Bylaws of the Medical Staff of White Oak Medical Center

Approved by the Governing Board:
July 15, 2014

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BYLAWS OF THE MEDICAL STAFF OF WHITE OAK MEDICAL CENTER

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1. ARTICLE ONE: DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

1.1. DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including the Hospital President, Vice President-Operations, Chief Financial Officer (CFO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and Associate Vice President of Quality and Patient Care.

Advanced Practice Professional (APP): An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs are designated by the Governing 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. APPs are not eligible for Medical Staff membership. The Governing Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), certified registered nurse practitioners (CRNP) and Surgical Assistants (SA).

Applicant: An individual who has submitted a complete application for appointment, reappointment or clinical privileges.

Board Certification or Board Certified: A designation for a Physician or other Practitioner 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 and has maintained certification as appropriate. The appropriate board certification shall be determined by the Department to which the Practitioner is assigned.

Board Certification Candidate: A Practitioner who has successfully completed a residency or fellowship program for the Practitioner's specialty and who is able to provide proof that he/she is an active candidate for Board Certification in accordance with the requirements of the applicable Department.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Clinical Privilege/Privilege: The permission granted by the Governing Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, psychological, dental, or podiatry services in the Hospital. Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or employment.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation and has a current, unrestricted license to practice dentistry.

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license and in accordance with a Hospital-approved scope of practice.

Executive Committee/Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

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

Fair Hearing Plan: The fair hearing plan as approved by the Medical Executive Committee and the Governing Board and incorporated into these Bylaws and the Hospital's corporate bylaws.

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 health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program, TriCare and the Veterans programs.

Governing Board/Board: The Governing Board of the Hospital, as defined in the Hospital's corporate bylaws.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

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.

Hospital: Adventist HealthCare, Inc. d/b/a White Oak Medical Center. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

Hospital President: The chief administrative officer of the Hospital or his/her designee.

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

License Status: Indicates the status of the practitioner's license, which is issued by the State licensure board. The categories defined by the State board are:

- active—full and unrestricted license to practice
- inactive—practitioner is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits practice
- restricted—board imposed limitation on practice
- suspended—board prohibits practice for a period of time as specified by the board

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

Medical Staff: The Medical Staff is the term referring to the Practitioners designated by the Governing Board to be eligible for Medical Staff membership and who are credentialed to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are Physicians, maxillofacial/oral surgeons, dentists, and podiatrists. The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

Medical Staff President: A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The Medical Staff President shall be a doctor of medicine or osteopathy.

Medical Staff Services: The Hospital employees assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Services responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Services is accountable to Administration. The documents maintained by the Medical Staff Services are the property of the Hospital.

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

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

Membership: The approval granted by the Governing Board to a qualified Practitioner to be a Member of the Medical Staff of the Hospital.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

Peer Review: The concurrent or retrospective review of an individual‘s behavior and performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice. With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action.

Podiatrist: A doctor of podiatric medicine legally authorized to practice podiatry by the State in which he performs such function or action.

Practitioner: An individual who is permitted by both the applicable state law(s) 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. The Governing Board has determined that the categories of individuals eligible for clinical privileges as a Practitioner are Physicians, maxillofacial/oral surgeons, dentists and podiatrists

Proctor: The proctor who is designated by the Medical Staff and is responsible to the Medical Staff in assessing clinical skills in this Hospital.

Proctoring: The process of objectively evaluating a Practitioner’s actual clinical skills in providing patient care in this Hospital.

Rules and Regulations: The Rules and Regulations of the Medical Staff, including those of its Departments and Sections, if applicable, as approved by the Medical Executive Committee and the Governing Board.

Section: A clinical sub-grouping of members of a Medical Staff Department in accordance with their subspecialty or specialized practice interest, as specified in these Bylaws.

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

State: Unless context indicates otherwise, the State of Maryland.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services. Any person providing telemedicine services to Hospital patients must be appropriately licensed in the State.

Unprofessional or Inappropriate Conduct: Conduct that adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a hostile work environment for Hospital employees or other individuals working in the Hospital, or begins to interfere with the individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

1.2. CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and the Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

2. ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES

2.1. NAME

The name of the Medical Staff shall be the Medical Staff of White Oak Medical Center.

2.2. PURPOSES AND RESPONSIBILITIES

The purpose and responsibilities of the Medical Staff are:

2.2.1. To provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Governing Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.

2.2.2. To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

2.2.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.

2.2.4. To serve as a primary means for accountability to the Governing Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard 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.

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

2.2.6. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;

2.2.7. To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;

2.2.8. To provide a means for communication and conflict management with regard to issues of mutual concern to the Staff, Administration, and the Governing Board,

2.2.9. To participate in identifying community health needs and establishing appropriate institutional goals;

2.2.10. To assist the Governing Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.

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

2.2.12. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies.

2.2.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.

2.3. ORGANIZED HEALTH CARE ARRANGEMENT; HIPAA COMPLIANCE.

2.3.1. The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital‘s Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians’ offices for purposes of 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, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives and Dependent Healthcare Professionals. Each Medical Staff member, each Physician with temporary, emergency or disaster relief privileges, Advanced Practice Professional with clinical privileges or practice prerogatives and Dependent Healthcare Professional agrees to comply with the Hospital‘s policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

3. ARTICLE THREE: APPOINTMENT/REAPPOINTMENT

3.1. NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care independently within the Hospital, and whom the Governing Board appoints. Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws.

3.1.1. GENERALLY. Patients may be admitted to the Hospital only on the orders of a Physician. All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Governing Board, and who shall be working within the scope of those granted privileges.

Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Governing Board based on their approval of the individual's Staff category or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Governing Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Governing Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations and Policies. Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants.

3.1.2. LICENSURE. The applicant must possess a current, active (as defined in these Bylaws)license in the State of Maryland for the practice of medicine, dentistry, podiatry or as an Advanced Practice Professional. If the applicant is a telemedicine provider located in a different state, the applicant must possess licensure in the state of Maryland. The applicant shall also be required to provide information related to any current or past licensure as a healthcare professional in any other States.

3.1.3. CONTROLLED SUBSTANCE REGULATION. To have prescribing privileges for controlled substances, the applicant must possess a current Maryland CDS permit and a federal Drug Enforcement Administration (DEA) registration for the State of Maryland. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and State and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the applicant. Pathologists and Diagnostic or Tele-Radiologists need not have prescribing privileges.

3.1.4. PROFESSIONAL EDUCATION AND TRAINING. The applicant must have graduated from a School of Medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, or a School of Dentistry accredited by the Commission on Accreditation of the American Dental Association, or a School of Podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or other accredited school appropriate to his/her profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school. An applicant Practitioner must also have successfully completed a residency program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) for allopathic physicians or AOA for osteopathic physicians, or that is accredited by the American Dental Association for dentists, or that is accredited by the Council

on Podiatric Medical Education for podiatrists, and the residency must be in the field of specialty for which the Practitioner requests clinical privileges.

3.1.5. CURRENT COMPETENCE, EXPERIENCE AND JUDGEMENT. The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Governing Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peer and professional references, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, peer and/or professional references and recommendation(s) provided by the Section or Department Chair(s).

3.1.6. BOARD CERTIFICATION. An applicant Practitioner must demonstrate current Board Certification, or provide proof of being a Board Certification Candidate. All applicants must achieve and maintain board certification in the specialty in which they are practicing no later than five (5) years after initial appointment. Any Member in good standing as of June 18, 2014 is deemed to have met applicable Board Certification requirements.

3.1.7. CONDUCT/BEHAVIOR. The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peer and professional references, the peer review process, and other facility affiliations; in addition, the applicant shall cooperate with a team approach to caring for patients and will communicate effectively with team members. Applicants must also cooperate with the peer review, quality assurance, and credentialing processes. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Section and Department Chair(s).

3.1.8. PROFESSIONAL ETHICS AND CHARACTER. By virtue of applying for medical staff membership or clinical privileges, and agreeing to abide by the Medical Staff Bylaws, the applicant shall be bound to adherence to the code of ethics of his/her professional discipline (e.g., the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant‘s practice if it is not listed). The applicant shall also agree to abide by the code of ethical business and professional behavior of this Hospital.

3.1.9. HEALTH STATUS/ABILITY TO PERFORM. The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental health issue that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Medical Staff President. Upon receipt of such notification, the Medical Staff President will meet with the applicant to determine the extent of the health issue. If it is determined that their health issue has the potential to adversely affect the applicant‘s ability to perform the essential functions of the clinical privileges requested, the Medical Staff President and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

3.1.10. COMMUNICATION SKILLS. The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients’ medical records, shall be recorded in a legible fashion, in English.

3.1.11. PROFESSIONAL LIABILITY INSURANCE. The applicant shall maintain professional liability insurance coverage, either through an insurance carrier authorized by the State of Maryland as a licensed provider of

professional malpractice insurance or by a program of insurance that is deemed adequate by the Hospital administration. Such coverage must extend to the clinical privileges requested by the applicant and must have limits of at least $1,000,000 for each claim and $3,000,000 in aggregate. The applicant shall agree to notify the Medical Staff Service office when their carrier cancels or does not renew for any reason a claims-made policy and that he/she will purchase the tail coverage or show proof that the new carrier is providing prior acts coverage. An applicant for Medical Staff membership only, with no clinical privileges, is not required to provide proof of professional liability insurance coverage.

3.1.12. ELIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS. The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person, as defined in these Bylaws, during the term of an appointment or granting of clinical privileges.

3.1.13. CRIMINAL ACTIONS. No individual shall be eligible for or continue to hold medical staff membership or clinical privileges when the individual has a conviction or a plea of guilty, no contest, and/or a debarment from any federal payor program (e.g., Medicare, Medicaid). Any applicant with any other type of criminal action or conviction shall be evaluated on an individual basis.

3.2. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Governing Board may decline to accept, or have the Staff review requests for Staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

3.2.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES. Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.

3.2.2 EXCLUSIVE CONTRACTS. The Governing Board may determine, in the interests of quality of patient care and as a matter of policy, that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners or professional service entities.

3.2.3 MEDICAL STAFF DEVELOPMENT PLAN. The Governing Board may decline to accept applications based on the requirements or limitations in the Hospital‘s Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.

3.2.4. EFFECTS OF DECLINATION. Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

3.3. EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a Member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.

3.4. NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.

3.5. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

3.5.1. Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant‘s performance;

3.5.2. Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a Member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with any consultation policies of the Medical Staff as set forth in the Rules and Regulations;

3.5.3. Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital;

3.5.4. Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant‘s professional practice;

3.5.5. Regularly attend meetings of the Medical Staff unless excused.

3.5.6. Discharge such Medical Staff, Department, Section, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff;

3.5.7. Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital;

3.5.8. Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

3.5.9. Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;

3.5.10. Participate in continuing education to maintain clinical skills and current competence.

3.5.11. Notify and update the Medical Staff and Hospital immediately (generally within five business days) upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations and Policies outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);

3.5.12. Agree that the Hospital or Medical Staff may obtain an evaluation of the applicant‘s performance by a consultant selected by the Medical Staff if the Hospital or Medical Staff considers it appropriate;

3.5.13. Maintain reasonable proficiency in the technology used by the Hospital in caring for its patients and maintaining its medical records; and,

3.5.14. Perform such other responsibilities as the Hospital or the Medical Staff may require.

3.6. TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges will be for a period of up to two years (24 months). Reappointments will be for a period not to exceed two years (24 months). In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender or expiration of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

3.7. CREDENTIALS VERIFICATION

3.7.1 APPLICATION. A separate credentials file will be maintained for each potential applicant for Staff membership or clinical privileges, although the Hospital may use a file that is maintained for each applicant within the Adventist HealthCare system. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in a prescribed format, and signed by the applicant. When an individual seeks to apply for initial appointment or is initially requesting clinical privileges, he/she shall be asked to complete an application. When a completed application is received, the information shall be verified by a process used by the Medical Staff Services office to determine whether the individual is eligible to apply. Prior to expiration of the current term of membership or clinical privileges for an individual who is a Member of the Medical Staff or who currently holds clinical privileges, the individual should be notified of the impending expiration and asked to complete an application for reappointment. When a completed application for reappointment is received, the information shall be verified by the Medical Staff Services office to determine whether the individual is eligible to reapply.

Adventist HealthCare, Inc. ("AHC"), and its subsidiaries and related entities, use a common credentialing verification and quality assurance system. By submitting an application for Medical Staff membership and/or clinical privileges, all Practitioners consent to their credentialing and quality information at each facility being entered into these systems, which will cause their credentialing and quality assurance information to be shared among all AHC entities, including but not limited to Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare White Oak Medical Center, Adventist Rehabilitation Hospital and Adventist HealthCare.. Verification of credentials may be conducted through this common system, although privileges at each facility will be determined by that facility.

3.7.2. BURDEN ON APPLICANT. The potential applicant or applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer and professional references, or other facilities is submitted directly to the Medical Staff Services office by such sources. The Medical Staff Services office shall not have any obligation to process any application for appointment or reappointment unless the application is complete, as defined by its policies and these Bylaws, and after a time limit defined in its policies, determine that there has been failure to comply and end efforts to process the application. Applications with misrepresntations or ommissions will not be processed. Only after a completed application has been received and all information verified, as specified by the Medical Staff, and the individual has been deemed eligible to apply, shall the Medical Staff Services office deem the application suitable for further evaluation by the Medical Staff. The Hospital shall analyze the information and determine whether additional information or investigation is needed to resolve any doubts, concerns, or gaps in the information. The applicant shall provide accurate, up-to-date information, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further

processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. Any Medical Staff committee or the Governing Board may request that the applicant appear for an interview with regard to the application. The Medical Staff Services Office shall notify the applicant , in writing,of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Neither the Medical Staff nor the Governing Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. Failure to provide a complete application, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Services Office shall provide, in writing,a statement to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The completed application shall include, without limitation:

3.7.2.1. Identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification shall be performed by the staff of Medical Staff Services prior to the provider treating their first patient.

3.7.2.3. For a new applicant, written permission for verification of the application, which may include a background check, as appropriate.

3.7.2.4. Evidence of current licensure in the State of Maryland and information from the applicant regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;

3.7.2.5. For applicants requesting medication prescribing privileges, evidence of a Federal DEA registration for Maryland, and Maryland controlled substance permit;

3.7.2.6. For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;

3.7.2.7. The names of at least two references, one (1) peer and one (1) professional in a leadership capacity, who will provide an evaluation of the applicant‘s medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested. ;

3.7.2.8. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;

3.7.2.9. Information regarding all current and past healthcare facility affiliations for the past five (5) years, including the name and address of the facility(s) and dates of affiliation;

3.7.2.10. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;

3.7.2.12. Medicare Provider NPI for the individual provider (e.g., not a NPI for a group practice);

3.7.2.13. Information as to any current or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the applicant to become an Ineligible Person, as well as any sanctions from a professional review organization;

3.7.2.14. Accurate and complete disclosure with regard to the following queries:

3.7.2.14.1. Whether the applicant's professional license or controlled substance registration (DEA for Maryland and Maryland CDS), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;

3.7.2.14.2. Whether the applicant has had any voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another hospital or other healthcare facility;

3.7.2.14.3. Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,

3.7.2.14.4. Whether the applicant has ever been subject to a criminal action, as defined in these Bylaws, or whether any such action is pending.

3.7.2.15. A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Section 3.1.9;

3.7.2.16. Evidence that the applicant has complied with the health screening and immunization requirements of the Hospital.

3.7.2.17. A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted, and that the applicant allows the applicant's credentialing and quality assurance information to be shared within the Adventist HealthCare system;

3.7.2.18. A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;

3.7.2.19. A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 3.1.9, and for a new applicant a permission to conduct a background check, and a statement providing absolute immunity and release from civil liability for all individuals, including Medical Staff members, requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

3.7.2.20. A statement from the applicant consenting to the release of information and providing absolute immunity and release from civil liability to all individuals providing information relative to the applicant's professional qualifications or background in association with future requests received by the Hospital from other healthcare organizations authorized to request such information.

3.7.2.21. A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.

3.7.2.22. All physicians, other Practitioners, and Advanced Practice Professionals shall sign a Confidentiality and Security Agreement at the time of application for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership

or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.

3.7.2.23. Unless the applicant is applying for medical staff membership only, all applications must include a specific written request for clinical privileges using prescribed forms. Requests for clinical privileges 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 each of the privileges requested.

3.7.2.24. As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to immediately provide (within one business day of being officially notified of a change in status) to the Medical Staff and the Hospital, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status for Maryland or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a quality improvement organization citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any involuntary payer contract termination, any change in health status that may affect the ability to perform the privileges requested, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care. Further, within seven business days, an applicant will provide notice of any change in location of his/her office and, within 30 days, notice of any change in his/her residential address.

3.7.2.25 Failure of an individual to provide information pertaining to that individual's qualifications for Medical Staff membership or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Hospital President, or any other committee authorized to request such information within a timeframe specified in the written request, may result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

3.7.2.26 All applications, including necessary attestations, must be completed within 120 days of their initial submission to Medical Staff Services. Any application that is not completed within such time will be deemed to be voluntarily withdrawn by the applicant, whereupon the applicant may reapply as an initial applicant, which will include, but not be limited to the submission of a new application and new application fee.

3.7.3. APPLICATION PROCESSING. After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:

3.7.3.1. Department Report: The Medical Staff Services shall make available the application and all supporting materials to the Chair of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the Section to be assigned if appropriate to the applicant's practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chair, the Medical Staff President or the Department Vice-Chair shall make the evaluation and recommendations. Following the Department Chair's evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.

3.7.3.2. Credentials Committee Report: The Credentials Committee shall receive from the Department Chair and review the completed application, supporting materials, the report of the Department Chair, and any such other available information as may be relevant to the applicant‘s qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report.

3.7.3.3. Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Department Chair, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chair, Credentials Committee, Medical Executive Committee or Governing Board. Criteria for additional inquiry are:

3.7.3.3.1. Inability to verify any of the information or credentials represented in the application;

3.7.3.3.2. Any unexplained gaps in medical staff membership, clinical privileges and/or work history;

3.7.3.3.3. Any other inconsistent or less than favorable information about the applicant‘s professional qualifications, competence or character, as judged by the Department Chair, Credentials Committee, Medical Executive Committee or Governing Board.

3.7.3.4. Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials, the reports of the Department Chair and the Credentials Committee, and any such other available information as may be relevant to the applicant‘s qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Governing Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Governing Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report.

3.7.3.5. Effect of Medical Executive Committee Recommendation

3.7.3.5.1. Deferral: The Medical Executive Committee may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the Medical Executive Committee to defer the application for further consideration shall state the reasons for deferral; provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee, Department Chair, or other designee, as deemed appropriate by the Medical Executive Committee.

3.7.3.5.2. Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Governing Board for action. The Governing Board may take immediate action on the application in accordance with the Governing Board's procedures, which may include delegating approval of such actions to a credentialing subcommittee of the Governing Board.

3.7.3.5.3. Adverse Recommendation: If the recommendation of the Medical Executive Committee is adverse under Article Seven of these Bylaws, the Medical Staff President shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Governing Board until after the applicant has exercised or waived such rights.

3.7.3.6. Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Governing Board shall act on the application at its next regular meeting following receipt of the recommendation from the Medical Executive Committee. The action of the Governing Board shall be taken at the next meeting after receiving a recommendation from the Medical Executive Committee.

3.7.3.6.1. If the Governing Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

3.7.3.6.2. If the Governing Board does not adopt the recommendation of the Medical Executive Committee, the Governing Board may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Governing Board, or the Governing Board may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Governing Board. If the Governing Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

3.7.3.6.3. If the action of the Governing Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Governing Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Governing Board shall take final action.

3.7.3.6.4. All decisions to appoint shall include a delineation of clinical privileges, the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified, along with the decision of the Governing Board's final action.

3.7.3.6.5. Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through Medical Staff Services office to the applicant within 15 days after the final decision. In the event a hearing and/or appeal was held, Article Seven shall govern notice of the Board's final decision.

3.7.4. All applications not acted upon within 275 days of their initial submission to Medical Staff Services (including by final action by the Governing Board) will be deemed to be voluntarily withdrawn, whereupon the applicant may reapply as an initial applicant, which includes, but is not limited to, the submission of a new application and new application fee.

3.8. CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension actions as provided in these Bylaws and shall be reported to the Credentials Committee:

3.8.1. Current licensure;

3.8.2. Drug Enforcement Administration and authorization from the State of Maryland for prescribing licensed independent practitioners.

3.8.3. Professional liability insurance in the amount specified in these Bylaws;

3.8.4. Specialty board certification, if required for membership or any of the clinical privileges granted;

3.8.5. Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,

3.8.6. Eligibility to participate in the Federal Health Care Program. (The OIG Sanction Report, the GSA List and the State Exclusion List shall be checked according to the frequencies defined by hospital policy.)

3.9. ELIGIBILITY FOR REAPPOINTMENT

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

3.9.1. Completed all medical records in accordance with Hospital policy;

3.9.2. Completed all continuing medical education requirements to comply with applicable privileging requirements;

3.9.3. Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

3.9.4. Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,

3.9.5. For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application shall be considered complete and processed further.

3.10. EXPIRATION OF CURRENT APPOINTMENT

3.10.1. If an application is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then-current term of appointment. Only after a complete application is received shall an individual be considered for reappointment or renewal of clinical privileges.

3.10.2. If an application for reappointment is submitted timely, but the Governing Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. The Board may subsequently grant reappointment and renewal of clinical privileges.

3.10.3. If an application for reappointment is not submitted within 30 days of the expiration of the last term of appointment, the applicant must submit an application as an initial applicant.

3.11. ASSISTANCE WITH EVALUATION

The Governing Board, the Medical Executive Committee, the Hospital President, or any committee authorized to review or evaluate applications for Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:

3.11.1. Obtain the assistance of an independent consultant or others to evaluate the healthcare professional being subject to review;

3.11.2. Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;

3.11.3. Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

3.11.4. Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

3.11.5. Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

3.12. PROFESSIONAL PRACTICE EVALUATION

The Governing Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Governing Board shall direct and enforce the establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include ongoing professional practice evaluation through the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospital‘s Performance Improvement Plan.

The Medical Staff measurement, analysis and improvement activities used in ongoing professional practice evaluation shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff Member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and profiling established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and departments of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity, including but not limited to the federal Health Care Quality Improvement Act.

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual‘s professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual‘s clinical performance shall also be included. The Hospital may use epidemiological and statistical methods to compare practice patterns of individuals on dimensions of cost, service use, or quality (including process and outcome) of care. The Hospital may consider resource consumption and quality of care by an individual through an examination of patterns of health care delivery. Profiles may be constructed for individuals or groups of individuals based on Hospital, geographic, specialty, and type of practice or other characteristics. Performance profiles, including the results of performance based measures such as patterns of

treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and profiles may include, but are not limited to, clinical and other information regarding each individual's:

3.12.1. Quality and appropriateness of patient care, including patient care outcomes;

3.12.2. Review of operative and other clinical procedures performed and their outcomes;

3.12.3. Patterns of blood and pharmaceutical usage;

3.12.4. Requests for tests and procedures;

3.12.5. Length of stay patterns;

3.12.6. Morbidity and mortality data;

3.12.7. Practitioner's use of consultants;

3.12.8. Performance as related to Healthcare Quality Alliance (HQA) core measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, data about Hospital Acquired Conditions (HAC), and other publicly-reported evidence-based performance measures;

3.12.9. Malpractice and professional liability experience;

3.12.10. Utilization of Hospital resources and facilities;

3.12.11. Timely, legible and accurate completion of patient medical records;

3.12.12. Professional conduct;

3.12.13. Attendance and participation in Medical Staff committee and Department meetings;

3.12.14. Attainment and maintenance of board certification;

3.12.15. Maintenance of required levels of professional liability insurance coverage;

3.12.16. Attainment of continuing education requirements; and,

3.12.17. Attribution to sentinel events, medical errors or other risk occurrences.

The Governing Board shall be responsible for assuring the use of clinical and other measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assessment shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assessment process.

Medical staff members and other individuals with clinical privileges are required to participate in all aspects of Medical Staff activities designed to verify the individual's ongoing qualifications and competency. If at any time a Medical Staff member or other individual with clinical privileges fails to provide required information pursuant to a formal request by the Credentials Committee, Medical Executive Committee, or the Hospital President, the individual's clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party, without the individual having a right to a hearing or appeal. For purposes of this section, "required information" shall refer to (1) physical or mental examination reports as specified elsewhere in these Bylaws, or (2) information from another healthcare facility or agency. If voluntary relinquishment of clinical privileges occurs while the individual is subject to an investigation, this will be reported in accordance with the requirements of State and federal law.

3.13. INITIAL STATUS AND PRACTICE EVALUATION

The Medical Staff shall have a process to evaluate the privilege-specific competence of a Practitioner who does not have documented evidence of performing the requested privilege(s) at the Hospital. This process may also be used when a question arises regarding a currently privileged Practitioner‘s ability to provide safe, high quality patient care. This process of focused professional practice evaluation shall be a time-limited period during which the Medical Staff evaluates and determines the Practitioner‘s professional performance. Focused professional practice evaluation may entail the use of one or more types of evaluation, including but not limited to chart review, monitoring of clinical practice patterns, simulation, clinical proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel). Clinical proctoring is an objective evaluation of an individual‘s actual clinical competence by a monitor or proctor who is responsible to the Medical Staff. When an initial applicant seeks clinical privileges, or an individual with existing clinical privileges seeks new privileges, or when the Medical Staff requires the individual‘s actual clinical competence to be evaluated for any other reason, the individual’s competency will be assessed, which may include proctoring or observation for the Privileges being evaluated. In most instances, proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, and are responsible to the Medical Staff.

3.13.1. For initial appointment/initial clinical privileges: At the time of initial appointments and initial granting of clinical privileges for an existing member of the Medical Staff, the Medical Staff shall determine a plan for conducting focused professional practice evaluation. The evaluation plan shall include method(s) and the time period of evaluation, based on the recommendation of the applicable Department, and may be subject to an extension of time for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges, including for an existing member of the Medical Staff. Each individual subject to privilege status may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chair of the Department to which the individual is affiliated.

3.13.2. For individuals with existing privileges who are requesting new privileges: A period of focused Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chair of the Department to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials Committee, the Medical Executive Committee, and the Governing Board shall have the option of specifying requirements for other evidence of competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. The individual requesting new privileges shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the new clinical privileges being requested. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual‘s actual clinical competence for the new clinical privileges granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual‘s performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual‘s Department Chair shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Governing Board.

3.13.3. For evaluating clinical competence for privileges previously granted: Medical Staff members or other individuals with existing clinical privileges who are identified for review of actual clinical competence may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chair of the Department to which the individual is affiliated. Focused professional practice evaluation may be indicated as the result of QA/PI, peer review or patient safety information, or due to inactivity with clinical privileges granted, or due to return from a leave of absence. The individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department

as appropriate to the clinical privileges subject to review. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's actual clinical competence for the clinical privileges subject to review. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual's Department Chair shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Governing Board.

3.13.4. Duties of Individuals with Privileges

3.13.4.1. During the initial evaluation period, a Practitioner must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Department Chair or other designated observers.

3.13.4.2. If a new member of the Medical Staff or other individual with clinical privileges fails, during the initial evaluation period, to:

3.13.4.2.1. Participate in the required number of cases;

3.13.4.2.2. Cooperate with the monitoring and observation conditions; or

3.13.4.2.3. Fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities, the individual's Medical Staff appointment and the clinical privileges shall be automatically relinquished at the end of the initial evaluation period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for initial appointment or privileges for two years.

3.13.4.3. If a member of the Medical Staff who has been granted additional clinical privileges or other individual granted additional clinical privileges fails, during the initial evaluation period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the initial evaluation period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two years.

3.13.4.4. If a member of the Medical Staff or other individual with clinical privileges who has been in a initial evaluation period for an evaluation of competence fails to participate in the required number of cases or cooperate with the monitoring and observation conditions, the clinical privileges under review shall be automatically relinquished at the end of the initial evaluation period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two years.

3.13.4.5. When, based on the evaluation performed during the initial evaluation period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

3.14. CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

3.14.1. Recommendations for appointment, reappointment, initial granting of privileges and/or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute a disciplinary action or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Seven of these Bylaws.

3.14.1.1. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.

3.14.1.2. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Six of these Bylaws shall commence.

3.14.1.3. If the individual refused to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed as part of a conditional appointment, reappointment, or privileges, then corrective actions as set forth in Article Six of these Bylaws shall commence.

3.14.2. Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Seven of these bylaws.

3.14.3. In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.

3.14.4. To end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment and privileging procedures.

3.15. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an application is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the individual as unacceptable for processing. If an application is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that permanently disqualify the applicant for membership, as has been so designated by prior action of the Governing Board, then the application shall be returned to the individual as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

3.16. MEDICO-ADMINISTRATIVE OFFICERS

3.16.1. A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

3.16.2. All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall delineate the clinical privileges of Medico-Administrative officers who request to admit and/or treat patients.

3.16.3. In the event a Practitioner who is employed by or has contracted with the Hospital, or otherwise serves in a Medico-Administrative position pursuant to a contract, is subject to removal from office through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws. Pursuant to any specific provisions of the contract, adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract will control.

3.17. INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.17.1. Practitioners providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or an agreement may be imposed. The Medical Staff, as in the case of other Practitioners, shall recommend the clinical privileges to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement.

3.17.2. The terms of any written contract between the Hospital and a Contract Practitioner or Contractor will take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract will control.

3.18. LEAVE OF ABSENCE

A Medical Staff Member or Advanced Practice Professional (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Medical Staff President. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and includes the reasons for the request. The Medical Executive Committee shall review and recommend leave of absence requests to the Governing Board, but in extenuating circumstances such as military leave, the Hospital President and/or Medical Staff President shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Governing Board. During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities (e.g., meeting attendance, committee service, and emergency service call obligations) shall be in abeyance. When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff Member or APP requesting the leave. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records. Exceptions shall be allowed only in the event that a Medical Staff Member or APP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

3.18.1. MEDICAL LEAVE OF ABSENCE. Members of the Medical Staff and APPs must report to the Medical Staff President any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. A Medical Staff Member or APP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue (as defined in Section 3.20 below). If an individual is

unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Chair of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action.

3.18.2. MILITARY LEAVE OF ABSENCE. Medical Staff Member or APP may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members or APPs who are on active military duty for more than one year will be afforded an automatic extension of their leave of absence until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.18.3. EDUCATIONAL LEAVE OF ABSENCE. A Medical Staff Member or APP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.

3.18.4. PERSONAL/FAMILY LEAVE OF ABSENCE. A Medical Staff Member or APP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor) or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

3.18.5. REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE.

3.18.5.1. The Medical Staff Member or APP on leave of absence must request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written notice to the Medical Staff President. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, or if changes have occurred, a detailed description of the nature of the changes. The Staff Member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the section of these Bylaws addressing practitioner health issues. If the leave of absence has extended past the Practitioner's or APP's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. The Medical Staff President will forward the request for reinstatement to the individual's Department Chair for a recommendation. The Department Chair shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Governing Board for approval. In acting upon a request for reinstatement, the Governing Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Section 5.2.4. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.18.5.2. Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Medical Staff

President and the Hospital President. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

3.18.5.3. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, this will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

3.18.6. FAILURE TO REQUEST REINSTATEMENT. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff Member or APP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for reappointment.

3.19. RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to the Medical Staff Services office. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner‘s or APP‘s Department Chair, the Medical Executive Committee, and the Board shall review letters of resignation. If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration. The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board and to the National Practitioner Data Bank, as required by federal law and state law.

3.20. PRACTITIONER HEALTH ISSUES

This section of the Bylaws applies to all individuals who provide patient care services in the Hospital and who have been granted clinical privileges. The Hospital and its Medical Staff are committed to providing quality care, which can be compromised if an individual with clinical privileges is suffering from a health issue. "Health issue" means any physical, mental, or emotional condition, or personality disorder, including alcohol or substance abuse, cognitive deterioration or loss of motor skills due to the aging process, and use of prescription medications, which could adversely affect an individual's ability to practice safely and competently. It also includes a contagious disease which could compromise patient safety or jeopardize other health care workers. The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges, for the purpose of facilitating the timely recognition and reporting of health issues. It is the policy of the Hospital to properly investigate and act upon concerns that an individual who is a Member of the Medical Staff or who has clinical privileges has a health issue. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).

3.20.1. SELF-REPORTING. During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff Member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.

3.20.1.1. A written report shall be given to the Hospital CMO, the Medical Staff President, the Chair of the individual‘s Medical Staff Department, and/or the Chair of the Credentials Committee. The

recipient of the report shall submit it, along with a written request to investigate, to the Credentials Committee, or the Practitioner Health Committee.

3.20.2. THIRD PARTY REPORTS. If a Medical Staff Member, Advanced Practice Professional, or Hospital employee witnesses symptoms of a health issue, they should report the incident. Patients, family members, or others who witness symptoms of a health issue shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting symptoms of a health issue shall be kept strictly confidential. Medical Staff members and others, as appropriate, shall be educated about recognition of health issues specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

3.20.2.1. An oral or, preferably, a written report shall be given to the Hospital Chief Medical Officer, the Medical Staff President, the Chair of the individual's Medical Staff Department, and/or the Chair of the Credentials Committee,. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may have a health issue. The person making the report does not need to have proof of the health issue, but must state the facts leading to the concern.

3.20.2.2. If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:

3.20.2.2.1. Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,

3.20.2.2.2. Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Practitioner Health Committee.

3.20.3. CONCERNS REQUIRING AN IMMEDIATE RESPONSE.

3.20.3.1. Anyone who is concerned that an individual has a health issue that poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant Department Chair, the Medical Staff President, the Chief Medical Officer, and/or their designees.

3.20.3.2. The Department Chair, Medical Staff President, and/or the Chief Medical Officer (or their designees) shall immediately assess the individual and, if necessary to protect patients, may relieve the individual of patient care responsibilities. The affected individual's hospitalized patients may be assigned to another individual with appropriate clinical privileges or to the appropriate practitioner on call. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The affected patients shall be informed that their practitioner is unable to proceed with their care due to illness.

3.20.3.3. Following the immediate response, the Department Chair, Medical Staff President, and/or the Chief Medical Officer (or their designees) shall file formal reports as described in these Bylaws, in order for the health issue to be more fully assessed and addressed by the Practitioner Health Committee.

3.20.4. REVIEW BY PRACTITIONER HEALTH COMMITTEE

3.20.4.1. The Practitioner Health Committee shall act expeditiously in reviewing concerns regarding a potential health issue. As part of its review, the Practitioner Health Committee may meet with the individual(s) who initially reported the concern.

3.20.4.2. If the Practitioner Health Committee believes that the practitioner has or might have a health issue, it shall meet with the individual. At this meeting, the individual should be told that there is a concern that his/her ability to practice safely and competently may be compromised by a health issue and advised of the nature of the concern, but should not be told who initially reported the concern.

3.20.4.3. The Practitioner Health Committee may require that the individual (i) undergo a physical or mental examination, (ii) submit to an alcohol or drug screening test (blood, hair, or urine), and/or (iii) be evaluated by a physician or organization and have the results of any such evaluation provided to it, in accordance with the Hospital policy regarding Medication Diversion. The Practitioner Health Committee shall select the health care professional(s) or organization to perform the testing and/or evaluation.

3.20.4.4. The Practitioner Health Committee may meet with the individual as part of its assessment. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Practitioner Health Committee may ask the individual under investigation health-related questions. In addition, if the Committee feels that the individual may have a health issue that significantly affects his/her ability to perform essential functions concerning patient care, it may discuss with the individual under review whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

3.20.5. OUTCOME OF INVESTIGATION. Based on all of the information it reviews as part of its investigation, the Practitioner Health Committee shall determine:

3.20.5.1. Whether the individual has a health issue, or what other problem, if any, is affecting the individual under investigation;

3.20.5.2. If the individual has a health issue, the nature of the health issue and whether it is classified as a disability;

3.20.5.3. If the individual's health issue is a disability, whether a reasonable accommodation can be made for the individual's health issue such that, with the reasonable accommodation, the individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;

3.20.5.4. Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,

3.20.5.5. Whether the health issue could negatively impact the quality of care or the health or safety of the individual, patients, Hospital employees, physicians or others within the Hospital;

3.20.5.6. If the Practitioner Health Committee determines that there is a reasonable accommodation that ensures patient safety, the Practitioner Health Committee shall attempt to work out a voluntary agreement with the individual. The Medical Executive Committee shall be kept informed of the voluntary agreement before it becomes final and effective. Based on the severity and nature of the health issue, the Practitioner Health Committee may recommend to the practitioner that he or she:

3.20.5.6.1. take a voluntary medical leave of absence to receive appropriate medical treatment or participate in a rehabilitation program; or

3.20.5.6.2. voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or

3.20.5.6.3. voluntarily agree to specific conditions.

3.20.5.7. If the Practitioner Health Committee recommends that the individual receive medical treatment or participate in a rehabilitation program, it may assist the individual in identifying appropriate resources.

3.20.5.8. If the individual does not agree to abide by the Practitioner Health Committee's recommendations, the matter shall be referred to the Medical Executive Committee for a review and possible investigation to be conducted pursuant to the Medical Staff Bylaws or any applicable credentials policy.

3.20.5.9. If the individual agrees to abide by the recommendations of the Practitioner Health Committee, a confidential report will be made to the applicable Department Chair, the Medical Staff President, the Chief Medical Officer, and the Chair of the Credentials Committee. In the event any of these individuals is concerned that the action of the Practitioner Health Committee is not sufficient to protect patients or other health care workers, the matter will be referred back to the Practitioner Health Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for review and possible investigation.

3.20.5.10. If the Practitioner Health Committee determines that there is no reasonable accommodation that can be made, or if the Committee cannot reach a voluntary agreement with the individual, the then the Practitioner Health Committee shall refer the matter with a recommendation to the Medical Executive Committee. The Medical Executive Committee may conduct its own investigation or adopt the recommendation of the Practitioner Health Committee and shall make a recommendation and report to the Governing Board, as appropriate to the action to be taken. If the Practitioner Health Committee‘s recommendation would provide the individual with a right to a hearing as described in the Medical Staff Bylaws, the individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws.

3.20.5.11. The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual‘s credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual‘s credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee or the Credentials or the Practitioner Health Committee.

3.20.5.12. Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

3.20.6. TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES. If it is determined that the individual has a health issue that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.20.6.1. An individual with a health issue shall not be reinstated until it is established, to the Medical Staff’s satisfaction, that the individual has successfully completed a rehabilitation program which is accredited by the Joint Commission or certified by the Department of Health and Mental Hygiene in which the Medical Staff has confidence, or has received treatment by health care practitioner who is competent and capable of dealing with the medical or psychological

health issue such that the Medical Staff has confidence that the condition is under sufficient control

.3.20.6.2. The Medical Staff is not required to extend membership or privileges to an individual with a health issue, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.20.6.3. Upon sufficient proof that the individual who has been found to have a health issue has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the individual for reinstatement of Medical Staff membership or clinical privileges.

3.20.6.4. In considering an individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

3.20.6.5. The Medical Staff must first obtain a letter from the physician Chair of the rehabilitation program where the individual was treated, or the physician directing the individual's medical or psychological treatment. The individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician Chair regarding the content of the letter:

3.20.6.5.1. Whether the individual is participating in the program or treatment;

3.20.6.5.2. Whether the individual is in compliance with all of the terms of the program or treatment plan;

3.20.6.5.3. Whether the individual attends AA/NA meetings regularly (if appropriate);

3.20.6.5.4. To what extent the individual's behavior and conduct are monitored;

3.20.6.5.5. Whether, in the opinion of the treating physician, the individual is rehabilitated or the health issue is under control;

3.20.6.5.6. Whether any conditions are required to allow the individual to safely resume practicing (e.g., supervision, limitation on work hours, limitation on privileges);

3.20.6.5.7. Whether an after-care program has been recommended to the individual (if appropriate), and if so, a description of the after-care program; and,

3.20.6.5.8. Whether, in the opinion of the treating physician, the individual is capable of resuming practice and providing continuous, competent care to patients.

3.20.6.6. The Medical Staff has the right to require opinion(s) from other physician consultants of its choice. Before making a recommendation on a request for reinstatement or lifting conditions, the Practitioner Health Committee may request the practitioner to undergo an examination by a physician of its choice to obtain a second opinion on the practitioner's ability to practice safely and competently. The Practitioner Health Committee shall make a recommendation to the Medical Executive Committee.

3.20.6.7. Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:

3.20.6.7.1. The individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;

3.20.6.7.2. If the practitioner was granted a formal medical leave of absence, the final decision to reinstate an individual's clinical privileges must be approved pursuant to the Leave of Absence process set forth in the Medical Staff Bylaws;

3.20.6.7.3. The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.

3.20.6.8. The individual must agree to submit to an alcohol or drug-screening test (if appropriate) at the request of the Hospital President or designee, the Medical Staff President, the Chair of the Practitioner Health Committee, or the pertinent Department Chair.

3.20.6.9. As a condition of reinstatement, the individual‘s credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three of these Bylaws. Minimally, licensure, DEA registration for Maryland, Maryland narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the health issue.

3.20.6.10. If at any point during the process of investigation, rehabilitation, treatment, or reinstatement the individual refuses or fails to comply with these procedures, the Medical Executive Committee shall forward the results of their investigation along with their recommendations, to the Governing Board for final action, subject to the provisions in Article Seven of these Bylaws and any state or federally mandated reporting requirements.

3.20.6.11. If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the Medical Executive Committee shall forward the results of their investigation along with their recommendations, to the Governing Board for final action, subject to the provisions in Article Seven of these Bylaws and any state or federally mandated reporting requirements.

3.20.6.12. If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the individual or others, the Chief Medical Officer or Hospital President may contact law enforcement authorities.

3.20.6.13. Nothing in this Section precludes immediate referral to the Medical Executive Committee or the elimination of any particular steps in this Section in dealing with conduct that may compromise patient care.

3.20.6.14. All requests for information concerning the individual shall be forwarded to the Hospital President for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

3.21. REQUIREMENTS REGARDING PROFESSIONAL CONDUCT

3.21.1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus it is the policy of the Hospital to require all individuals working in the Hospital, including Medical Staff members, APPs, and other individuals with clinical privileges to treat others with

respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of unprofessional or inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.

3.21.2. Unprofessional or inappropriate conduct or behavior is defined as those which adversely affects or impacts the Hospital operations or the ability of others to get perform their jobs done competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purposes of these Bylaws, examples of unprofessional or inappropriate conduct include, but are not limited to:

3.21.2.1. Rude, threatening or abusive behavior or comments to Hospital personnel, Advanced Practice Professionals, patients, or Practitioners.

3.21.2.2. Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.

3.21.2.3. Verbal attacks, which are of a personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel, Medical Staff, Advanced Practice Professionals, contracted staff, or patients.

3.21.2.4. Irrelevant or inappropriate comments, drawings, or illustrations made in a patient‘s medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Advanced Practice Professionals, nurses, other Hospital personnel, or Hospital policies.

3.21.2.5. Criticism that is addressed to a recipient in such a manner as to that intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.

3.21.2.6. Disruption of Hospital operations, Hospital or Medical Staff committee(s) or departmental affairs.

3.21.2.7. Imposing onerous requirements on the nursing staff, other Hospital staff, Hospital-affiliated providers, APPs, or contractors, such as assigning work that is outside of their scope of practice as allowed under their state license, or outside of the scope of their Hospital job description, Hospital-approved duties, or clinical privileges, or contrary to Hospital policies and procedures, or that would otherwise jeopardize patient safety, quality of patient care or the Hospital‘s or staff member‘s compliance with laws, regulations or standards.

3.21.2.8. Lying, cheating, knowingly making false accusations, altering, or falsifying any patient‘s medical records or Hospital documents.

3.21.2.9. Verbal or physical maltreatment of another individual, including physical or sexual assault.

3.21.2.10. Harassment, including words, gestures and actions, verbal or physical, that interferes with a person‘s ability to competently perform his/her job.

3.21.2.11. Conduct or behavior that causes a hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation: offensive comments, jokes, innuendos, sexually-oriented statements, printed material, material distributed through electronic media or items posted on walls or bulletin boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.

3.21.2.12. Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:

3.21.2.12.1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment.

3.21.2.12.2. Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment.

3.21.2.12.3. Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.

3.21.2.12.4. Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.

3.21.3. Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.

3.21.4. The Medical Staff leadership and Hospital leaders may provide education to all Medical Staff members and other individuals with clinical privileges regarding appropriate professional behavior and conduct. The Medical Staff leaders and Hospital leaders shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of policies associated with appropriate professional conduct and shall institute procedures to facilitate prompt reporting of inappropriate or unprofessional conduct, and prompt action as appropriate under the circumstances.

3.21.5. An employee who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with the Hospital's Human Resources policies. A Member of the Medical Staff and other individual with clinical privileges who engage in unprofessional or inappropriate conduct shall be dealt with in accordance with this Section of the Bylaws. Unprofessional or inappropriate conduct resulting from a health issue as defined in the Practitioner Health Issues section of these Bylaws should be dealt with using whichever Section is most appropriate for the conduct in question. If the matter involves an employed Practitioner or APP, the Hospital President shall consult with appropriate Medical Staff leaders, and legal counsel will determine which of any applicable policies will be applied.

3.21.6. In the event of any apparent or actual conflict between these Bylaws and the Rules and Regulations, policies of the Medical Staff, or other policies, the provisions of these Bylaws shall control.

3.21.7. This section of the Bylaws outlines initial collegial steps (i.e., warnings and meetings with a Practitioner) that may be taken in an attempt to resolve complaints about unprofessional or inappropriate conduct exhibited by a Practitioner. However, there may be a single incident of unprofessional or inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in these Bylaws precludes immediate referral to the Hospital President, the Medical Executive Committee or to the Governing Board, with the Hospital President, Medical Executive Committee or the Governing Board implementing immediate actions, which may include but is not limited to summary suspension, the filing of criminal charges, or the elimination of any particular step outlined herein so as to take immediate action in dealing with a complaint regarding unprofessional or inappropriate conduct.

3.21.8. Nurses, other Hospital employees, or other individuals who observe, or are subjected to, unprofessional or inappropriate conduct by a Practitioner may notify their supervisor about the incident or, if their supervisor's behavior is at issue, they may notify the Hospital President (or designee). Any

Practitioner who observes such behavior may notify the Hospital President directly. Upon learning of the occurrence of an incident of unprofessional or inappropriate conduct, the supervisor/Hospital President shall request that the individual who reported the incident document it in writing. If the observer of inappropriate or unprofessional conduct does not wish to provide a written report, the supervisor/Hospital President may document it, while also attempting to ascertain the observer‘s reasons for declining and providing encouragement to do so.

3.21.9. The documentation shall, to the extent possible, include:

3.21.9.1. The date and time of the questionable behavior;

3.21.9.2. A factual description of the questionable behavior;

3.21.9.3. The name of any patient or patient‘s family members who were involved in the incident, including any patient or family Member who witnessed the incident;

3.21.9.4. The circumstances which precipitated the incident;

3.21.9.5. The names of other witnesses to the incident;

3.21.9.6. Consequences, if any, of the unprofessional or inappropriate conduct as it relates to patient care, personnel, or Hospital operations;

3.21.9.7. Any action taken to intervene in, or remedy, the incident; and,

3.21.9.8. The name and signature of the individual reporting the matter.

3.21.10. The supervisor shall forward a documented report to the Hospital President, who shall immediately notify the Chief Medical Officer and the Medical Staff President. The Hospital President, Chief Medical Officer and the Medical Staff President shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

3.21.11. If a reporting individual is unwilling or uncomfortable with reporting unprofessional or inappropriate conduct using the procedure described in Section 3.21.8, then a report of the incident may be made to the appropriate Hospital official.

3.21.12. The supervisor/Hospital President who took the report shall follow-up with the individual who made the report by informing the individual that the matter is being reviewed, thanking the individual for reporting the matter, and instructing the individual to report any further incidents of inappropriate or unprofessional conduct. The individual making the report shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.

3.21.13. After a determination that the incident of unprofessional or inappropriate conduct has occurred, the Medical Staff President and/or Hospital President (or their respective designees) shall meet with the Practitioner. If appropriate, this initial meeting should be collegial. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The Practitioner shall be advised that, if the incident occurred as reported, his/her conduct was inappropriate and inconsistent with the standards of the Hospital and the Bylaws. The identity of the individual preparing the report of unprofessional or inappropriate conduct shall not be disclosed at this time, unless the Hospital President and Medical Staff President agree in advance that it is appropriate to do so. In all cases, the Practitioner shall be advised that any retaliation of any type by him/her against the person reporting the incident or anyone involved in the incident will be grounds for his/her immediate exclusion from all Hospital facilities.

3.21.14. This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.

3.21.15. The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The Medical Staff President shall cause the summary and any response that is received to be kept in the confidential portion of the Practitioner's credentials file. The Hospital President shall cause the written report(s) of the incident, summary of the meeting, and any other records regarding the incident or the meeting to be kept as a confidential risk management record.

3.21.16. If another report of unprofessional or inappropriate conduct involving the Practitioner is received, the report will be evaluated by the applicable Department Chair, the Chief Medical Officer, or the Medical Staff President and, upon finding reasonable evidence of merit to the complaint, a second meeting shall be held. At least three people (e.g., the Medical Staff President, the Chair of the Credentials Committee, other medical staff leader, and/or the Hospital President, Chief Medical Officer or legal counsel) shall be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that the matter may be referred to the Medical Executive Committee or to the Governing Board for more formal action.

3.21.17. Following this meeting, a letter shall be sent to the Practitioner. The letter shall describe the unprofessional or inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm that the Practitioner could be excluded from all Hospital facilities for a period of time, a request that a formal investigation could be commenced pursuant to the Bylaws, and any other remedies could be taken to adequately protect the patients, hospital staff and others from continued unprofessional or inappropriate conduct. The letter will also define the conditions of continued practice at the Hospital which shall make continued Medical Staff membership and clinical privileges contingent on the Practitioner's adherence to the conditions and expectations for professional conduct. The Practitioner shall be required to sign it. The Medical Staff President shall cause records of the second meeting and the letter to the Practitioner to be filed in the confidential portion of the credentials file. The Hospital President shall cause records of the second meeting and the letter to the Practitioner to be filed in confidential risk management files. If the Practitioner refuses to sign the letter, the Hospital President and/or the Medical Staff President shall request that a formal investigation be commenced pursuant to the Bylaws and the advice of legal counsel should be obtained.

3.21.18. The Medical Executive Committee shall be fully apprised of the previous warnings issued to the Practitioner and the actions taken to address the concerns.

3.21.19. The Medical Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including hearing or appeal, shall then be conducted under the direction of the Board.

3.21.20. When, despite prior warning, the Practitioner continues to engage in unprofessional or inappropriate conduct, the Practitioner may be excluded from the Hospital's facilities and a precautionary suspension imposed during which time an investigation shall be conducted to determine the need for a professional review action. Immediate exclusion and precautionary suspension may also be imposed for a single event when a Practitioner's conduct is so unprofessional or inappropriate that failure to take such action may result in an imminent danger to the health of any individual. Precautionary suspension shall be imposed in accordance with Article Six of these Bylaws. All suspensions of physicians' privileges, regardless of duration or cause, may be reportable to the Maryland licensing board for physicians under Maryland law.

3.22. ACCESS TO MEDICAL STAFF FILES

3.22.1. To preserve and protect the confidentiality of credentialing, peer review, adverse action, and disciplinary proceedings, as required by these Bylaws and State law, an applicant, Member, or past Member shall only have access to any information in any files maintained by the Medical Staff Services Office and quality assurance offices of the Hospital as provided in this Section. An applicant or Member will be given copies of his/her own files in the event of a credentialing, peer review, or disciplinary proceeding at the Hospital involving such applicant or Member that gives such applicants or Members hearing rights. If the applicant or Member requests access to his/her Medical Staff files or Hospital quality assurance files in the absence of any such proceeding, the applicant or Member shall be permitted to review such files, but only in the presence of both a Medical Staff Services Office employee only after all confidential information (e.g., reference letters, peer review information) have been removed from the file prior to such review. The applicant or Member is not entitled to a copy of the file(s) or any information in the files unless he/she is the subject of an adverse proceeding, as set forth above.

3.22.2. The Maryland licensing boards and other regulatory bodies have the legal authority to subpoena copies of a current or past Member's credentialing, peer review and disciplinary proceedings files. The Member may be notified in writing of any such subpoena.

4. ARTICLE FOUR: CATEGORIES OF THE MEDICAL STAFF

4.1. CATEGORIES

The Staff shall include the categories set forth below. At the time of appointment and at the time of each reappointment, the Medical Staff Member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.

4.2. LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

4.3. ACTIVE STAFF

4.3.1. REQUIREMENTS FOR ACTIVE STAFF

The Active Staff category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight. To remain eligible to be a member of the Active Staff for the next term of appointment, a Practitioner must have a minimum of 24 patient encounters (admissions, consults, procedures, assessments, etc.) every two (2) years

4.3.2. PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and department meetings and serve on committees of the Board, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.

4.3.3. OBLIGATIONS OF ACTIVE STAFF

Each Member of the Active Staff shall:

4.3.3.1. Discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws;

4.3.3.2. Be eligible to participate on emergency on-call coverage for emergency care services within his/her Medical Staff Department or Section as specified by the requirements of the assigned Medical Staff Department;

4.3.3.3. Provide continuous care and supervision of his/her patients in the Hospital or arrange for an equally eligible, qualified and privileged alternative;

4.3.3.4. Actively participate in the quality assessment and performance improvement activities of the Hospital;

4.3.3.5. Attend Medical Staff and Department meetings; and

4.3.3.6. Perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations, including any future changes to these Bylaws or Rules and Regulations and directives issued by the Medical Executive Committee.

4.4. COURTESY STAFF

4.4.1. REQUIREMENTS FOR COURTESY STAFF

The Courtesy Staff category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to admit patients, remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes.

4.4.2. PREROGATIVES OF COURTESY STAFF

Members of the Courtesy Staff shall not be eligible to vote or hold office within the Medical Staff organization. A Courtesy Staff Member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and Department meetings.

4.4.3. OBLIGATIONS OF COURTESY STAFF

Each Member of the Courtesy Staff shall discharge the basic obligations of staff members as required in these Bylaws; be eligible to participate on emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange an equally eligible, qualified and privileged alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations or Policies.

4.5. CONSULTING STAFF

4.5.1. REQUIREMENTS FOR CONSULTING STAFF

The Consulting Staff category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but do not wish to admit patients, but remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes.

4.5.2. PREROGATIVES OF CONSULTING STAFF

Members of the Consulting Staff shall not be eligible to vote or hold office within the Medical Staff organization. An Courtesy Staff Member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and Department meetings.

4.5.3. OBLIGATIONS OF CONSULTING STAFF

Each Member of the Consulting Staff shall discharge the basic obligations of staff members as required in these Bylaws; be eligible to participate on emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange an equally eligible, qualified and privileged alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations.

4.6. COMMUNITY STAFF

4.6.1. REQUIREMENTS FOR COMMUNITY STAFF

The Community Staff category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s). The Community Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Community Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Board. Since no clinical privileges are granted, Community Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation. They are also exempt from all requirements regarding board certification.

4.6.2. PREROGATIVES OF COMMUNITY STAFF

Members of the Community Staff may visit their hospitalized patients, and review their patients' medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Community Staff shall not be eligible to vote or hold office within the Medical Staff organization.

4.6.3. OBLIGATIONS OF COMMUNITY STAFF

Each Member of the Community Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required.

4.7 APPROVED OBSERVER STAFF

Upon recommendation by the appropriate Department or Section chair, and with the approval of the Credentials Committee and the Medical Staff President (or his/her designee), physicians who are not appointed to the Medical Staff may observe educational activities in a clinical setting at the Hospital as Approved Observers. Approved Observers need not be licensed as physicians in Maryland or in any other state. An applicant for Approved Observer status shall submit a Curriculum Vitae and information that must include, at a minimum, information regarding education, training and professional qualifications.

Because Approved Observers are not members of the Medical Staff, they may not participate in direct or indirect patient care or management in any way. Approved Observers may participate in educational activities only under the direct responsibility of a member of the Medical Staff. Approved Observer status shall be granted for a period of not more than one year and may be renewed upon recommendation by the appropriate Department or Section chair, with notification to the Credentials Committee and the Medical Staff President, and after receipt of an updated Curriculum Vitae. Approved Observers may not attend Medical Staff committee meetings except by invitation of the President of the Medical Staff, and may not vote at any meetings attended. Approved Observer status may be terminated with or without cause by the appropriate Department or Section chair or the Medical Staff President, with notification to the Credentials Committee and the Medical Staff President or Department and Section chairs, as applicable. Procedural and fair hearing rights do not apply to the failure to grant, or the termination of, Approved Observer status.

4.8 VISITING TRAINEES.

Physicians who possess a Maryland license (or who are granted an exception from licensing by the Maryland Board of Physicians) and for whom evidence of adequate malpractice insurance is provided may engage in limited clinical activities for purposes of occasional, short-term training by assisting an attending physician under his/her direct, on-site supervision to the extent lawfully permitted and as approved by the Credentials Committee, the Medical Staff President and the Hospital President (or designee). Upon recommendation by the appropriate Department or Section chair, and with the prior approval of the Credentials Committee, the Medical Staff President and the Hospital President (or his/her designee), physicians at the post-doctoral and faculty level who are not appointed to the Medical Staff may observe educational activities in a clinical setting at the Hospital as Visiting Trainees. An applicant for Visiting Trainee status shall submit a completed application form, a Curriculum Vitae, and information that must include, at a minimum, information regarding education, training and professional qualifications.

Because Visiting Trainees are not members of the Medical Staff, they may not participate in direct or indirect patient care or management in any way except with the direct, on-site supervision of a sponsoring member of the Medical Staff. Visiting Trainee status shall be granted for a period of not more than one year and may be renewed upon recommendation by the appropriate Department or Section chair, with approval from to the Credentials Committee, the Medical Staff President and the Hospital President, and after receipt of an updated Curriculum Vitae. Visiting Trainees may not attend Medical Staff committee meetings except by invitation of the President of the Medical Staff, and may not vote at any meetings attended. Visiting Trainee status may be terminated with or without cause by the appropriate Department or Section chair or the Medical Staff President, with notification to the Credentials Committee and the Hospital President or Department and Section chairs, as applicable. Procedural and fair hearing rights do not apply to the failure to grant, or the termination of, Visiting Trainee status.

4.9. HONORARY RECOGNITION

4.9.1. REQUIREMENTS FOR HONORARY RECOGNITION

Honorary Recognition shall be granted to Practitioners and Advanced Practice Professionals retired from professional practice who are recognized for their noteworthy contributions to the

health and medical sciences, or previous long-standing service to the Hospital. Because they are retired, Practitioners with Honorary Recognition are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any credentialing process.

4.9.2. PREROGATIVES OF HONORARY RECOGNITION

Practitioners with Honorary Recognition shall be invited and welcome to attend educational and social functions of the Hospital and Medical Staff.

4.10. EMERITUS STAFF CATEGORY

Any Practitioner who is at least 60 years old and who has also been a member of the Medical Staff for at least 20 years may apply for the Emeritus Staff category. If such status is granted, the Practitioner shall be exempt from paying dues or complying with meeting attendance requirements. Emeritus Staff members must be credentialed and granted clinical privileges like other categories of the Medical Staff.

4.11. TELEMEDICINE CATEGORY.

Any Practitioner may apply for privileges to see patients only via telemedicine as provided in these Bylaws. Any Practitioner in this category shall meet all applicable requirements pertaining to the Members of the Medical Staff; provided, however, that Practitioners in such category are not required to attend Medical Staff meetings, nor are they required to see their patients face-to-face.

4.12. CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff Member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a Member consistent with the requirements of the Bylaws. The Board must approve any change in category and the Member must pay appropriate dues in the new category.

4.13. MEDICAL STUDENTS, INTERNS, EXTERNS, RESIDENTS, FELLOWS, AND APP TRAINEES

Medical students, interns, externs, residents, fellows, and Advanced Practice Professional trainees, such as physician assistants, nurse practitioners, and nurse midwives (hereinafter referred to collectively as "medical trainees") are individuals who are currently enrolled in a medical school or graduate medical education program approved by the Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at the Hospital. Medical trainees shall not be considered independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. Medical trainees shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. The school or program shall provide a written description of the role, responsibilities, scope of practice, and patient care activities of participants in the training program. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a medical trainee to provide services at this Hospital. Medical trainees may render patient care services at the Hospital only pursuant to and limited by the following:

4.13.1. Medical trainees must be registered in this State in accordance with State law and shall be limited by applicable provisions of the professional licensure requirements of this State;

4.13.2. A written affiliation agreement between the Hospital and the sponsoring medical school or training program must be executed that will specify responsibility for supervision of the medical trainees and malpractice insurance coverage; and,

4.13.3. While functioning in the Hospital, medical trainees must abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Hospital President, Chief Medical Officer, or Medical Staff President. Medical trainees may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A medical trainee shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. Medical trainees may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Sections, or committees, but shall have no voting rights.

4.13.4. The Chief Medical Officer shall be responsible for overseeing medical trainees and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program and quality and safety concerns.

4.13.5. As defined in Section 4.12 above, medical trainees are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., moonlighting or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

4.14. ADVANCED PRACTICE PROFESSIONALS

The term, Advanced Practice Professional (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Governing Board and shall be credentialed through the same processes as a Medical Staff Member, as described in Article Three, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), and certified registered nurse practitioners (CRNP) and Surgical First Assistants (SA.)

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff Member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, Health Care Industry Representatives (HCIRs), operating room nurses and technicians, perfussionists, clinical assistants, auto transfusionists, orthotics/prosthetics, registered and practical nurses, dental technicians, lactation

consultants, doulas, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. These categories of dependent healthcare professionals are not considered Advanced Practice Professionals. Although a Medical Staff Member may provide employment, sponsorship and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff Member, these Bylaws shall not apply to such dependent healthcare professionals. Dependent healthcare professionals are listed here only to distinguish them from APPs.

4.14.1. REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

As permitted by state law, APPs shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff Member and the terms for supervision of the APP by a Medical Staff Member shall be documented in a sponsorship agreement between the APP and the sponsoring Medical Staff Member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

4.14.1.1. Name of the sponsoring Medical Staff Member and name of any alternative sponsoring Medical Staff members;

4.14.1.2. Completed sponsoring Medical Staff Member‘s evaluation;

4.14.1.3. Requested clinical privileges, which will specify the degree of supervision required for the performance of each clinical privilege, and will be signed by the sponsoring Medical Staff Member(s);

4.14.1.4. Signed agreement by the sponsoring Medical Staff Member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

4.14.2. PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Department/Section meetings. An APP may admit patients to the Hospital only if eligible for admitting privileges if allowed by State laws, and only if granted admitting privileges by the Governing Board. Patients admitted by an APP shall be under the care of a physician.

4.14.3. OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS:

Each APP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

4.15. DUTY TO SUPERVISE.

A Medical Staff Member who fails to fulfill the responsibilities as outlined in these Bylaws, the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

5. ARTICLE FIVE: CLINICAL PRIVILEGES

5.1. EXERCISE OF PRIVILEGES

Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 5.3 and 5.4 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Board. The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations. Clinical privileges may be granted, continued, modified, or terminated by the Governing Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

5.2. DELINEATION OF PRIVILEGES

5.2.1. APPLICATION

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Section 3.5. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to Section 3.7.2, the responsibility for producing a complete application and request for clinical privileges shall be the applicant's.

5.2.2. ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary, emergency or disaster relief privileges may be granted admitting privileges. The privilege to admit shall be delineated and is not automatic. Generally, only Physicians are granted admitting privileges; patients who receive care from non-Physicians must be admitted under the care of a Physician.

5.2.3. MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Clinical privileges for performing a medical history and physical examination shall be delineated. A medical history and physical examination shall be completed, documented, and signed for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by the Practitioner in accordance with State law and hospital policy. Therefore, if the medical history and physical examination were performed by an APP, it shall be countersigned by the Practitioner no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. In addition, an updated medical history

and physical examination shall be completed, documented, and signed by the Practitioner (or countersigned by the Practitioner if completed, documented and signed by an APP) for each patient in the following circumstances, except in a medical emergency:

5.2.3.1. If the only medical history and physical examination on record was completed prior to admission or registration: An update shall be required within 24 hours after admission or registration

5.2.3.2 If the patient requires a surgery or procedure requiring anesthesia services that was not included in the plan of the most recent medical history and physical examination: An update shall be required prior to surgery or procedure requiring anesthesia services

A medical history and physical examination update shall consist of the following:

5.2.3.3 Documentation that a review of a valid medical history and physical examination was performed

5.2.3.4 Documentation that the patient was reexamined

5.2.3.5 Documentation of any changes that might be significant for the planned course of treatment, or lack thereof.

5.2.4. ADDITIONS TO OR INCREASES IN CLINICAL PRIVILEGES

A request by an individual with clinical privileges for additional clinical privileges or an increase in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

5.2.4.1. Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be verified.

5.2.4.2. Training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be verified.

5.2.4.3. Evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant practitioner-specific performance data when available.

5.2.4.4. An evaluation provided by peers of the applicant shall be included in deliberations when adding or increasing privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

5.2.4.5. Applicants are required to report malpractice insurance coverage information for the new privileges or increased clinical privileges requested, and claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.

5.2.4.6. The Hospital shall query the National Practitioner Data Bank when new clinical privileges or increased clinical privileges are requested.

5.2.4.7. When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified.

5.2.4.8. When adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:

5.2.4.8.1 Previously successful or currently pending challenges, or voluntary or involuntary relinquishment, of licensure or registration.

5.2.4.8.2 Voluntary or involuntary reduction in privileges or termination of privileges or membership.

5.2.4.8.3. Involvement in any liability actions, including any final judgments or settlements.

5.2.5. BASIS FOR PRIVILEGE DETERMINATION

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested. Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references and peer recommendations that include written information about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status as related to ability to perform the privileges requested, information from the applicant's current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chair of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Governing Board to only certain settings within the Hospital, as appropriate to each setting. The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation, as provided for in Article Three of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Governing Board, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

5.2.5.1. For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;

5.2.5.2. For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;

5.2.5.3. The applicant‘s clinical judgment and technical skills;

5.2.5.4. Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;

5.2.5.5. Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

5.2.5.6. Relevant practitioner-specific data that are compared to aggregate data;

5.2.5.7. Morbidity and mortality data, when available;

5.2.5.8. Practitioner‘s use of consultants;

5.2.5.9. Practitioner‘s performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with core measures protocols.

The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient, including the consulting physicians, assistants at surgery, nursing and administrative personnel. Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three of these Bylaws.

5.2.6. DELINEATION

Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Three of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant‘s change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted. The delineation of an individual‘s privileges shall include the limitations, if any, on the individual‘s privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.

5.2.7. PRIVILEGES TO TRAIN STAFF ON NEW TECHNOLOGY

To support the introduction of a new procedure or new technology at the Hospital, the Governing Board shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offering of training for the procedure/technology fits within the Hospital‘s operational planning and is appropriate for the Hospital‘s patient population. Training shall not be conducted until first approved by the Governing Board based on a recommendation from the Medical Executive Committee, and it will only be conducted in accordance with Maryland law.. The trainer and the trainee shall be credentialed as described in Article Three of these Bylaws to verify the qualifications necessary for these roles. The trainer and trainees must meet Maryland licensing

requirements, provide proof of appropriate malpractice insurance coverage (as otherwise required by these Bylaws), a reference letter, and proof of appropriate clinical privileges at another licensed facility. Clinical privileges shall be specifically delineated for the role, in which the individual shall serve, and the new procedure or new technology to be taught. The trainer and the trainee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

5.2.7.1. Trainer: An expert surgeon/physician who undertakes to impart his/her clinical knowledge and skills in a defined setting to a trainee. The trainer must be appropriately privileged, skilled, and experienced in the procedure(s) and/or technique(s) in question, as defined by his/her Department. To serve as a trainer in a specific procedure or technique, the surgeon/physician (trainer) must have appropriate clinical experience in the particular field of expertise.

5.2.7.2. Trainee: The trainee must be a Member of the Medical Staff in good standing.

5.2.8. NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Governing Board, based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospital or that overlaps more than one Department shall initially be reviewed by the Credentials Committee. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

5.2.9. CLOSING/DISCONTINUING A SERVICE OR ENTERING AN EXCLUSIVE CONTRACT

As part of the process for ongoing evaluation and planning of patient care services, the Governing Board, following discussion with the Medical Executive Committee, may determine that a particular patient care service should be closed or discontinued. Before such a decision is implemented, the parties should seek to resolve any issues via the Conflict Resolution Process set forth in these Bylaws. Any affected practitioner may request that the Conflict Resolution Process be followed. In the event that a patient care service is closed or discontinued, the Governing Board may retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and APPs of the clinical privileges that have been retracted. Any Clinical Privileges that are retracted due to changes in the services provided by the Hospital shall not be considered an adverse action; therefore, there shall be no right to hearing and appeal in association with decisions to change the services offered by the Hospital and no adverse action reports will be made to the licensing boards or the NPDB.

5.2.10. TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions. In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

5.2.10.1. When a telemedicine provider is providing services from a different State, licensure will be verified for the state of Maryland where the hospital is located.

5.2.10.2. Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries may be limited to the top five high volume affiliations and any healthcare organization from which the practitioner was reassigned during the last five years.

5.2.10.3. Because they do not treat patients face-to-face, Practitioners who seek only telemedicine privileges need not maintain DEA or Maryland CDS registration.

5.2.11. UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the applicant‘s qualifications or competence, an applicant whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to the reporting requirements of State and federal law.

5.3. TEMPORARY PRIVILEGES

Temporary clinical privileges may be granted only to Practitioners and APPs who have submitted a complete application for Privileges at this Hospital and may be granted to meet patient care needs or new applicants. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or APP exercising such privileges. A Practitioner or APP shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination or expiration of temporary privileges.

5.3.1. QUALIFICATIONS FOR NEW APPLICANTS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license in the state of Maryland, a current and unrestricted federal DEA registration for Maryland and Maryland CDS permit (except for pathologists, diagnostic radiologists and practitioners seeking only telemedicine privileges) reflecting a valid Maryland address, and evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Governing Board (except as otherwise specified in these Bylaws), and, for Practitioners, a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care. Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify that the applicant is not an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the GSA List, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges

shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, Policies, and applicable Hospital policies.

5.3.2. QUALIFICATIONS FOR PATIENT CARE NEED.

Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice for a limited period of time as defined herein. After receipt of a written request for temporary privileges for an urgent patient care need, a Practitioner or APP otherwise qualified for Medical Staff membership may be granted temporary privileges if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients. In such event, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient(s) or 120 consecutive days, whichever is less. A Practitioner or APP may be granted temporary privileges under this condition for no more than two instances in a twelve-month period. After a Practitioner or APP has been granted temporary privileges under this condition for the second instance within twelve months, he/she shall be required to apply for Medical Staff membership and/or clinical privileges before providing additional patient care, treatment or services at the Hospital.

5.3.3. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Hospital President or designee upon receiving a recommendation from the appropriate Department Chair and Medical Staff President or designee under the conditions noted below. All temporary privileges may be granted for a maximum of 120 days. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by hospital policy. Temporary privileges shall automatically terminate at the earlier of the end of the specific period for which they were granted or when the applicant's application is fully approved. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, and shall meet the following minimum criteria:

5.3.3.1. There are no current or previously successful challenges to licensure or registration;

5.3.3.2. There are no adverse membership actions at another hospital; and

5.3.3.3. There are no adverse actions against the applicant's privileges at another hospital.

5.4 DISASTER RELIEF PRIVILEGES.

Potential disaster situations shall be described in the Hospital Emergency Operations Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural or man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs, disaster relief privileges may be granted to an appropriately qualified Practitioner, based upon the needs of the Hospital to augment staffing due to the disaster situation. Disaster relief privileges shall be approved by the Hospital Emergency Incident Commander (Hospital President/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the Medical Staff President or the EOP-designated Medical Staff Director. All decisions to grant disaster relief privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case- by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing. The Medical Staff President or the EOP designated Medical Staff Director shall also assign a Member of the

Medical Staff to responsibilities for supervising Practitioners granted disaster relief privileges, through direct observation, mentoring, or clinical record review. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Disaster relief privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Disaster relief privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or 120 consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 5.5, a Practitioner would be permitted to provide patient care using emergency privileges.

5.4.1. Disaster relief privileges may be granted upon presentation of a government-issued photo identification and *any* of the following, and the qualifications required in Section 5.3.1 of this Article shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting emergency privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the Hospital, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours:

5.4.1.1. A current picture hospital ID card;

5.4.1.2. A current license to practice in the State of Maryland;

5.4.1.3. Primary source verification of the license;

5.4.1.4. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;

5.4.1.5. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,

5.4.1.6. Presentation by a current hospital or medical staff Member(s) with personal knowledge regarding the practitioner‘s identity.

5.4.2. The following order of preference should be used in granting disaster relief privileges:

5.4.2.1. Expert Practitioners from government agencies and medical staff members from other Adventist HealthCare hospitals;

5.4.2.2. Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff Member(s) with personal knowledge regarding the practitioner‘s identity.

5.4.2.3. Volunteers from the community or surrounding areas.

5.4.3. If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

5.4.4. Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.

5.4.5. The Medical Staff will oversee the professional practice of volunteer Practitioners.

5.4.6. The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster relief privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Hospital President/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Medical Staff President or the EOP designated Medical Staff Director.

In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, disaster relief privileges terminate.

5.5. EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff Member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. ARTICLE SIX: CORRECTIVE ACTIONS

6.1. CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. 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, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) unprofessional, inappropriate, disruptive or harassing, (as defined in these Bylaws and in Hospital

policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below 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 such factors as concern about harm to patients or Hospital operations. If it is determined to direct the matter to the Medical Executive Committee, the Medical Executive Committee may make immediate recommendations to the Governing Body, 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.

6.2. COLLEGIAL INTERVENTIONS

These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, 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. 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.

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

6.2.1.1. Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

6.2.1.2. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;

6.2.1.3. Proctoring, monitoring, consultation, and letters of guidance;

6.2.1.4. 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;

6.2.1.5. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

6.2.1.6. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

6.2.1.7. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

6.2.1.8. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

6.2.1.9. Requirements to seek assistance for a health issue, as provided in these Bylaws.

6.2.2. The relevant Medical Staff leaders 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.

6.2.3. The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will 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.

6.3. PRECAUTIONARY SUSPENSION/RESTRICTION OF CLINICAL PRIVILEGES

6.3.1. Grounds for Precautionary Suspension or Restriction:

6.3.1.1. Whenever a practitioner or other individual with clinical privileges willfully disregards these Bylaws or the Medical Staff Rules & Regulations or Hospital Policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, or to prevent interference with the orderly operation of the Hospital, the President of the Medical Staff, the chief of a clinical department, the Hospital President (or designee), the Governing Board Chair, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.

6.3.1.2. A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

6.3.1.3. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

6.3.1.4. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Hospital President and the President of the Medical Staff, and shall remain in effect unless it is modified by the Medical Staff President or the Medical Executive Committee. The Department Chair for the department to which a suspended or restricted practitioner is assigned or the Chief Medical Officer shall be responsible for arranging appropriate medical coverage for any of the practitioner‘s patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute practitioner. A suspended or restricted practitioner‘s elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another practitioner as requested by each patient.

6.3.2. Reporting Requirement:

6.3.2.1. In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual‘s privileges for more than 30 days.

6.3.2.2. Reports shall also be made to the Maryland licensing authorities, in compliance with applicable State law.

6.3.3. Medical Executive Committee Procedure:

6.3.3.1. As soon as possible after such precautionary suspension, the Medical Executive Committee shall be convened to review the matter resulting in a precautionary suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

6.3.3.2. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee must determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

6.3.4. Reporting Requirement:

6.3.4.1. If the Medical Executive Committee‘s recommendation is not adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall not be entitled to a hearing and appeal.

6.3.4.2. If the Medical Executive Committee‘s recommendation is adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall be afforded procedural rights to an appellate review as outlined in Article Seven of these Bylaws. The terms of the precautionary suspension shall remain in effect pending a decision by the Governing Board.

6.4. PEER REVIEW PROCESS

6.4.1 Matters that are not directly referred to the Medical Executive Committee will be referred by the Medical Staff President or designee to the applicable department chair, who may involve the applicable Section chair, as appropriate. Each department will be supported by a quality coordinator, assigned by the Hospital, who may assist the department chair in identifying and/or addressing the matter.

6.4.2. If the matter seems to primarily relate to behavioral issues, the department chair may refer the matter to the Leadership Council. Issues to be addressed by the Leadership Council may also include, but are not limited to, those matters that:

*require immediate or expedited review
*involve practitioners from two or more departments
*involve a refusal to cooperate with utilization oversight activities
*trend of informational letters (e.g., noncompliance with rules, policies and protocols)
*involve professionalism or conduct
*involve possible health issues
*demonstrate an apparent pattern or recurrence despite prior interventions.

6.4.3 The Leadership Council will be composed of the Chair of the Professional Practice Evaluation Committee (“PPEC”); the President of the Medical Staff; the Chief Medical Officer; and the immediate Past President of the Medical Staff (or another Active member of the Medical Staff in good standing and who is appointed by the President of the Medical Staff), who will serve as its Chair. Ex officio members without vote will include the Medical Staff Services Director or designee. The Leadership Council will meet, on an as-needed basis, at the request of its Chair, and it may meet in person or by conference call. The Leadership Council will report its findings and recommendations to the Medical Executive Committee The Leadership Council will operate by majority vote.

6.4.4. If the matter seems to primarily relate to clinical concerns, the department chair may select a subject matter expert (which may include the department and/or section chair). The subject matter expert

will review the matter and report his/her findings to the department chair, who will report the findings to the PPEC. If the subject matter expert cannot appropriately review the matter, the matter may be referred directly to the PPEC for evaluation and action. The PPEC will report its findings to the Medical Executive Committee for review and action, as set forth in the Bylaws.

6.5. INVESTIGATIONS

6.5.1. Initiation of Investigation:

6.5.1.1. 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. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so. The affected practitioner shall be notified if an investigation is opened.

6.5.1.2. The Governing Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Governing Board, or an ad hoc committee.

6.5.1.3. The President of the Medical Staff shall keep the Hospital President fully informed of all action taken in connection with an investigation.

6.5.2. 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 Governing Board, 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.

6.5.3. 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 material to the matter being investigated. A written report shall be prepared and promptly submitted to the body that requested the investigation.

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

6.5.4.1. Determine that corrective action is not warranted and dismiss the matter;

6.5.4.2. Decide to use one of the alternatives to corrective action, as described in paragraph 6.2 of these Bylaws; or,

6.5.4.3. Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Seven.

6.6. SUSPENSION OR TERMINATION

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Hospital

President, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Hospital President, and the individual's membership may be automatically terminated, as set forth below. The individual will be notified in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice, as set forth below. The President of the Medical Staff or designee will take necessary steps to enforce the suspension and the individual will be notified

6.6.1. The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

6.6.1.1. Licensure

If an individual's license to practice in the state of Maryland is revoked or suspended by the state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.6.1.2. Controlled Substance Registration

If an individual's DEA registration for Maryland or Maryland controlled substance registration permit is revoked, suspended, or restricted, (i.e., disciplinary action is taken by the DEA or State), he/she may be automatically suspended from practicing in the Hospital. If an individual fails to maintain a current unrestricted registration, (i.e., there is a lapse in renewal or failure to request all schedules needed for the prescribing privileges granted) the individual's prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

6.6.1.3. Liability Insurance

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

6.6.1.4. Eligibility to Participate in Federal Programs

If an individual is debarred and thus loses his/her ability to participate in any federal or State payer program (including but not limited to Medicare and Medicaid), his/her privileges will be immediately deemed revoked.

6.6.2.1. Medical Records

A medical record is considered to be delinquent when it has not been completed for any reason within 30 calendar days following a patient's discharge. Failure to complete a medical record and medical record delinquency will be defined by Hospital policy, which may include failure to comply with requirements pertaining to the use of electronic record-keeping systems. A Medical Staff Member or other individual with Privileges, following notification of the delinquency, may be administratively suspended in accordance with Hospital policy. The suspension may continue until all of the individual's delinquent records are completed. Such delinquency will not be considered to be an adverse action unless it is considered to be such by the Medical Executive Committee.

6.6.2.2. Misrepresentation

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is a material or substantive misrepresentation, as judged by the Medical Executive Committee, the individual's membership and clinical privileges may be terminated. Substantial or material misrepresentation of the applicant's qualifications, competence or character may be grounds for the Governing

Board to permanently disqualify an individual from applying for membership or clinical privileges or to set a specific time period after which the applicant may reapply.

6.6.2.3. Criminal Arrest or Indictment

In the event that an individual is arrested or indicted for alleged criminal acts, an immediate investigation into the circumstances of the arrest or indictment shall be made, following the investigations process set forth in these Bylaw.. The Medical Executive Committee shall review the circumstances leading to the arrest or indictment and may determine if further action is warranted prior to the outcome of the legal action. If the Medical Executive Committee recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in these Bylaws.

6.6.3. Reporting Requirement

Reports will be submitted to the National Practitioner Data Bank and appropriate State licensing agencies, as required by State and federal laws and regulations.

6.7. COVERAGE DURING SUSPENSIONS

When a precautionary suspension or an automatic suspension has been imposed, the Hospital will arrange for alternate coverage. When the individual being suspended or restricted is a Practitioner, the President of the Medical Staff or the Chief Medical Officer shall arrange for alternative medical coverage of a suspended Practitioner‘s patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Advanced Practice Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

6.8. REINSTATEMENT FOLLOWING A SUSPENSION

Requests for reinstatement following non-administrative suspension will be reviewed by the relevant department chair, the Chair of the Credentials Committee and the President of the Medical Staff, who will make recommendations to the Medical Executive Committee. Only the Medical Executive Committee may reinstate Privileges following a non-administrative suspension. This determination will then be forwarded to the the Governing Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Governing Board for review and recommendation.

6.9. AUTOMATIC RESIGNATION

6.9.1. Failure to Apply for Reappointment or Renewal of Privileges

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). If a member is on a leave of absence or active military duty when his/her membership and privileges expire, the member may apply for reappointment as an existing member of the Medical Staff, but such leave or duty does not extend the two-year term of appointment. In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired.

6.9.2. Failure to be Reinstated Following Automatic Suspension

When an individual is automatically suspended due to failure to maintain a current license, a controlled substance registration, liability insurance, or eligibility to participate in Federal programs, , or any other reason for automatic suspension, and the automatic suspension continues for more than 60 days without

verified evidence of reinstatement of the expired credential, reinstatement as a participant in Federal programs, or completion of medical records, then the individual shall be deemed to have voluntarily resigned from the Staff, voluntarily relinquished all clinical privileges, and waived any rights to fair hearing or appeal process. The individual shall be notified of the automatic voluntary resignation and the need to submit a new application if reinstatement of membership or clinical privileges is desired.

7. ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES

7.1. OVERVIEW

Fair hearing and appellate review procedures shall be used when professional review actions are being taken when it involves any individual applying for Medical Staff membership, for an existing Medical Staff Member, and for any other individual applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, and after a reasonable effort to obtain the facts of the matter, and in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures and other procedures as are fair to the individual are afforded to the individual subject to professional review actions. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Section 7.9.4 of these Bylaws.

7.2. EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1. COLLEGIAL ACTIONS

Collegial actions are attempts to improve a Practitioner's or APP's performance or conduct without corrective action. Collegial actions do not trigger hearing rights. Use of a collegial action does not preclude the use of corrective action.

7.2.2. AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed staff or exclusive contract or in accord with a Medical Staff development plan. The hearing and appeal rights under these Bylaws do not apply to an individual who has clinical privileges retracted or automatically terminated due to the Hospital closing or discontinuing a service, or entering into an exclusive contract.

7.2.3. MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the individual's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

7.2.4. AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Medical Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws for reasons not related to the Practitioner's qualifications, competence or professional conduct (e.g., loss of license or malpractice insurance coverage).

7.2.5. REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Staff membership. Participation in the emergency room on-call panel is determined solely by the department chair or Chief Medical Officer, within his/her sole discretion. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

7.2.6. ADMINISTRATIVE ACTIONS

A practitioner does not have the right to a hearing in any of the following circumstances:

7.2.6.1. Change to specific medical staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;

7.2.6.2. Actions taken due to failure to attend meetings as required;

7.2.6.3. Denial, termination or reduction of temporary, emergency, or disaster relief privileges;

7.2.6.4. Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;

7.2.6.5. Any other actions except those listed in Section 7.3.

7.3. HEARING RIGHTS

7.3.1. ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws if recommended by the Medical Executive Committee or if taken by the Governing Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where a right to hearing exists. The following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

7.3.1.1. Denial of initial staff appointment;

7.3.1.2. Denial of reappointment;

7.3.1.3. Non-administrative suspension of staff membership;

7.3.1.4. Revocation of staff membership;

7.3.1.5. Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;

7.3.1.6. Denial of requested clinical privileges;

7.3.1.7. Involuntary reduction in clinical privileges;

7.3.1.8. Precautionary suspension or restriction of clinical privileges, as defined in Article Six;

7.3.1.9. Revocation of clinical privileges; or,

7.3.1.10. Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

7.3.2. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 7.3.1 shall promptly be given written notice of such action by overnight delivery, hand delivery, or certified mail, return receipt requested. Such notice shall:

7.3.2.1. State the reasons for an adverse recommendation or action, with enough specifics to allow response;

7.3.2.2. Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

7.3.2.3. Advise the Practitioner that the Practitioner has 30 days following receipt of the notice to submit a written request for a hearing to the Medical Staff President.

7.3.2.4. State that failure to request a hearing within 30 days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Governing Board.

7.3.2.5. State a summary of the Practitioner‘s rights at the hearing.

7.3.2.6. State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

7.3.3. REQUEST FOR HEARING

A Practitioner shall have 30 days following his/her receipt of a notice pursuant to Section 7.3.2 to file a written request for a hearing. Such requests shall be delivered to the Hospital President either in person or by certified mail.

7.3.4. FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

7.3.4.1. An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Governing Board.

7.3.4.2. An adverse action by the Governing Board shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Governing Board.

7.4. HEARING PREREQUISITES

7.4.1. SPECIAL WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Medical Staff President shall inform the Hospital President. At least 30 days prior to the hearing, the Practitioner shall be sent a special written notice stating the following:

7.4.1.1. The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;

7.4.1.2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;

7.4.1.3. The Practitioner involved has the right:

7.4.1.3.1. To be present at the hearing;

7.4.1.3.2. To representation by an attorney or other person of the Practitioner's choice;

7.4.1.3.3. To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

7.4.1.3.4. To call, examine, and cross-examine witnesses;

7.4.1.3.5. To present evidence determined to be relevant by the Chair of the hearing panel, regardless of its admissibility in a court of law; and,

7.4.1.3.6. To submit a written statement at the close of the hearing.

7.4.1.4. Upon completion of the hearing, the Practitioner involved has the right:

7.4.1.4.1. To receive a record of the proceedings upon payment of a reasonable charge;

7.4.1.4.2. To receive the written recommendation of the hearing panel, including a statement of the basis for the recommendations; and,

7.4.1.4.3. To receive a written decision of the Governing Board, including a statement of the basis for the decision.

7.4.1.5. The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

7.4.2. APPOINTMENT OF HEARING PANEL

7.4.2.1. By Medical Staff: A hearing occasioned by an adverse recommendation of the Medical Executive Committee shall be conducted by an ad hoc hearing committee appointed by the President of the Hospital.

7.4.2.2. By Governing Board: A hearing occasioned by an adverse action of the Governing Board shall be conducted by a hearing panel appointed by the Chair of the Governing Board.

7.4.2.3. Composition of Hearing Panel: The hearing panel shall be composed of at least three members of the Medical Staff if the Medical Executive Committee was the body that voted to take

the action that triggered hearing rights. One of the members so appointed will be designated as the Chair. The Chair will preside over the hearing. No Member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a Member from serving. No Member shall be appointed who is known to be in direct economic competition with the Practitioner, or is a Member of the Medical Executive Committee or Governing Board. If practicable, at least one Member shall be of the same medical specialty as the Practitioner. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the hearing panel, the Medical Executive Committee or the Governing Board may appoint Practitioners who are not members of the Medical Staff.

7.4.2.4. Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any Member of the hearing committee for any cause, which would indicate bias or predisposition, by notifying the President of the Medical Staff within 10 days of receipt of the notice of the hearing arrangements. The Chair, or if challenged, the President of the Medical Staff, shall decide the validity of such challenges. His/her decision shall be final.

7.5. HEARING PROCEDURE

7.5.1. PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.3.4.

7.5.2. PRESIDING OFFICER

The Chair of the hearing panel shall be the presiding officer. The Chair of the hearing panel will act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she will be responsible for ensuring that the panel's report is timely submitted to the appropriate bodies, as set forth in these Bylaws.

7.5.3. APPOINTMENT OF A HEARING OFFICER

The Medical Staff President will select a hearing officer. Such hearing officer will be an attorney experienced in conducting hearings. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. The hearing officer may be present during deliberations, but may not vote.

7.5.4. REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice. The Medical Executive Committee or the Governing Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

7.5.5. RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

7.5.5.1. Call and examine witnesses;

7.5.5.2. Introduce exhibits;

7.5.5.3. Cross-examine any witness on any matter relevant to the issues;

7.5.5.4. Impeach any witness;

7.5.5.5. Rebut any evidence; and

7.5.5.6. Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

7.5.6. PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing panel is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The hearing panel shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the hearing panel Chair‘s discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

7.5.7. BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

7.5.8. RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing panel may select the method to be used for making the record, such as court reporter or electronic recording unit.

7.5.9. POSTPONEMENT

Request for postponement of a hearing shall be granted by the presiding officer to a date agreeable to the hearing panel only by stipulation between the parties or upon a showing of good cause.

7.5.10. PRESENCE OF HEARING PANEL MEMBERS AND VOTE

A majority of the hearing panel, but in no event less than three members, must be present throughout the hearing and deliberations. If a panel member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or to vote.

7.5.11. RECESSES AND ADJOURNMENT

The hearing panel may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Both parties shall be entitled to submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence and concluding written statements, the hearing shall be closed. The hearing panel shall, at

a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

7.6. HEARING PANEL REPORT AND FURTHER ACTION

7.6.1. HEARING COMMITTEE REPORT

Within 30 days after the final adjournment of the hearing, the hearing panel shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire hearing panel (excluding the hearing officer), and shall forward the same, together with the hearing record and all other documentation considered by it, to the Medical Executive Committee, with copies to the Hospital President and the Practitioner.

7.6.2. ACTION ON HEARING PANEL REPORT

Within 30 days after receipt of the written report of the Hearing Panel, the Medical Executive Committee or Governing Board, as the case may be, shall consider the report and affirm, modify or reverse its recommendations or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the Hospital President.

7.6.3. NOTICE AND EFFECT OF RESULT

7.6.3.1. The Hospital President shall promptly send a copy of the result and report to the Practitioner by special notice, to the President of the Medical Staff, to the Medical Executive Committee and to the Governing Board.

7.6.3.2. Effect of Favorable Result:

7.6.3.2.1. Adopted by the Medical Executive Committee: If the Medical Executive Committee‘s recommendation is favorable to the Practitioner, the Hospital President shall promptly forward it, together with all supporting documentation, to the Governing Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee‘s recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Governing Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Governing Board shall take final action at its next regularly scheduled meeting. The Hospital President shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.6.3.2.2. Adopted by the Governing Board: If the Governing Board‘s initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Governing Board and the matter shall be considered closed.

7.6.3.3. Effect of Adverse Result for Practitioner: If the result of the Medical Executive Committee or of the Governing Board continues to be adverse to the Practitioner in any of the respects listed in Section 7.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Governing Board as provided in Section 7.7.1.

7.7. APPELLATE REVIEW

7.7.1. Time for Appeal

7.7.1.1. Within 10 days after receipt of notice of the Hearing Panel's recommendation either party may request an appeal. The request shall be in writing, delivered to the Hospital President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Governing Board for final action.

7.7.2. Grounds for Appeal:

7.7.2.1. The grounds for appeal shall be limited to the following:

7.7.2.1.1. There was substantial failure to comply with the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

7.7.2.1.2. The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.7.3. Time, Place and Notice

7.7.3.1. Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Governing Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.7.4. Nature of Appellate Review

7.7.4.1. The Governing Board may consider the appeal as a whole body, or the Chair of the Governing Board may appoint a Review Panel composed of no less than three persons, either members of the Governing Board or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Governing Board.

7.7.4.2. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Governing Board (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

7.7.4.3. The Governing Board (or Review Panel) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence, or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Governing Board (or Review Panel).

7.7.5. Appellate Review of Governing Board Modification or Reversal of Hearing Panel Recommendation

7.7.5.1. If the Governing Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Governing Board shall notify the affected individual through the Hospital President that he/she may appeal the proposed modification or reversal. The Governing Board shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Governing Board has the final say in the matter, regardless

of what the Hearing Panel recommends, as long as the decision of the Governing Board reasonably relates to the operation of the Hospital and is administered fairly.

7.7.6. Final Decision of the Board

7.7.6.1. After the Governing Board (I) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Governing Board shall consider the matter and take final action at its next regularly scheduled meeting.

7.7.6.2. The Governing Board may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel. The Governing Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Governing Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

7.7.6.3. The Governing Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

7.7.7. Further Review

7.7.7.1. Except where the matter is referred by the Governing Board for further action and recommendation by any individual or committee, the final decision of the Governing Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Governing Board in accordance with the instructions given by the Governing Board.

7.8. RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Governing Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Governing Board provides otherwise.

7.9. GENERAL PROVISIONS

7.9.1. NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

7.9.2. RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article Twelve in these Bylaws relating to immunity from liability in all matters relating thereto.

7.9.3. CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law.

7.9.4. HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Advanced Practice Professionals - APPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for APPs:

7.9.4.1. Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has 30 days in which to request a hearing. If the APP does not request a hearing within 30 days, the APP shall have waived right to a hearing.

7.9.4.2. Hearing Panel: The Hospital President (or his/her designee) shall appoint a hearing panel, which will include three members. The panel members shall include the Hospital President (or his/her designee), the Medical Staff President or another officer of the Medical Staff, and a peer of the APP. None of the panel members shall have had a role in the adverse recommendation or action.

7.9.4.3. Rights: The APP subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses.

7.9.4.4. Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.9.4.4.1. A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

7.9.4.4.2. A determination adverse to the APP shall result in notice to the APP of the right to appeal the decision to the Chair of the Governing Board.

7.9.4.5. Final Decision: The decision of the Chair of the Governing Board shall be final.

7.9.5. EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report to the appropriate state professional licensure board (i.e., the state agency that issued the individual‘s license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.

8. ARTICLE EIGHT: MEDICAL STAFF OFFICERS

8.1. ELECTED OFFICERS OF THE STAFF

8.1.1. IDENTIFICATION

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

8.1.2. QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office. To qualify for the position of Medical Staff President or Medical Staff President-Elect, a Member of the Medical Staff must be a doctor of medicine or osteopathy. Except for these specific qualification requirements, no Medical Staff Member actively practicing in the Hospital is ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

8.1.2.1. Be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two (2) years for the position of Secretary/Treasurer, three (3) years for the position of President-Elect, and at least five (5) years for the position of President;

8.1.2.2. Have no pending adverse recommendations concerning medical staff appointment or clinical privileges;

8.1.2.3. Be willing to faithfully discharge the duties and responsibilities of the position;

8.1.2.4. Have experience in a leadership position for at least two years, or other involvement in performance improvement functions;

8.1.2.5. Attend continuing education relating to medical staff leadership and/or credentialing functions prior to and during the term of the office.

8.2. TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

8.2.1. TERM OF OFFICE

Each officer shall serve a two year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the Medical Staff President‘s term, the Medical Staff President-Elect shall automatically assume that office and the Medical Staff President shall automatically serve as the Immediate Past Medical Staff President.

8.2.2. ELIGIBILITY FOR RE-ELECTION

No Medical Staff officer may serve consecutively more than one term in the same position.

8.3. ATTAINMENT OF OFFICE

8.3.1. NOMINATION

At least 60 days before the Fall semi- annual General Medical Staff meeting of each election year, the Nominating Committee shall convene and submit to the Medical Staff President one or more qualified nominees for the offices of Medical Staff President-Elect and Secretary-Treasurer. The Nominating Committee shall report the names of the nominees to the Staff at least 30 days before the meeting. Nominations may also be made by petition signed by at least ten percent of the active staff, with a signed statement of willingness to serve by the nominee, filed with the Medical Staff President at least 10 days before the meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

8.3.2. ELECTION

Voting at the Fall semi-annual meeting shall be by voice, show of hands, secret written ballot, or electronic vote, at the discretion of the Medical Staff President, Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.

8.3.3. BOARD RATIFICATION/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Section officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities. The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:

8.3.3.1. The activities such leaders undertake shall be performed on behalf of the Hospital;

8.3.3.2. The activities shall be performed in good faith,

8.3.3.3. That any professional review action shall be taken:

8.3.3.3.1. In the reasonable belief that the action was in the furtherance of quality health care;

8.3.3.3.2. After a reasonable effort to obtain the facts of the matter;

8.3.3.3.3. After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

8.3.3.3.4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.

8.3.3.4. The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

8.3.3.5. Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification.

8.4. VACANCIES

8.4.1. WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status in good standing.

8.4.2. OFFICE OF THE MEDICAL STAFF PRESIDENT

When a vacancy occurs in the office of the Medical Staff President, then the Medical Staff President-Elect shall step into the role of the Medical Staff President. If the remaining term of the departing Medical Staff President was 90 days or less, the Medical Staff President-Elect will complete the remaining of the departing Medical Staff President, plus the term as Medical Staff President to which he/she was elected. If the remaining term of the departing President was more than 90 days, the Medical Staff President-Elect will fill in until the Medical Executive Committee arranges for a special election to fill the role of Medical Staff President. In the event of the simultaneous vacancy in both the Medical Staff President and Medical Staff President-Elect positions or in the entire officer positions, the Medical Executive Committee will appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Medical Executive Committee will convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

8.4.3. MEDICAL STAFF OFFICERS OTHER THAN THE MEDICAL STAFF PRESIDENT

When a vacancy occurs in the office of the Medical Staff President-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a Medical Staff President and Medical Staff President-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past Medical Staff President, the office shall remain vacant until after the next election.

8.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.5.1. RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

8.5.2. REMOVAL

Any elected Medical Staff officer or a member of the Medical Executive Committee may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Governing Board, or with the majority vote of the Governing Board. Grounds for removal may include any one or more of the following causes, without limitations:

8.5.2.1. Failure to perform the duties of office;

8.5.2.2. Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

8.5.2.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

8.5.2.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

8.5.2.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Governing Board prior to a vote on removal.

8.5.3. RECALL FROM OFFICE

Any elected Medical Staff officer or a member of the Medical Executive Committee may be recalled from office, with or without cause. Recall of a Medical Staff officer or a member of the Medical Executive Committee may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the Medical Staff members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. Such meeting will be held within 30 days of an appropriate request. A recall shall require two-thirds of the votes of the eligible Medical Staff members attending the specially-called meeting who are eligible to vote; The recall will become effective upon approval of the Governing Board.

8.6. RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

8.6.1. MEDICAL STAFF PRESIDENT

The Medical Staff President shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for the organization and conduct of the Medical Staff, and supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the Medical Staff President are to:

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

8.6.1.2. Serve as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

8.6.1.3. Serve as ex-officio Member of all other Medical Staff committees without vote, unless otherwise specified;

8.6.1.4. Appoint and discharge the Chairs of all Medical Staff ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Governing Board;

8.6.1.5. Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff‘s compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

8.6.1.6. Be accountable and responsible to the Governing Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

8.6.1.7. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Hospital President and the Governing Board, and serve as an ex-officio Member of the Board, with a vote;

8.6.1.8. Receive, interpret, and participate in the communication of the opinions, policies, and directives of the Administration and the Governing Board to the Medical Staff, following appropriate periodic meetings with the Administration;

8.6.1.9. Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,

8.6.1.10. Perform all other functions as may be assigned to the Medical Staff President by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Governing Board.

8.6.2. MEDICAL STAFF PRESIDENT-ELECT

The Medical Staff President-Elect shall perform the duties of the Medical Staff President in the absence or temporary inability of the Medical Staff President to perform. The Medical Staff President-Elect shall serve as the vice-chair of the Medical Executive Committee, the chair of the Credentials Committee and shall perform such additional duties as may be assigned by the Medical Staff President or the Board.

8.6.3. SECRETARY-TREASURER

The Secretary-Treasurer shall be a Member of the Medical Executive Committee and Credentials Committee and also serves as chair of the Finance Committee. The duties of the Secretary-Treasurer are to:

8.6.3.1. Maintain a roster of Medical Staff members;

8.6.3.2. Assure accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

8.6.3.3. Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Medical Staff President;

8.6.3.4. Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,

8.6.3.5. Oversee a record of Medical Staff dues, collections, and accounts for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.3.6 Will be, from time to time, required to participate in a medical staff leadership development course.

8.6.4. IMMEDIATE PAST MEDICAL STAFF PRESIDENT

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Medical Staff President shall serve as an advisor and mentor to the Medical Staff President, shall participate as a Member of the Medical Executive Committee and Credentials Committee, chair of the Professional Practice Evaluation Committee, and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Medical Staff President.

8.7. CHIEF MEDICAL OFFICER

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Section 3.16 of these Bylaws apply.

8.7.1. QUALIFICATIONS

The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership or clinical privileges to provide patient care services.

8.7.2. RESPONSIBILITIES AND AUTHORITY

The Chief Medical Officer shall serve as an advisor to the officers of the Medical Staff and as a liaison between the Medical Staff and the Administration of the Hospital. The authority of the Chief Medical Officer shall be that of an administrator of the Hospital, as assigned by the Hospital President. Specific responsibilities include, but are not limited to:

8.7.2.1. Administratively oversee the Medical Staff Services in performance of the credentialing function;

8.7.2.2. Serve as a designee of the Hospital President in reviewing and approving applications for emergency or disaster relief privileges;

8.7.2.3. Serve as an ex-officio Member of all Medical Staff committees, without vote;

8.7.2.4. Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

8.7.3. APPOINTMENT

After having received input from the Medical Executive Committee, Chief Medical Officer shall be appointed by the Hospital President and approved by the Governing Board.

8.7.4. VACANCY

In the event of a vacancy in the position of Chief Medical Officer, the Medical Staff President shall ensure that any Medical Staff functions associated with the position are performed.

9. ARTICLE NINE: CLINICAL DEPARTMENTS AND SECTIONS

9.1. The Medical Staff is divided into the following Departments:

9.1.1. Anesthesiology which includes Pain Management;
9.1.2. Cardiology, which consists of the following Sections:
- 9.1.2.1 General Cardiology;
- 9.1.2.2 Interventional Cardiology; and
- 9.1.2.3 Electrophysiology

9.1.3. Critical Care Medicine;
9.1.4. Emergency Medicine;
9.1.5. Medicine, which consists of the following Sections:
- 9.1.5.2. Gastroenterology;
- 9.1.5.3. Hematology/Medical Oncology;
- 9.1.5.4. Infectious Disease;
- 9.1.5.5. Internal Medicine/Family Medicine;
- 9.1.5.6. Nephrology;
- 9.1.5.7. Neurology;
- 9.1.5.8. Physical Medicine and Rehabilitation;
- 9.1.5.9. Pulmonary Medicine; and

9.1.5.10 Hospitalists

9.1.6. Obstetrics and Gynecology which includes Maternal Fetal Medicine, Reproductive Endocrinology, and Gynecology Oncology;

9.17. Pathology;

9.1.8. Pediatrics, which includes Neonatology;

9.1.9. Psychiatry;

9.1.10. Radiology, which includes Nuclear Medicine and Radiation Oncology; and

9.1.11. Surgery, which includes the following Sections:

9.1.11.2. General Surgery;

9.1.11.3. Neurological Surgery;

9.1.11.4. Ophthalmology;

9.1.11.5. Orthopedic Surgery

9.1.11.6. Otolaryngology, which includes Oral and Maxillofacial Surgery and Dentistry;

9.1.11.7. Plastic Surgery;

9.1.11.8. Podiatry;

9.1.11.10. Urology.

9.1.11.11 Thoracic and Vascular Surgery

9.1.11.12 Cardiac Surgery

9.2. REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS AND SECTIONS

Each Medical Staff Member and other individuals with clinical privileges shall be assigned to one Department by the Governing Board based on recommendations from the Credentials Committee and the Medical Executive Committee. A Medical Staff Member or other individual with clinical privileges may be assigned to a Section if one exists related to the Member‘s or individual‘s clinical specialty. A Member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations and the authority of the Department Chair.

9.3. FUNCTIONS OF DEPARTMENTS

The Departments shall meet no less than semi-annually to perform the following functions:

9.3.1. CLINICAL FUNCTIONS

9.3.1.1. Serve as a forum for the exchange of clinical information regarding services provided by Department members;

9.3.1.2. Provide recommendations to the Department Chair and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;

9.3.1.3. Provide recommendations to the Department Chair regarding professional criteria for clinical privileges designed to assure the Medical Staff and the Governing Board that patients shall receive quality care. The recommendations shall include:

9.3.1.3.1. Criteria for granting, withdrawing and modifying clinical privileges;

9.3.1.3.2. A procedure for applying these criteria to individuals requesting privileges.

9.3.1.4. Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;

9.3.1.5. Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;

9.3.1.5.1. By establishing uniform patient care processes;

9.3.1.5.2. By establishing similar clinical privileging criteria for similar privileges;

9.3.1.5.3. By using similar indicators in performance improvement activities.

9.3.1.6. Provide recommendations to the Department Chair and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;

9.3.1.7. Ensure effective mechanisms for the clinical supervision of Advanced Practice Professionals, and House Staff practitioners, if any.

9.3.2. ADMINISTRATIVE FUNCTIONS

9.3.2.1. Provide information and/or recommendations to the Department Chair with regard to the criteria for granting clinical privileges within the Department;

9.3.2.2. Ensure that individuals within the Department who admit patients have privileges to do so, and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.

9.3.2.3. Provide information and/or recommendations to the Department Chair and/or the Medical Executive Committee with regard to Medical Staff Policies;

9.3.2.4. Provide recommendations to the Department Chair and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.

9.3.3. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

9.3.3.1. Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis. However, for Departments that have a small number of members, or whose members are in practice arrangements that may raise reasonable concerns about conflicts of interest, such functions may be performed by sending matters outside the Hospital for external peer review, particularly if the issue under review relates to clinical competence and other such technical determinations;

9.3.3.2. Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals;

9.3.3.3. Ensure appropriate quality control is performed, if applicable to the Department;

9.3.3.4. Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department‘s performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

9.3.4. COLLEGIAL AND EDUCATIONAL FUNCTIONS

9.3.4.1. Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.

9.4. FUNCTIONS OF SECTIONS

The Sections shall meet as often as necessary at the call of the Department or Section Chair to perform the following functions:

9.4.1. The Section meetings shall serve as a forum to discuss clinical aspects of care related to the Section;

9.4.2. The Section may be requested by the Department Chair or Medical Executive Committee to meet to discuss specific issues related to quality assessment, peer review, performance improvement, and/or credentialing. In such cases, the Section shall report their findings directly to the Department Chair or the Medical Executive Committee.

9.5. OFFICERS OF DEPARTMENTS AND SECTIONS

9.5.1. IDENTIFICATION

The officers of the Departments shall be the Department Chair the Department Vice-Chair as well as the Section Chairs.

9.5.2. QUALIFICATIONS

The officers of the Departments and Sections shall be active staff members in good standing and shall be either board certified or to demonstrate comparable competence affirmatively established through the credentialing process. Each Department Chair and Vice-Chair shall have demonstrated ability in at least one of the clinical areas of the Department. The Section Chair shall have demonstrated ability in the specialty represented by the Section.

9.5.3. ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote and in attendance at the meeting of the Department which occurs prior to the November Medical Executive Committee during the same year as the election of officers for the Medical Staff. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year. Section Chairs will be elected in the same manner as Department Chairs.

9.5.4. TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Department and Section Chairs will serve a term of office of two years with the exception of contracted departments and sections. A person may serve more than one term, but not consecutively, unless otherwise approved by the Medical Executive Committee.

9.5.5. RESIGNATION

Any Department or Section officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

9.5.6. REMOVAL

Any Department or Section officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Governing Board, or with the majority vote of the Governing Board. Grounds for removal may include any one or more of the following causes, without limitations:

9.5.6.1. Failure to perform the duties of office;

9.5.6.2. Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

9.5.6.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

9.5.6.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,

9.5.6.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least 15 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Governing Board prior to a vote on removal. There is no right of appeal or due process for such action.

9.5.7. RECALL BY MEDICAL STAFF

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of the Department members eligible to vote in medical staff elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. The recall shall become effective upon approval of the Governing Board.

9.5.8. VACANCY

In the event of a vacancy in one of the Department officer positions, the Medical Staff President shall appoint an interim officer until an election can be held at the next Department meeting. In the event of a vacancy in a Section Chair position, the Chair of the Department to which the Section is affiliated shall appoint a new Section Chair.

9.5.9. RESPONSIBILITY AND AUTHORITY

9.5.9.1. Department Chair: Each Department Chair shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chair. Each Department Chair shall be responsible for the following duties:

9.5.9.1.1. Presiding at all meetings of the Department;

9.5.9.1.2. Serving as an ex-officio Member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

9.5.9.1.3. Serving as a Member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and

performance improvement activities of the Department to the Medical Executive Committee;

9.5.9.1.4. Conducting all clinically related activities of the Department;

9.5.9.1.5. Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;

9.5.9.1.6. Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

9.5.9.1.7. Participating in the evaluation of Practitioners practicing within the department;

9.5.9.1.8. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

9.5.9.1.9. Recommending clinical privileges for each Member of Department;

9.5.9.1.10. Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;

9.5.9.1.11. Integrating the Department into the primary functions of the Hospital;

9.5.9.1.12. Coordinating and integrating interdepartmental and intradepartmental services;

9.5.9.1.13. Developing and implementing policies and procedures that guide and support the provision of services;

9.5.9.1.14. Recommending a sufficient number of qualified and competent persons to provide care or services;

9.5.9.1.15. Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;

9.5.9.1.16. Ensuring the continuous assessment and improvement of the quality of care and services provided;

9.5.9.1.17. Maintaining quality control programs, as appropriate;

9.5.9.1.18. Ensuring the orientation and continuing education of all persons in the Department.

9.5.9.1.19. Recommending appropriate space and other resources needed by the Department.

9.5.9.2. Department Vice-Chair: The Vice-Chair shall assist the Department Chair in the performance of the Chair‘s duties, and shall assume the duties of the Chair in his/her absence.

9.5.9.3 Section Chair: The Section Chair shall be responsible for promoting quality of patient care in the Section. Each Section Chair shall be responsible for the following duties:

9.5.9.3.1. Calling and giving notice of a meeting of the Section members, to be held on an ad hoc basis, when issues are identified that require the members to deliberate quality of care issues unique to their specialty. The Section Chair shall preside at all of the meetings of the Section;

9.5.9.3.2. Being accountable to the Department Chair with regard to the activities and functioning of the Section, specifically to report any quality assessment and performance improvement activities of the Section at the meetings of the Department.

9.5.9.3.3. Attend no less than 50% of department meetings annually.

10. ARTICLE TEN: FUNCTIONS AND COMMITTEES

10.1. FUNCTIONS OF THE MEDICAL STAFF

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments, Sections, and committees that compose the Medical Staff structure.

10.1.1. GOVERNANCE

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

10.1.1.1. Establish a framework for self-governance of Medical Staff activities and accountability to the Governing Board.

10.1.1.2. Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.

10.1.2. PLANNING

The leaders of the Hospital include members of the Governing Board, the Hospital President and other senior managers, Department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico- administrative positions, and the Chief Nursing Officer and other senior nursing leaders. Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

10.1.2.1. Planning patient care services;

10.1.2.2. Planning and prioritizing performance improvement activities;

10.1.2.3. Budgeting;

10.1.2.4. Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non- members of the Medical Staff who have delineated clinical privileges;

10.1.2.5. Recruitment, retention, development, and continuing education of all staff;

10.1.2.6. Consideration and implementation of clinical practice guidelines as appropriate to the patient population.

10.1.2.7. Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department.

10.1.2.8. When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.

10.1.2.9. If emergency services are not provided at the Hospital, the Medical Staff shall have written policy and procedures for appraisal of emergencies, initial treatment, and referral of patients when needed.

10.1.2.10. The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest.

10.1.2.11. The attending physician, as a representative of the Medical Staff, shall be informed of autopsies that the Hospital intends to perform.

10.1.3. CREDENTIALING

The Medical Staff is fully responsible to the Governing Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

10.1.3.1. Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.

10.1.3.2. Establish professional criteria for membership and for clinical privileges.

10.1.3.3. Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.

10.1.3.4. Submit recommendations to the Governing Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.

10.1.3.5. Establish a mechanism for fair hearing and appellate review.

10.1.3.6. Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.

10.1.4. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY.

The Governing Board requires that the Medical Staff is accountable to the Governing Board for the quality of care provided to patients. All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital‘s quality assessment and performance improvement activities. All organized services related to patient care shall be evaluated. The Hospital‘s quality assessment and performance improvement activities shall be described in detail in the Hospital’s performance improvement plan. Through the activities of the Medical Staff Departments and

Sections, the Medical Staff Professional Practice Evaluation Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below. The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Governing Board.

10.1.4.1. The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Governing Board, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:

10.1.4.1.1. That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

10.1.4.1.2. That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

10.1.4.1.3. That clear expectations for safety are established.

10.1.4.1.4. That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital‘s performance and reducing risk to patients.

10.1.4.1.5. That the determination of the number of distinct improvement projects is conducted annually.

10.1.4.2. Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital‘s quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

10.1.4.2.1. Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;

10.1.4.2.2. Root cause analysis, investigation and response to any unanticipated adverse events;

10.1.4.2.3. Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

10.1.4.2.4. Review and analysis of performance based on the results of core measures and other publicly reported performance information;

10.1.4.2.5. Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;

10.1.4.2.6. Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

10.1.4.2.7. Use of blood and blood components, including the review of any significant transfusions reactions;

10.1.4.2.8. Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;

10.1.4.2.9. Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;

10.1.4.2.10. Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and,

10.1.4.2.11. Use of developed criteria for autopsies.

10.1.4.3. Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities shall include, but are not limited to a review of the following:

10.1.4.3.1. Analyzing and improving patient satisfaction;

10.1.4.3.2. Education of patients and families;

10.1.4.3.3. Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,

10.1.4.3.4. Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;

10.1.4.3.5. The quality of history and physical exams;

10.1.4.3.6. Surveillance of nosocomial infections.

10.1.4.4. Medical Staff Peer Review: Findings relevant to an individual are used in an ongoing evaluation of the individual's competence. When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff Member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.

10.1.5. CONTINUING AND GRADUATE MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy. The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.1.5.1. The type and nature of care offered by the Hospital; and,

10.1.5.2. The findings of performance improvement activities. Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of medical trainees in carrying out their patient care responsibilities.

10.1.6. BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

10.1.6.1. Remain consistent with the Bylaws of the Governing Board;

10.1.6.2. Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;

10.1.6.3. Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities; and,

10.1.6.4. Remain consistent with Hospital policies.

10.1.7. MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATIONS

The Medical Staff shall provide oversight for developing future medical staff leaders by defining desired leadership characteristics, identifying and recruiting future potential medical staff leaders from among the Members of the Medical Staff, and determining the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.

10.2. PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments, Sections, and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the Medical Staff President may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

10.3. DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Practitioner Health Committee, the Professional Practice Evaluation Committee, the Medical Education Committee, the Bylaws Committee, and the Nominating Committee.

10.4. OPERATIONAL MATTERS RELATING TO COMMITTEES

10.4.1. REPRESENTATION ON HOSPITAL COMMITTEES

The Nominating Committee will nominate Members to serve on various Hospital committees. Their selection will be approved by the Medical Executive Committee.

10.4.2. EX OFFICIO MEMBERS

The Hospital President, the President of the Medical Staff, and the Chief Medical Officer are ex-officio members of all Medical Staff committees. The Hospital President may designate another senior

administrative Member to attend any meeting in his/her place. At the prerogative of the Governing Board, Board Member(s) may be appointed by the Governing Board to serve as representative(s) of the Governing Board on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

10.4.3. APPOINTMENT OF CHAIRS AND MEMBERS

After nomination by the Nominating Committee, the Medical Executive Committee will appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the Chairs and any appointed members of the Medical Executive Committee, Credentials Committee, Peer Review Committee and any other committee performing a professional review activity shall be subject to ratification by the Governing Board per Section 8.3.3 of these Bylaws. The Hospital President, in consultation and with the approval of the Medical Staff President, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

10.4.4. TERM, PRIOR REMOVAL AND VACANCIES

If a Chair or Member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the Medical Staff President, the Medical Executive Committee, or the Governing Board may remove that Member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each Member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the Member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

10.4.5. NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than seven days before the meeting.

10.4.6. MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported voting system, fax, or email as approved by the Hospital.

10.4.7. QUORUM AND ATTENDANCE

The minimum number of members necessary to conduct business at PPEC, Credentials and the Medical Executive Committee shall be one-third of the voting members of the committee. To be counted towards meeting the quorum requirement, a member must either be present in person, or by interactive telecommunications. Members shall be required to attend no less than 75% of these meetings.

10.4.8. MANNER OF ACTING

Once a quorum has been established, a committee shall take action with a majority of the votes by those who are present and who have voting rights. No action of a committee shall be valid unless taken at a

meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

10.4.9. ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

10.4.10. MINUTES

Each committee and subcommittee shall record minutes of each meeting in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for perpetuity.

10.4.11. PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

10.4.12. REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

10.4.13. COMMITTEES, DEPARTMENTS AND SECTIONS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual's professional qualifications professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

10.4.13.1. Purpose of Peer Review: The purpose of the Hospital's peer review processes, programs, and proceedings are to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

10.4.13.1.1. To improve the quality of health care provided to patients;

10.4.13.1.2. To reduce morbidity and mortality at the Hospital;

10.4.13.1.3. To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

10.4.13.1.4. To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

10.4.13.2. Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff Member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

10.4.13.3. Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical records, review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.

10.4.13.4. Circumstances for Peer Review: The primary purpose of peer review activities shall be to improve an individual‘s performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual‘s performance patterns or trends vary substantially from the expected. Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual‘s performance are possibly significant to the cause of the event. Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the Medical Staff President, Hospital President, Medical Executive Committee, or any other committee authorized to review or evaluate an individual‘s performance, or the Governing Board. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the Medical Staff President, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review of evaluate an individual‘s performance, or the Governing Board.

10.4.13.5. Peer Review Panel: Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a Member or staff to a professional review body, or any person under contract with a professional review body. Ad hoc peer review panels may be selected for specific focused review by the Medical Staff President, Hospital President, Medical Executive Committee, any other Medical Staff committee authorized to review or evaluate care, or the Governing Board.

10.4.13.6. Timeframes for Review: Focused peer review activities shall be conducted and the results reported in accordance with Medical Staff policy. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.

10.4.13.7. Participation in Review: The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual.

10.4.13.8. Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. The names of individuals who present or provide information during a peer review process should be documented.

10.4.13.9. Custody: Peer review information, including Medical Staff records, shall be maintained under the custody of the Medical Staff President and the Hospital President.

10.4.13.10. Medical Staff Officers: Members of the Governing Board, licensing agencies, accreditation and regulatory authorities, the Hospital President, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Governing Board and the Hospital President and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.

10.4.13.11. Outside Requests for Information: The Medical Staff Services Office and the Medical Staff President (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution. The request must include information that the Practitioner or other individual with clinical privileges is a Member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

10.4.13.12. Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

10.4.13.13. Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the Hospital President (or his/her designee) and the Medical Staff President (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the Hospital President or Medical Staff President:

10.4.13.13.1. Specific statutory, regulatory or other appropriate authority to review the requested materials;

10.4.13.13.2. The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

10.4.13.13.3. The materials sought are the most direct and least intrusive means to accomplish the purpose;

10.4.13.13.4. Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;

10.4.13.13.5. If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.

10.4.13.14. Subpoenas: All subpoenas of Medical Staff records shall be referred to the Hospital President (or his/her designee).

10.4.13.15. Legal Counsel: Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

10.4.13.16. Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the Hospital President and the Medical Staff President for evaluation.

10.4.13.17. Peer Review Meetings: All peer review committee functions shall be performed only at meetings held on the campus of the Hospital.

10.5. MEDICAL EXECUTIVE COMMITTEE

10.5.1. COMPOSITION

The Medical Executive Committee will be composed of Medical Staff members, of which a majority of voting members shall be fully licensed physician members of the Medical Staff actively practicing in the Hospital. The membership shall include the Medical Staff President, the Medical Staff President-Elect, the Immediate Past Medical Staff President, the Secretary-Treasurer, the Chairs of each Medical Staff Department, representation from hospital-based physician groups, the Chairs of the standing committees (including the Professional Practice Evaluation Committee), the Performance Improvement Council chair, an Advanced Practice Professional, the Chief Medical Officer, Hospital President, and other members as selected by the Nominating Committee, Medical Executive Committee, and Governing Board. The Advanced Practice Professional, the Chief Medical Officer and Hospital President shall be ex-officio members without a vote. No Medical Staff Member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. The Medical Staff President shall serve as the Chair of the committee.

10.5.2. DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 10.1.1 and 10.1.2, and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

10.5.2.1. Providing for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board.

10.5.2.2. Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

10.5.2.3. Collaborate with other leaders of the organization in Hospital planning.

10.5.2.4. Review the qualifications, evidence of current competence, and the recommendations of a Department Chair and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, staff category, assignment to Departments and Sections, clinical privileges, and any disciplinary actions.

10.5.2.5. Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities, including receiving reports from the Hospital's Performance Improvement Council.

10.5.2.6. Conduct and supervise Medical Staff peer review activities.

10.5.2.7. Receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities.

10.5.2.8. Make recommendations directly to the Governing Board with regard to all of the following:

10.5.2.8.1. The Medical Staff structure;

10.5.2.8.2. The mechanism used to review credentials and to delineate individual clinical privileges;

10.5.2.8.3. Recommendations of individuals for Medical Staff membership;

10.5.2.8.4. Recommendations for delineated clinical privileges for each Practitioner;

10.5.2.8.5. The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;

10.5.2.8.6. Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;

10.5.2.8.7 The mechanism by which Medical Staff membership may be terminated; and,

10.5.2.8.8. The mechanism for fair hearing procedures.

10.5.2.9. Report at each General Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

10.5.3. MEETINGS AND REPORTING

The Medical Executive Committee will meet at least ten times per year. It will report the activities of the Medical Staff and the Medical Executive Committee to the Governing Board.

10.6. CREDENTIALS COMMITTEE

10.6.1. COMPOSITION

The Credentials Committee will be composed of at least six voting members who will be active Medical Staff Members and Advanced Practice Professionals in good standing. The voting membership will include, but not be limited to, the Medical Staff President-Elect who shall chair the committee, two past Medical Staff Presidents, the Chair of the Professional Practice Evaluation Committee, the Secretary-Treasurer and at least three others as selected by the Nominating Committee. In addition to the Hospital President and the Chief Medical Officer, the ex-officio members without vote shall also include a designated representative from the Medical Staff Services department. The Credentials Committee may seek recommendations, as appropriate, from individuals with particular expertise in the matters being reviewed, including the applications and privileges of non-Physicians.

10.6.2. DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws in Section 10.1.3, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for Membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

10.6.2.1. Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;

10.6.2.2. Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

10.6.2.3. Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;

10.6.2.4. Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

10.6.3. MEETINGS AND REPORTING

The Credentials Committee shall meet at least ten times per year, and shall report their recommendations and activities to the Medical Executive Committee.

10.7. PRACTITIONER HEALTH COMMITTEE

10.7.1. COMPOSITION

The Practitioner Health Committee will be comprised of the members of the Credentials Committee, sitting by special designation as the Practitioner Health Committee on an as-needed basis. It will keep separate minutes from those of the Credentials Committee. The Practitioner Health Committee is responsible for reviewing and making recommendations to the Credentials Committee, the Medical Executive Committee, and the Governing Board regarding all aspects of any Practitioner's health, either individually or collectively. It will meet at the request of the Credentials Committee, the Medical Executive Committee, the Medical Staff President, or the Hospital President.

10.8. PROFESSIONAL PRACTICE EVALUATION COMMITTEE

10.8.1. COMPOSITION

The Professional Practice Evaluation Committee shall be composed of active staff members in good standing. The Immediate Past Medical Staff President will be the chair, although if he/she declines or is unable to serve in such capacity, the Medical Staff President may select a replacement chair. Other voting members will be selected by the Nominating Committee and will include the physician chair of the Performance Improvement Council, who shall have a vote, and the Hospital President and the Chief Medical Officer, who will both serve without vote. The Professional Practice Evaluation Committee shall also have the option of calling upon any Member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment being subject to the approval of the Medical Staff President acting on behalf of the Medical Executive Committee and the Governing Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Section 8.3.3. Ad hoc members of the committee shall not have voting rights on the committee.

10.8.2. DUTIES AND AUTHORITY

The Professional Practice Evaluation Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership participation in the Hospital‘s performance improvement program through the activities of the Medical Staff Departments, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Professional Practice Evaluation Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual‘s performance, the committee shall conduct peer review or an ongoing evaluation of the individual‘s competence and make recommendations accordingly. In addition, the Professional Practice Evaluation Committee shall perform the following specific functions:

10.8.2.1. Participate in an annual evaluation of the Hospital‘s Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.

10.8.2.2. Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

10.8.3. MEETINGS AND REPORTING

The Professional Practice Evaluation Committee shall meet at least six (6)times per year, and shall report their recommendations and activities to the Medical Executive Committee.

10.9. BYLAWS COMMITTEE

10.9.1. COMPOSITION

The Bylaws Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the Immediate Past Medical Staff President, the current Medical Staff President, the Medical Staff President-Elect, the Secretary-Treasurer, and two at-large members of the Active Staff, as selected by the Nominating Committee in addition to the Hospital President (or his/her designee) and the Chief Medical Officer, who shall serve without vote. The chair will be a member of the active staff in good standing, as nominated by the Nominating Committee and elected by the Medical Staff. The Medical Staff Services Director may also attend meetings but will not have a vote.

10.9.2. DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in Section 10.1.6, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and the Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions.

10.9.3. MEETINGS AND REPORTING

The Bylaws Committee shall meet at least annually or at the request of the Medical Executive Committee, and shall report its recommendations and activities to the Medical Executive Committee.

10.10. FINANCE COMMITTEE

10.10.1. COMPOSITION

The Finance Committee will be composed of the Secretary-Treasurer of the Medical Staff, who will serve as chair, at least two members to be elected from the Active Staff, and a member to represent the Hospital administration to be appointed by the Hospital President. The Medical Staff Services Director shall also attend the meetings but will have no vote.

10.10.2. DUTIES AND AUTHORITY

The Finance Committee will supervise the collection of Medical Staff dues and other funds, as well as their disbursement as directed by the Active Staff. Disbursements of up to $1,000 apiece may be made upon the discretion of the President of the Medical Staff, without the concurrence of the Finance Committee chair or other members of the Finance Committee, although all such expenditures will be reported to the Finance Committee at its next meeting.

10.10.3. MEETINGS AND REPORTING

The Finance Committee shall meet at least annually or at the request of the Medical Executive Committee, and shall report its recommendations and activities to the Medical Executive Committee.

10.11. NOMINATING COMMITTEE

10.11.1. COMPOSITION

The Nominating Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the Medical Staff President-Elect, who shall chair the meeting, the Medical Staff President, the Immediate Past Medical Staff President, and the Chair of each Department. The Hospital President and the Chief Medical Officer may be asked for input but then may be excused from the meeting. The Medical Staff Services Director shall also attend the meetings but will have no vote.

10.11.2. DUTIES AND AUTHORITY

The Nominating Committee shall perform its functions under the oversight and direction of the Medical Executive Committee. The Nominating Committee shall define desired leadership characteristics, identify and recruit future potential medical staff leaders from among the Members of the Medical Staff, and shall advise the Hospital President, the Chief Medical Officer, and the Medical Executive Committee of the education and development needs of potential medical staff leaders so as to be successful in future roles. The Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions,

consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

10.11.3. MEETINGS AND REPORTING

The Nominating Committee shall meet such that it can produce a slate of candidates to be approved by the Medical Executive Committee and published at least 30 days before the annual meeting of the Medical Staff.

11. ARTICLE ELEVEN: MEETINGS

11.1. MEDICAL STAFF YEAR

The Medical Staff year shall be the period from January 1 to December 31 of each year.

11.2. MEDICAL STAFF MEETINGS

11.2.1. REGULAR MEETINGS

The regular meeting of the Medical Staff shall be held at least semi-annually at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

11.2.2. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the Medical Staff President and shall be called by the Medical Staff President at the request of the Medical Executive Committee or any 50 members of the Active Staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.3. DEPARTMENT AND SECTION MEETINGS

11.3.1. REGULAR MEETINGS

Regular meetings of each Department shall be held at least semi-annually, or more frequently as necessary to perform the functions of Departments as specified in Article 9 of these Bylaws. The Sections shall meet as often as necessary to perform Section functions.

11.3.2. SPECIAL MEETINGS

Special meetings of a Department may be called at the direction of the Chair of the Department and shall be called by the Chair or 30% of the members of the active staff of the Department by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.4. ATTENDANCE REQUIREMENTS

11.4.1. GENERALLY

Active staff members of the Medical Staff shall be required to attend 50% of the general staff meetings. Departments may make their own attendance requirements. Attendance shall be considered at the time of reappointment when evaluating whether a Member has met the obligations associated with Medical Staff membership.

11.4.2. SPECIAL APPEARANCES

Participation requirement for a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

11.5. MEETING PROCEDURES

11.5.1. NOTICE OF MEETINGS

Notice of the date, time and place of the semi-annual Medical Staff meetings shall be given not less than 14 days or more than 31 days prior to a regular meeting, and not less than three days prior to a special meeting of the general Medical Staff by written notice by email to each Member of the active staff at his/her address as shown in Medical Staff records. The Medical Executive Committee or the Medical Staff President may send notice to members of other categories of the Medical Staff, the Hospital President, members of Administration and others. Email shall be deemed to be received within 24 hours of when it is sent. Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven days prior to the meeting.

11.6. QUORUM

11.6.1. GENERAL STAFF MEETINGS

At least 50 Active Staff members must be present in person to constitute a quorum for the transaction of business at any General Medical Staff semi-annual meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.6.2. DEPARTMENT OR SECTION MEETINGS

At least 20% of the Active Staff members shall constitute a quorum for the transaction of business at any Medical Staff Department or Section meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

11.7. MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff semi-annual meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of voting Department members present at a Medical Staff Department meeting at which a quorum is present shall be the act of the Department. Voting at any meeting of any Medical Staff committee, department, or section shall be by voice, show of hands, secret written ballot, or electronic vote, as the discretion of the applicable meeting chair.

11.8. VOTING RIGHTS

Only Active Staff members have the right to vote.

11.9. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

11.10. MINUTES

The Secretary-Treasurer shall ensure the preparation of minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary-Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department Chair and each Section Chair shall ensure that minutes are prepared for their respective Department or Section meetings.

11.11. PROCEDURAL RULES

The Medical Staff President, or in his/her absence, the Medical Staff President-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert‘s Rules of Order, as may be modified by the Medical Staff.

12. ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASE

12.1. AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every Member of the Medical Staff or individual with clinical privileges agrees that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Governing Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges (including temporary, emergency, or disaster relief privileges), each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

12.2. CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Governing Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the Hospital President, Administrative officials, the Governing Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a Member of the Medical Staff, authorized representatives of the Staff, the Administration or the Governing Board.

12.3. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment /performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, Section, or committee is inconsistent with appropriate standards of conduct for this Medical Staff and may be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach may subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

12.4. IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

12.4.1. Applications for appointment to the Medical Staff or for clinical privileges;

12.4.2. Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;

12.4.3. Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;

12.4.4. Hearing and appellate review;

12.4.5. Medical care evaluations;

12.4.6. Peer review evaluations;

12.4.7. Utilization review and resource management; and,

12.4.8. Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person‘s professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

12.5. RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff Member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss and liability, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

12.6. SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

12.7. NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

13. ARTICLE THIRTEEN: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

13.1. MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Governing Board shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions. The Governing Board shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws, including the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws. The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Governing Board shall uphold the Medical Staff Bylaws that have been approved by the Governing Board.

13.2. EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

13.3. METHODOLOGY

13.3.1. MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the Medical Staff President, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least 10% of the voting members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. If the proposed revision is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the revision via written notice of the proposed change to all voting members of the Medical Staff no less than 20 days prior to the meeting at which the Bylaws changes are to be voted upon. If the proposed revision is made by written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the revision via written notice of the proposed change to all members of the Medical Executive Committee no less than 20 days prior to the meeting upon which the Bylaws changes are to be voted. The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s).

If a quorum is present as described in Section 11.6.1, for the purpose of enacting a Bylaw change, the change shall require an affirmative vote of greater than 50% of the members voting in person.In the event of a conflict within the Medical Staff regarding Medical Staff Bylaws, the Medical Staff process for conflict management shall be implemented. Bylaw changes adopted by the Medical Staff shall become effective following approval by the Governing Board, which approval shall not be unreasonably withheld.

Following significant changes to the Bylaws, Rules and Regulations or Medical Staff Policies, Medical Staff members shall be provided with a revised text.

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Governing Board may provisionally approve, the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within 10 days after the Governing Board has approved the amendment. The voting members of the Medical Staff shall have an additional 20 days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Governing Board if necessary.

Neither the Governing Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below. As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Governing Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the Medical Executive Committee‘s or Medical Staff‘s approval, including using the conflict management process as set out below in Section 13.5.9. In such a situation, the Governing Board‘s amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within 10 days of the amendment becoming final.

13.3.2. RULES & REGULATIONS AND MEDICAL STAFF POLICIES

13.3.2.1. Subject to approval by the Governing Board, the Medical Executive Committee, acting on behalf of the Medical Staff, may adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Bylaws of the Governing Board.

13.3.2.2. Department Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Governing Board, each Department may formulate its own Department Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. Such Department Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Bylaws of the Governing Board.

13.4. TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations and Policies.

13.5. GENERAL PROVISIONS

13.5.1. SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital.

13.5.2. AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

13.5.3. NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

13.5.4. NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations. Alternatively, notices may be sent by email or by commercial overnight delivery service to the address on file with the Medical Staff Services Office.

13.5.5. NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations. Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

13.5.6. CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Governing Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself/herself.

13.5.6.1. When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. For this reason, no Medical Staff member may be involved in peer review involving a member of his/her own professional practice group unless specifically approved by the Medical Executive Committee. Also, if a

member subject to peer review is in a specialty with a small number of Practitioners, external peer review information may be sought as deemed appropriate by the Professional Peer Evaluation Committee. However, an individual with a perceived conflict may provide relevant information and may answer any questions concerning the matter before leaving the discussion.

13.5.6.2. Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Medical Staff President (or to the Vice Chief if the Medical Staff President is the person with the potential conflict), or the applicable Department Chair or Committee Chair. The Medical Staff President or the applicable Department Chair or Committee Chair will make a final determination as to whether the provisions in this Article should be triggered.

13.5.6.3. The fact that a Department Chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.

13.5.6.4. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

13.5.7. NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

13.5.8. CONFLICT

In the event that these Bylaws, including provisions for fair hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

If at any point there is a lack of clarity in these Bylaws, the authority to interpret these Bylaws rests with the Medical Executive Committee or Board of Directors.

13.5.9. CONFLICT MANAGEMENT/RESOLUTION

13.5.9.1. CONFLICTS BETWEEN THE BOARD AND THE MEDICAL EXECUTIVE COMMITTEE

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

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

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

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

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

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

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

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

The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

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

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

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

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

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

13.5.10. ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.