations of the Hospital, and may be a basis for corrective action in accordance with the provisions set forth in these Bylaws.

9.2. IMMUNITY

9.2.1. By applying for and/or accepting Appointment or Reappointment to the Medical Staff or a change in Medical Staff category, and by applying for, accepting and/or exercising Clinical Privileges within the Hospital, each Applicant or Medical Staff Member extends immunity to, and releases from all claims, damages, and liability to the fullest extent permitted under applicable law:

9.2.1.1. The Hospital, the Medical Staff, and any employee, officer, director, agent, or representative thereof, for any action taken or recommendation made by any Hospital or Medical Staff employee, officer, director, agent, or representative within the scope of his duties as such and in accordance with these Bylaws; and

9.2.1.2. Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital or Medical Staff employee, officer, director, agent or representative thereof concerning any former or current Applicant or Member.

9.2.2. The immunity provided by these Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's and/or the Medical Staff's activities.

9.2.3. The immunity provided by these Bylaws shall be in addition to other protections provided by law, and shall not be construed to limit such protections in any way.

ARTICLE 10

ADVANCED PRACTICE PROFESSIONALS

10.1. Advanced Practice Professionals fall under the scope of the Hospital's Policy on Advance Practice Professionals. Refer to the Medical Staff Approved Advanced Practice Professional Policy for detail on scope of practice, oversight by supervising physician and other requirements approved by the Medical Staff.

10.2. The Medical Staff may grant clinical privileges to specific non-physician practitioner individuals or groups excluded from Medical Staff membership in compliance with State Law. The Board of Directors has final approval authority for the granting of privileges to non-physician practitioner individuals or groups recommended by the medical staff. The medical staff may grant privileges, through its normal privileging process, to individual members of the non-physician practitioners listed below or to the individual non-physician practitioners in the groups below in compliance with State Law:

1. Physician assistant
2. Nurse practitioner
3. Clinical nurse specialist
4. Certified registered nurse anesthetist
5. Certified nurse-midwife
6. Clinical social worker
7. Clinical psychologist
8. Registered dietitian or nutrition professional.

ARTICLE 11

CORRECTIVE ACTION

1. Intent.

The intent of the Medical Staff and the Board of Directors is to provide for a fair review of decisions that adversely affect Practitioners while also protecting patients and affording all persons participating in or providing information in connection with such review activity the benefit of all privileges, immunities, and protections from liability to the fullest extent available under federal and State law.

2. Criteria for Initiation

Concerns about a Medical Staff member or other practitioner with clinical privileges may be raised from a variety of sources, including but not limited to:

- complaints by patients or staff
- identification of potential issues by the Hospital's administration, including the risk management, Medical Staff, and quality assurance departments
- concerns raised by other practitioners
- concerns identified by the FPPE/OPPE processes
- reports from other institutions or programs
- reports from state licensing boards, federal payor programs, and professional associations
- reports from the news media

When reliable information indicates that a Practitioner may have exhibited behavior, demeanor or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital, (2) unethical, (3) unprofessional, inappropriate, disruptive or harassing, (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) not within applicable professional standards, the President of the Medical Staff, appropriate Department Chair, Credentials Committee Chair, or Hospital President shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible. A determination will then be made by the Medical Staff President as to whether to refer the matter to the Medical Executive Committee or to otherwise deal with the matter in accordance with this Article. The Medical Staff President's decision will be based on factors such as concern about harm to patients or Hospital operations. If it is determined that the matter should be directed to the Medical Executive Committee, the Medical Executive Committee may make immediate recommendations to the Board of Directors, may direct that an investigation be conducted in accordance with this Article, or may refer the matter to other appropriate Medical Staff departments, sections or committees for further evaluation or investigation.

3. Collegial Interventions.

These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, when applicable, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. However collegial intervention is not appropriate in all cases. Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a hearing and appeal, and shall not require reporting to the state licensure board or the NPDB,

except as otherwise provided in these Bylaws.

11.3.1. Collegial intervention is a part of the Hospital's professional review activities and may include, but is not limited to, the following:

a. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
b. Informal discussions or formal meetings regarding the concerns raised about conduct or performance;
c. Proctoring, monitoring, consultation, and letters of guidance;
d. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;
e. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
f. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
g. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
h. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
i. Suggestions or requirements to seek assistance for a health issue, as provided in these Bylaws.

11.3.2. The relevant Medical Staff leader(s), which may include the Hospital President, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.

11.3.3. The relevant Medical Staff leader(s) will determine whether to document any collegial intervention effort. This documentation should be placed in an individual's confidential file. The individual may have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

11.3.4 The vast majority of providers typically are professional and have no issues that require attention. Instead, regular feedback on progress should be provided. When a provider has a single or new concern raised, an informal meeting should be arranged to rectify the situation with either the Department or Subsection Chair. Should an apparent pattern subsequently develop, then an awareness intervention with the Department or Subsection Chair, Medical Staff Leaders and the President of the Medical Staff (or representative) should occur. If this intervention is unsuccessful and the pattern remains, then the Performance Improvement Committee (PIC) should intervene and further guide an intervention as the authority body. If successful change in behavior by the Provider is not obtained, then the PIC must reconvene to determine next steps and possible disciplinary action. Based on the severity of an individual occurrence different levels of the above process may be utilized.

11.4. Precautionary/Summary Suspension.

Precautionary suspension (also referred to as "summary suspension") is the immediate suspension of some or all of a Member's clinical privileges when it is deemed that the Member's conduct, behavior, health or circumstances pose an immediate risk of harm or an immediate or imminent danger to patients, staff and the general public.

a. In order for a summary suspension to be imposed, there must be at least a consultation or agreement by at least two parties, which can include members of the Executive Committee, the Department Chair, the President of the Medical Staff, the President of the Hospital or the Board of Directors.

b. The Member shall be notified in person if possible and by letter sent certified mail, return receipt requested, commercial overnight delivery service, hand delivery, or other acceptable commercial means (e.g., fax, email) from the Hospital administration (which may include the Medical Staff Services office).

c. Within ten days of the notification of the summary suspension, the suspended Member may request in writing that an informal interview before the Medical Executive Committee be held at its next regularly scheduled meeting.

d. The interview shall not constitute a hearing under these Bylaws and shall not be governed by the fair hearing provisions in these Bylaws.

e. If the Medical Executive Committee, by majority vote, upholds the summary suspension, the Member will be given notice of such action and may exercise his/her right to a fair hearing under these Bylaws.

f. If the Medical Executive Committee rescinds the summary suspension, the Member is not entitled to a hearing under these Bylaws.

g. The Action shall be immediately reported in writing to the Hospital President and the President of the Medical Staff.

11.5. Investigations.

11.5.1. Initiation of Investigation:

a. When a question involving clinical competence or professional conduct is referred to, or raised by the Medical Executive Committee, the Medical Executive Committee may order an investigation to be conducted in accordance with this Section. The affected practitioner shall be notified if an investigation is opened.
b. The Board of Directors may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board of Directors, or an ad hoc committee.
c. The President of the Medical Staff shall keep the Hospital President fully informed of all action taken in connection with an investigation.

11.5.2. An investigation may be initiated in response to the circumstances in a single case, or to investigate a pattern or trend in performance. The investigation may involve an interview with the Practitioner and/or an interview of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practical after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board of Directors, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing.

11.5.3. The investigation shall include, as deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information relevant to the matter being investigated. A written report shall be prepared and promptly submitted to the body that requested the investigation.

11.5.4. As soon as practicable after the conclusion of an investigation, the Medical Executive Committee or the Board of Directors may:

a. Determine that corrective action is not warranted and dismiss the matter;
b. Decide to use one of the alternatives to corrective action; or,
c. Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to the fair hearing rights in these Bylaws.

ARTICLE 12

FAIR HEARINGS

12.1. Grounds for Hearing.

Any one or more of the following actions or recommended actions shall constitute an "Adverse Action" or "Adverse Recommendation" for the purposes of these Bylaws, and unless otherwise provided herein shall constitute grounds for a hearing:

1. Denial of Medical Staff Appointment, Reappointment, and/or requested Clinical Privileges.

2. Denial of requested advancement in Medical Staff category or membership status, or involuntary reduction in Medical Staff category or membership status.

3. Revocation, suspension, or restriction of Medical Staff membership and/or Privileges.

4. Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to provisional staff status, or the granting of new Privileges, or imposed because of insufficient activity, or proctoring or consultation that does not otherwise restrict the Practitioner's Privileges).

5. Suspension of Staff membership and/or Privileges until completion of specific conditions or requirements.

6. Summary suspension of Staff membership and/or Privileges during the pendency of corrective action or hearings and appeals procedures.

7. Any other corrective action or recommendation that must be reported to the applicable state licensing board or the National Practitioner Data Bank.

The hearing and appellate review rights set forth in these Bylaws do not apply to:

1. Termination of Medical Staff membership and Clinical Privileges of those Practitioners providing Hospital-based services as an individual member of the House Staff or as a member of a group pursuant to a contract with the Hospital, where such termination is coincident with and results from termination of the contract;

2. Automatic revocation of Privileges arising from failure to meet the basic requirements for Medical Staff membership and clinical privileges, such as loss of professional license;

3. Adverse actions that do not affect Medical Staff Privileges such as issuance of a letter of admonition or a letter of reprimand;

4. Placement of an Applicant for Appointment on a waiting list for an over-utilized Department.

12.2. Request for Hearing.

1. Special Notice of Action or Recommended Action

In all cases where the authorized body has recommended or taken any of the actions constituting grounds for a hearing as set forth in these Bylaws, the body shall give the affected Practitioner Special Notice of its action or recommended action and Special Notice of the Practitioner's right to request a hearing. Such Special Notice shall:

1. Specify the action that has been taken or has been recommended to be taken against the Practitioner;

2. Provide a brief indication of the reasons for the action or recommended action, including a list of any charts being questioned;

3. Inform the Practitioner that he has the right to request a hearing on the action or recommended action;

4. Instruct the Practitioner that he must request such a hearing by providing written Special Notice to the President of the Medical Staff with a copy to the President of the Hospital within 30 days after the Practitioner's receipt of the Special Notice of Action or Recommended Action, or the Practitioner's right to a hearing will be forfeited; and

5. Summarize the Practitioner's rights during the course of a hearing.

2. Request for Hearing

1. The Practitioner shall have 30 days after the Practitioner's receipt of the Special Notice of Action or Recommended Action to request a hearing. The request shall be in writing and shall be addressed to the President of the Medical Staff with a copy to the President of the Hospital, and shall be delivered personally to the addressee or sent Registered or Certified United States Mail, Return Receipt Requested.

2. The Practitioner shall state, in writing, his intentions with respect to attorney representation at the time he files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

3. The Practitioner shall provide a written list of the names and addresses of witnesses (if any) expected to testify at the hearing on behalf of the Practitioner at the time the Practitioner files his request for a hearing. The Practitioner shall amend this witness list when additional witnesses are identified. The failure to have provided the name and address of any witness at least 10 days prior to the hearing date at which the witness is to appear may constitute good cause for a postponement of the hearing or for the Presiding Officer to exclude the witness's testimony. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation could not reasonably have been anticipated.

4. If the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing or appellate review to which he might otherwise have been entitled in the matter that was the subject of the Special Notice of Action or Recommended Action, and to have accepted such action or recommended action as valid and proper.

12.3. Hearing Procedure.

1. Special Notice of Hearing

Within 15 days after the date of receipt of a request for a hearing, the President of the Medical Staff shall schedule and arrange for the conduct of a hearing. He shall provide the Practitioner with written Special Notice of the hearing. Such Special Notice shall include:

1. The time, place, and date of the hearing, which date shall not be less than 30 days after the Special Notice of such hearing, nor more than 90 days from the President of the Medical Staff's receipt of the request for a hearing. However, when the request is received from a Practitioner who is under a suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed 20 days from the date the President of the Medical Staff receives the request for a hearing unless the Practitioner agrees

otherwise.

2. A list of the names and addresses of witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing. This witness list shall be amended when additional witnesses are identified. The failure to have provided the name and address of any witness at least 10 days prior to the hearing date at which the witness is to appear may constitute good cause for a postponement of the hearing or for the Presiding Officer to exclude the witness's testimony. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation could not reasonably have been anticipated.

2. Hearing Committee

1. When a hearing is requested, the President of the Medical Staff shall appoint a Hearing Committee consisting of at least five members who shall not have actively participated in the formal consideration of the matter at any previous level and shall not be in direct economic competition with the Practitioner and should include impartial peers. The President of the Medical Staff may appoint alternates who meet the standards described above and who can serve on the Hearing Committee if a member of the Hearing Committee becomes unavailable. The President of the Medical Staff may, within his discretion, appoint Practitioners who are not Medical Staff Members to serve on the Hearing Committee or to serve as alternates under appropriate circumstances. The President of the Medical Staff shall designate a Chair of the Hearing Committee who shall handle all pre-hearing matters and shall preside over the hearing, unless a Hearing Officer has been appointed in accordance with the provisions below.

2. The President of the Medical Staff shall inform the Practitioner in writing of the names of the Practitioners serving on the Hearing Committee at least 15 days before the date of the hearing. This notice shall further state that if the Practitioner believes that any member of the Hearing Committee cannot reach a fair and impartial decision, he must assert his claim of prejudice in writing to the President of the Medical Staff within five days of his receipt of such notice, stating the reasons for his belief. The President of the Medical Staff shall consider the reasons stated and determine whether the member shall remain on the Hearing Committee or be replaced. If the challenged member is not replaced, the reasons shall be stated in writing and sent to the Practitioner.

3. Hearing Officer

At the request of the MEC, the President of the Medical Staff may appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney-at-law qualified to preside over a hearing and preferably shall have experience in Medical Staff matters. If requested by the Hearing Committee, the Hearing Officer may participate in the deliberations of the Hearing Committee and be a legal advisor to it, but he shall not be entitled to vote.

4. Presiding Officer

The Presiding Officer at the hearing shall be the Hearing Officer as described above or, if no such

Hearing Officer has been appointed, the Chair of the Hearing Committee. The Presiding Officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He shall have the authority and discretion to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure or the admissibility of evidence.

5. Failure to Appear or Proceed

   Absent a showing of good cause, as determined within the sound discretion of the Presiding Officer, the Practitioner's failure to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute a waiver of the request for a hearing and a voluntary acceptance of the recommendations or actions involved. The recommendations or actions shall be forwarded to the Board of Directors, which shall take final action on the matter.

6. Postponements and Extensions

   Postponements and extensions of time beyond the time expressly permitted herein may be requested by any affected person, and shall be permitted by the Chair of the Hearing Committee upon a showing of good cause.

7. Representation

   1. The Practitioner, the body whose decision prompted the hearing, and the Hearing Committee shall have the right to be represented at the hearing by an attorney or any other individual at the respective party's own expense.

   2. Regardless of whether the body whose decision prompted the hearing is represented at the hearing by an attorney or another individual, such body may appoint a representative from the Medical Staff or from the Board of Directors (whichever body's decision prompted the hearing), who may present the body's recommendation, decision or action taken and the materials in support thereof, and may examine witnesses.

8. Discovery

   1. Rights of Inspection and Copying

      The Practitioner may inspect and copy (at his own expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its own expense) any documentary information deemed relevant to the charges that the Practitioner has in his possession or under his control. Requests for such discovery shall be honored as soon as practicable. Failure to comply with reasonable discovery requests made at least ten days prior to the hearing shall constitute good cause for a postponement of the hearing.

2. Limits on Discovery

    1. The Presiding Officer shall rule on discovery disputes that the parties are unable to resolve.

    2. Discovery may be denied when denial is justified to protect peer review or the interests of fairness and equity.

    3. The right to inspect and copy documentary information set forth above does not extend to confidential information referring to individually identifiable Practitioners other than the Practitioner under review and does not create or imply any obligation to modify or create documents in order to satisfy a request for information.

3. Pre-Hearing Document Exchange

    At the request of either party, the parties shall exchange all documents that will be introduced at the hearing. Such documents must be exchanged at least ten days prior to the hearing. A failure to comply with this section shall constitute good cause for the Presiding Officer to limit the introduction of any documents not provided to the other party in a timely manner.

9. Procedural Disputes

    It shall be the duty of the parties to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

    The parties shall be entitled to file motions as deemed necessary to give full effect to rights established pursuant to this fair hearing plan and to resolve such procedural matters as the Presiding Officer determines may be properly resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the Presiding Officer, with a copy to the moving party. The Presiding Officer shall determine whether to permit oral argument on any such motion. The Presiding Officer's ruling on the motion shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the Presiding Officer.

10. Record of the Hearing

The Hearing Committee shall maintain a record of the hearing by a court reporter present to make a record of the hearing. The cost of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Committee may, but shall not be required to, order that the oral evidence be taken only (a) on oath administered by any person

designated by the Committee and entitled to notarize documents in this State or (b) by affirmation under penalty of perjury to the Presiding Officer.

11. Rights of the Parties

Provided that such rights are exercised in an efficient and expeditious manner, each party to a hearing shall have the right to:

1. Call and examine witnesses for relevant testimony;
2. Introduce relevant exhibits or other documents;
3. Cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, or otherwise to rebut any evidence; and
4. Submit a written statement in support of its position. The Hearing Committee may request that such statement be filed following the conclusion of the presentation of oral testimony.
5. The body whose decision prompted the hearing may call and examine the Practitioner as if under cross-examination.
6. The Hearing Committee may call and/or examine the Practitioner; may question any other witness called by either party; and may call and question additional witnesses if the Hearing Committee deems such action appropriate.

12. Rules of Evidence

Hearings before the Hearing Committee shall be informal. The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in the hearing. Any relevant evidence, including hearsay, shall be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

13. Burdens of Presenting Evidence and Proof

1. The Hearing Committee need not adhere to a rigid order of proof. However, the body whose decision prompted the hearing should generally have the initial duty to present evidence for each case or issue in support of the action or recommended action at issue. The Practitioner shall be obligated to present evidence in response.

2. The Practitioner shall bear the ultimate burden of persuading the Hearing Committee, by a preponderance of the evidence presented at the hearing, that the reasons for the adverse action or recommended action lacked foundation in fact, or that the action or recommended action was arbitrary or unreasonable.

14. Conduct of the Hearing

1. At least three members of the Hearing Committee must be present to conduct the hearing, and no member of the Hearing Committee may act by proxy.

2. The affected Practitioner, his attorney or representative, as the case may be, and the representative of the body whose decision prompted the hearing or its legal counsel may question any person who testifies at the hearing.

3. In all cases, the Presiding Officer shall give the person requesting the hearing an opportunity to make a statement as to why he believes that the Adverse Action or Adverse Recommendation was improper.

4. During the course of the hearing, any member of the Hearing Committee may interrupt at any time to ask a question or request the presentation of additional evidence.

5. The Presiding Officer shall take any measures reasonably necessary to advance the proceeding, to terminate repetitive or irrelevant inquiries, and to prevent time-consuming and extraneous debate and argument.

6. Any requests for a recess or temporary suspension of the hearing may be granted if the Chair of the Hearing Committee, at his discretion, determines that it is appropriate.

15. Adjournment and Conclusion

1. The Presiding Officer may adjourn the hearing and reconvene the same at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

2. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Committee shall then conduct its deliberations and render a decision and accompanying report. Final adjournment of the hearing shall be at such time as the Hearing Committee has concluded its deliberations.

16. Basis of Decision

The decision of the Hearing Committee shall be based upon the evidence and written statements produced at the hearing, including:

1. Oral testimony of witnesses;
2. Briefs or written statements presented in connection with the hearing;
3. Any material contained in the Hospital or Medical Staff personnel files regarding the Practitioner which shall have been made a part of the hearing record
4. Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record; and
5. Any other evidence admitted in the hearing.

17. Written Decision of the Hearing Committee

1. Within 15 days after final adjournment of the hearing, the Hearing Committee shall render a written decision, unless the Practitioner is currently under suspension, in which case the Hearing Committee shall render a written decision within ten days after final adjournment of the hearing.

2. The Hearing Committee's written decision shall be delivered to the President of the Medical Staff, the President of the Hospital, and the Practitioner by Registered or Certified United States Mail, Return Receipt Requested or commercial overnight delivery service.

3. Such written decision shall contain the Hearing Committee's findings of fact, conclusions and recommendations concerning each matter contained in the Special Notice of Action or Recommended Action. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal as described below. The Hearing Committee's written decision shall be forwarded to the MEC for its information and to the Board of Directors for final action.

12.4. Appeal Rights.

1. Time for Appeal

Within 30 days after receipt of the Hearing Committee's written decision, either the Practitioner or the Body whose decision prompted the hearing may request an appellate review by the Board. Said request shall be in writing and shall be either personally delivered to the President of the Hospital or sent to the President of the Hospital by Registered or Certified United States Mail, Return Receipt Requested. The request for appellate review shall include a brief statement of the reasons for the appeal. If the appellate review is not requested within the period prescribed herein, both parties to the hearing shall be deemed to have accepted the Hearing Committee's decision and the Board may take final action on the matter.

2. Reasons for Appeal

The reasons for appeal from a hearing shall be limited to:

1. Substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny the Practitioner a fair hearing, and/or

2. Actions taken arbitrarily, unreasonably, or capriciously.

3. Time, Place and Special Notice

When appellate review is requested, the Board shall, within 30 days after the date of receipt by the President of Special Notice of such request, schedule and arrange for an appellate review. The Board shall give the Practitioner Special Notice of the time, place and date of the appellate review. The date of appellate review shall be not less than 15 days nor more than 90 days from the date of receipt by the President of the request for appellate review, provided, however, that when a request for

appellate review is from a Practitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 45 days from the date of the President's receipt of the request for appellate review. The time for appellate review may be extended, for good cause, by the Board.

4. Board Members

When an appellate review is requested, the Executive Committee of the Board of Directors shall serve as the Appeal Board. Knowledge of the matter involved shall not preclude any person from participating in an appellate review, provided that the person did not take part in a prior hearing on the same matter. For the purposes of this subsection, participating in an initial decision to recommend Adverse Action shall not be deemed to constitute participation in a prior hearing on the same matter.

5. Appellate Hearing Procedure

The proceedings shall be in the nature of an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Board may accept additional oral or written evidence, subject to a foundation showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence. The Board alternatively may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his position on appeal, and, in its sole discretion, the Board may allow each party or representative to appear personally and make oral argument. At the conclusion of oral argument, if allowed, the Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.

6. Appellate Decision

Within 15 days after the conclusion of the appellate review proceedings, the Board shall render a final decision in writing. The Board may affirm, modify or reverse the Hearing Committee's findings of fact, conclusions and recommendations, or, in its discretion, remand the matter for further review and recommendation by the Hearing Committee or any other body or person. Copies of the Board's decision shall be delivered to the Practitioner, the President of the Medical Staff, and the President of the Hospital by personal delivery or by Registered or Certified United States Mail, Return Receipt Requested or commercial overnight delivery service.

7. Further Review

Except where the matter is remanded for further review and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the Hearing Committee or any other body or person, said committee, body or person shall promptly conduct its review and make its recommendations to the Board. This further review process and the time required to report back shall not exceed 30 days

in duration, except as the Board may otherwise determine.

8. Right to One Hearing

   Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as of right to more than one hearing and one appellate review on any matter which shall have been the subject of an action or recommended action by either the MEC or the Board of Directors or both.

9. Substantial Compliance.

   Technical, immaterial, and non-prejudicial deviations from the procedures set forth in this fair hearing plan shall not be grounds for invalidating any action taken hereunder.

10. Reporting Obligations.

    It is the intent of the Hospital and the Medical Staff to comply with all State and federal laws mandating reporting of certain actions to the appropriate state licensing authority and the National Practitioner Data Bank.

ARTICLE 13

ADOPTION, AMENDMENT, FORCE AND EFFECT OF MEDICAL STAFF GOVERNING DOCUMENTS

13.1 MEDICAL STAFF BYLAWS AND CREDENTIALS MANUAL

a. **Development** -The Medical Staff has the initial responsibility to formulate, adopt and recommend to the Board of Directors the Medical Staff Bylaws and Credentials Manual, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner, in the interest of providing patient care of the generally recognized professional level of quality, safety and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

b. **Adoption, Amendment & Review**

   i. When necessary, the Bylaws, Credentials Manual, and Rules and Regulations will be revised to reflect changes in regulatory requirements, Hospital policies, and current practices with respect to Medical Staff organization and functions.

   ii. Neither the Medical Staff, MEC nor the Board may unilaterally amend the Medical Staff Bylaws or Credentials Manual.

   iii. Adoption or amendment may not be delegated to the MEC by the Medical Staff. The Medical Staff must be included in the process pursuant to this Section.

c. **Medical Staff** -- The Medical Staff Bylaws and Credentials Manual may be amended, adopted, or repealed by a 2/3 vote of the medical staff at a meeting where a quorum is present. The Medical Staff must be given 15 business days written notice of the proposed Bylaws changes, either by mail or electronic means. Any action to revise such documents requires the approval of the Board.

The voting members of Medical Staff have the right to propose amendments to the Bylaws or Credentials Manual at any meeting of the Medical Staff. Such proposals must then be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process set forth in these Medical Staff Bylaws may be implemented.

d. **Board** -- The Medical Staff Bylaws and Credentials Manual may be adopted, amended or repealed by the affirmative vote of a majority of the Board. Should the Medical Staff fail to exercise its responsibility and authority as required and after notice to the Medical Staff and a reasonable response time, the Board may resort to its own initiative in formulating or amending such documents. In such event, the Board shall take staff recommendations and views into account during its deliberations. If necessary, the conflict resolution process will be initiated.

13.2 MEDICAL STAFF RULES AND REGULATIONS

a. **Adoption and Amendment**

i. Subject to the approval of the Board, the Medical Executive Committee may adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as to the level of practice that is to be required of each practitioner or APP in the Hospital.

ii. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed, without previous notice, at any regular meeting of the Medical Executive Committee at which a quorum is present, or with prior notice at any special meeting by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

i. The voting members of Medical Staff have the right to propose amendments to the Rules and Regulations at any meeting of the Medical Staff. Proposals must then be communicated to the MEC for any action. If there is a conflict between the MEC and the Medical Staff, the conflict resolution process of these Bylaws may be implemented.

iii. The Medical Staff, MEC or the Board cannot unilaterally amend the Medical Staff Rules and Regulations. Rules and Regulations may only be amended with the approval of the MEC and the Board.

b. Review - The Medical Staff Rules and Regulations shall be reviewed periodically, as determined by the Medical Staff, and shall be revised as necessary to reflect changes in regulatory requirements, Hospital policies, and current practices with respect to Medical Staff organization and functions.

13.3 DEPARTMENTAL RULES AND REGULATIONS

a. Subject to the review of the Medical Executive Committee and approval by the Board, each department may formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations must be consistent with these Bylaws, the general Rules and Regulations of the Medical Staff and other policies of the Hospital.

b. The voting members of Medical Staff have the right to adopt or amend Departmental Rules and Regulations at any meeting of the Medical Staff. Proposals must then be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process of these Medical Staff Bylaws may be implemented.

c. Departmental Rules and Regulations shall be incorporated into the general Medical Staff Rules Regulations.

d. Adoption and amendments, review, and Board processes described for Medical Staff Rules and Regulations will apply to Departmental Rules and Regulations after a simple majority vote by voting members of the applicable Department. Urgent amendments may be made as set forth in these Bylaws.

e. The Medical Staff, MEC or the Board cannot unilaterally amend the Departmental Rules and Regulations.

13.4. SUSPENSION, SUPPLEMENTATION OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Medical Staff Bylaws or Medical Staff Rules and Regulations (including Department Rules and Regulations) in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of care to patients. However, should the Board so suspend, override, supplement or replace such Bylaws or Rules and Regulations, it shall consult with the MEC or the Medical Staff at their next regular meetings (or at a specially called meeting as provided in these Bylaws), and shall thereafter proceed as provided in these Bylaws for amendment and adoption of Bylaws and Rules and Regulations provisions.

13.5. DOCUMENTATION & DISTRIBUTION

a. Amendments to the Bylaws, Credentials Manual, and Rules and Regulations shall be documented by issuance of a new version, reflecting the dates of approval by the MEC and the Board of Directors. The revised version, as adopted, will be signed by the President of the Medical Staff, the Hospital President, and the Chair of the Board of Directors.

b. A copy of the current versions of the Bylaws, Credentials Manual, and Rules and Regulations will be made available to any Member of the Medical Staff upon request.

13.6. FORCE AND EFFECT

Each Member of the Medical Staff shall abide by these Medical Staff Bylaws, Credentials Manual, and

Rules and Regulations, as may be amended from time to time and including all documents incorporated by reference herein, and by any policies and procedures promulgated hereunder, as well as any applicable Hospital policies and procedures.

ARTICLE 14
GENERAL PROVISIONS

14.1 CONFLICT RESOLUTION

a. **Board and MEC and/or Medical Staff**

i. Whenever there is a conflict between the Board and the MEC or the Board and the Medical Staff, a Joint Conference will be convened.

ii. The Joint Conference will consist of an equal numbers of Medical Staff and Board members if the conflict is between the Board and the Medical Staff.

iii. If the conflict is between the Board and the MEC, the Joint Conference will consist of an equal number of MEC and Board members.

b. **MEC and Medical Staff** – Whenever there is a conflict between the MEC and the Medical Staff, including but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto affecting the elements required by the Joint Commission to be included in the Medical Staff Bylaws, the Medical Staff or MEC may request a Joint Conference consisting of the MEC and an equal number of Medical Staff members as selected by the Medical Staff. Board members may be invited to attend the Joint Conference, if agreed upon by the MEC and Medical Staff Members attending the Joint Conference.

c. **Conflict Management Process -** The involved parties will meet as early as possible to identify and clarify the conflict and attempt to resolve the issue through direct communication between the groups. A facilitator may be utilized if agreed upon by both sides.

Addendums to Medical Staff Bylaws

- Credentialing Manual
- Medical Staff Rules and Regulations
- All Medical Staff Policies and Procedures

These Bylaws of the Medical Staff were last revised and approved by the Medical Staff on October 17, 2021 and were approved by the Board of Directors on November 1, 2021.

Review: September 1990
August 1991
September 1991
October 1994
August 1995
August 1998
February 2000
June 2000
April 2003
February 2006
December 2008
October 2009
December 2011
September 5, 2015
September 2017