UM BALTIMORE WASHINGTON MEDICAL CENTER

MEDICAL STAFF BYLAWS

Approved by the Medical Executive Committee: July 12, 2016
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ARTICLE I NAME

The name of this organization shall be the Medical Staff of Baltimore Washington Medical Center.

ARTICLE II DEFINITIONS

In these Bylaws, these words shall have the following meanings:

1. AFFILIATE means those allied health professionals who are authorized to practice at the Hospital and who possess Clinical Privileges. Affiliates are non MD / DO health care providers that include but are not limited to psychologists, physician assistants, dentists, podiatrists and nurse practitioners. Affiliates include those who are permitted to provide patient care services independently within the Hospital without direct supervision within the scope of their licensure and designated Clinical Privileges (psychologists) ("Independent Affiliates"), and those who are dependent upon an employment relationship with a Medical Staff Member or the Hospital that requires direct supervision (physician assistants and nurse practitioners) ("Dependent Affiliates").

2. APPLICANT means either a Medical Staff Member or an Affiliate applying (as an initial appointee or for reappointment) for membership on the Medical Staff and/or for Clinical Privileges.

3. BOARD CERTIFIED or BOARD CERTIFICATION means holding a certificate issued by the American Board of Medical Specialties (or its equivalent for the Practitioner's practice area, as determined by the Credentials Committee).

4. BOARD OF DIRECTORS or BOARD means the governing body of Baltimore Washington Medical Center.

5. BYLAWS shall mean these Medical Staff Bylaws, as well as any Medical Staff Rules and Regulations that are adopted by the Medical Staff and approved by the Board that apply to Practitioners.

6. CHIEF EXECUTIVE OFFICER means the individual appointed by the Board to act on its behalf in the overall day-to-day administration of the Hospital (or his/her designee).

7. CHIEF MEDICAL OFFICER means the Physician designated by the Hospital as its Chief Medical Officer.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff Member or Affiliate to render specific diagnostic, therapeutic, medical, dental or surgical services after consideration of the applicant's qualifications and the setting characteristics including facilities, equipment, number and type of qualified support personnel and resources.

9. DENTIST means an individual who is, was, or will be licensed to practice dentistry by the Maryland State Board of Dental Examiners, including oral and maxillofacial surgeons, general dentists, pedodontists, periodontists, prosthodontists, orthodontists, and oral pathologists.

10. *EX OFFICIO* means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

11. HOSPITAL means the acute-care facility operated by The Baltimore Washington Medical Center Association, Inc.

11.1 HOUSE PHYSICIAN means those Adjunct physicians who provide care to patients of other attending physicians, including completing admitting note, attending to emergencies and other routine matters for which the attending or consulting physician may not be immediately and/or personally available.

12. MEDICAL STAFF means the formal organization entitled "Medical Staff of Baltimore Washington Medical Center" comprised of all licensed practitioners who are privileged to attend patients in the Hospital. It does not include Affiliates as Members, although Affiliates must be granted Clinical Privileges through the Medical Staff credentialing process in accordance with these Bylaws, in order to practice at this Hospital.

13. MEDICAL STAFF MEETINGS means the meetings of the full Medical Staff.

14. MEMBER means a physician, dentist, or podiatrist who has been granted membership on the Medical Staff. It does not include Affiliates.

15. PHYSICIAN means a physician who is licensed to practice medicine by the Maryland Board of Physicians.

16. PODIATRIST means a podiatrist who is licensed to practice podiatry by the Maryland State Board of Podiatric Medical Examiners.

17. PRACTITIONER means a health care professional who is a physician, dentist, nurse practitioner, physician assistant, certified registered nurse anesthetist, podiatrist, or psychologist.

18. QUORUM means, unless these Bylaws otherwise specifically so provide, the group of the voting members of the committee present, unless these Bylaws otherwise specifically provide.

19. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt requested.

20. STATE means the State of Maryland.

ARTICLE III ESTABLISHMENT AND PURPOSE

3.1 Establishment of Medical Staff.

A. There shall be established within the Hospital a Medical Staff, which shall consist of all Practitioners who have been granted the right to exercise Clinical Privileges within the Hospital. No Practitioner, including those employed by or contracted to the Hospital, may admit patients or provide medical services to any patient in the Hospital unless he/she has been granted appropriate Clinical Privileges through the Medical Staff credentialing process set forth in these Bylaws. The Board of Directors of the Hospital shall, in the exercise of its discretion, delegate to the Medical Staff the responsibilities of providing appropriate professional care to the Hospital's patients.

B. Subject to approval by the Board of Directors, the Medical Staff shall adopt such Medical Staff Bylaws, Rules and Regulations as may be necessary to implement the general principles found within such Bylaws, to promote the delivery of quality health care within the Hospital, and to provide for the effective operation of the Hospital. Each Practitioner shall exercise his/her Clinical Privileges within the Hospital subject to the provisions contained within such Bylaws, Medical Staff rules and regulations, departmental rules and regulations and further subject to the policies and procedures of the Hospital and directives of the Board of Directors. This accountability includes compliance with standards of the Maryland Board of Physicians**,** the Maryland Department of Health and Mental Hygiene, The Joint Commission, the U.S. Department of Health and Human Services, and other appropriate agencies or organizations as identified from time to time by the Hospital, with the consent of the Medical Executive Committee (to be ratified by the Medical Staff at a Medical Staff Meeting).

C. The Medical Staff will strive to ensure quality patient care through its direct responsibilities in the functions of quality assurance, peer review, credentialing, risk management, and professional education.

3.2 Purpose of Medical Staff.

The Medical Staff is an integral part of the Hospital and not considered a separate entity. These Medical Staff Bylaws shall serve as a framework for self-governance of Medical Staff activities and are not intended to create an entity separate from the Hospital. The Practitioners granted Clinical Privileges at the Hospital through these Medical Staff Bylaws are not considered employees of the Hospital, except as set forth in any specific agreement between a Practitioner and the Hospital indicating such. The Board of Directors retains the right and obligation to make final decisions regarding Medical Staff matters and to initiate action when required to protect Hospital patients and to seek quality care.

3.3 The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws.

3.4 These Bylaws apply with equal force to both sexes whenever a gender term is used.

ARTICLE IV MEDICAL STAFF MEMBERSHIP AND APPLICATIONS FOR CLINICAL PRIVILEGES

4.1 Nature of Membership and Clinical Privileges.

Membership on the Medical Staff and/or Clinical Privileges shall be extended only to Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to the Medical Staff shall confer on the Practitioner only such Clinical Privileges as have been granted by the Board in accordance with these Bylaws. No Practitioner shall admit or provide services to patients in the Hospital unless he/she has been granted appropriate Privileges in accordance with the procedures set forth in these Bylaws.

4.2 Qualifications for Membership and Clinical Privileges.

A. In order to be qualified for Medical Staff membership and/or Clinical Privileges, a Practitioner must provide adequate documentation that he/she:

1. Have a current, unrevoked, and unsuspended license to practice his/her profession in the State of Maryland;
2. Has documented education, background, experience, training, and demonstrated current clinical competence within his/her field of practice as demonstrated by recent experience in the management of patients representative of those admitted to this Hospital;
3. Adheres to the ethics of his/her profession;

4. Have the ability to consistently and competently exercise the requested Privileges, including documentation of mental and emotional stability and physical health status;
5. Has a good reputation and professional character;
6. Has the ability to work harmoniously with other professionals and Hospital personnel and interact appropriately with such persons, as well as with patients and the general public;
7. Is willing to discharge Medical Staff responsibilities;
8. Does not support, practice, or claim to practice any exclusive or sectarian system of medicine;
9. Meets the requirements, if any, for membership in the department he/she intends to join;
10. Has performed adequately as a member of the medical staff at other hospitals or health care facilities, if the Applicant or Member has held such other membership;
11. If the application is for initial appointment, the Applicant shall supply at least three adequate references. At least one–of these references should be from the Applicant's most recent chief of service. At least two references must be from physicians. The third reference should be from a physician, or, in the case of a non-physician applicant, from an appropriate allied health professional with appropriate and direct supervisory and/or training experience for the applicant. All references shall be familiar with the applicant's recent professional competence and character in a hospital setting;
12. Has provided sufficient documentation of pending and past liability claims and judgments, any settlements or monetary payments made, and any denials or cancellations of any professional liability insurance policy;
13. Has professional liability insurance issued by an insurer acceptable to the Board and admitted to issue such insurance in the State of Maryland in an amount of not less than $1,000,000 per claim/$3,000,000 aggregate. The Practitioner shall supply all requested information, including the name of the present carrier, current limits of coverage, current types of coverage, restrictions on coverage, and whether coverage has been continuously maintained since the Practitioner first obtained professional liability insurance. If any Practitioner changes insurance carriers for any reason, changes from occurrence to claims-made coverage, or has his/her insurance coverage terminated or limited for any reason, such Practitioner shall immediately notify the Medical Staff Office in writing. Failure to maintain such insurance shall result in automatic suspension in accordance with Section 12.3 of these Bylaws;
14. Is located close enough to the Hospital to fulfill Medical or Affiliate Staff responsibilities, for the purpose of providing timely and continuous care. This includes being personally present at the Hospital as necessary or appropriate for hospitalized or emergency department patients.

15. Has provided truthful and accurate responses to such other items of information or inquiry which may be contained on the application for initial appointment or reappointment, including but not limited to questions regarding any hospital(s) where the Applicant was appointed or employed (including name of hospital, term of appointment or employment, and privileges held); the Applicant's medical history (including current mental and physical health status); and pending or previous investigations or actions regarding hospital privileges, licensure, and other professional registrations, associations, and certifications;
16. Has fulfilled the continuing medical education requirements as specified by the Maryland Board of Physicians or other applicable State licensing board and has available for submission and inspection upon request by the Hospital the requisite documentation for the preceding six years; and
17. Has maintained all appropriate certifications and licenses to adequately practice his/her profession, such as a current unrestricted U.S. Drug Enforcement Administration Certificate and Maryland Controlled Dangerous Substance Certificate, where applicable to their practice.
18. Has agreed to fulfill all responsibilities concerning emergency department call;
19. If requested by the hospital, a completed statement concerning conflict of interest.

A. In addition to the qualifications for membership and Privileges set forth above, all statutory and regulatory requirements of the federal government and the State of Maryland regarding the credentialing of physicians are incorporated herein and become qualifications for membership.

B. In addition to the minimum requirements set forth in this Article and updating all information set forth in Section 4.2A of these Bylaws, all Applicants for reappointment shall demonstrate satisfactory compliance with the following additional qualifications:

1. Required degree of attendance at Medical Staff Meetings as defined elsewhere in these bylaws and satisfactory participation in Medical Staff affairs;
2. Compliance with these Bylaws, rules, regulations, and Hospital policies;
3. Acceptance of committee assignments and attendance at committee meetings;
4. Acceptable coverage of the Hospital's Emergency Department (provided, however, that if the Applicant has continuously maintained Clinical Privileges at the Hospital for at least 25 years, he/she may request not to participate in such assignments. This will be at the discretion of the chair of the department when adequate ED coverage can be provided by the remaining members of the department.
5. Appropriate use of the Hospital's facilities for care rendered to the Practitioner's patients; and
6. Complete and accurate answers to all questions concerning the Practitioner's pattern of performance based on an analysis of any claims filed against the Practitioner; quality and risk data; review of current clinical skills; compliance with continuing education requirements; assessment of current mental and physical health status; and attitudes, cooperation, and ability to work with others.

7. Complied with the policies and procedures regarding the use of electronic medical records systems.

C. All Applicants and Members shall have the burden of adequately documenting and demonstrating that their credentials meet the qualifications necessary to assure the Medical Staff and Board of Directors that the patients treated by them shall be given appropriate medical care. No Practitioner shall be entitled to appointment to the Medical Staff or to exercise particular Clinical Privileges in the Hospital merely by virtue of the fact that he/she: is duly licensed to practice his/her profession in the State of Maryland or any other state; is a member of any professional organization; has had prior, current or pending Maryland licensure; is employed at Baltimore Washington Medical Center; or has privileges at other hospitals.

D. All Practitioners are deemed to have consented, as a condition to submitting an application for appointment or reappointment, to mental or physical examination or immediate testing of blood and/or urine for controlled dangerous substances and/or alcohol, in circumstances where probable cause is found to exist, upon request of both the President of the Medical Staff and the Chief Executive Officer (or their designees).

Probable cause may include, but not be limited to, erratic behavior, apparent inability to perform work duties, odor of alcohol or controlled substances (e.g., marijuana), or any other behavior that reasonably gives rise to concern for patient, Medical Staff or employee safety, and that reasonably appears to result from consumption or use of controlled substances or alcohol.

Any positive test result for drugs or alcohol under this subsection will be reviewed by the President of the Medical Staff, the Chief Executive Officer, and the Medical Staff Member who has been positively tested to determine appropriate disposition. All aspects of this testing process, including the rights of the tested person, shall be governed by the requirements of State and Federal law, and in particular, Section 17-214 of the Health-General Article, Maryland Code.

E. Medical Staff memberships and Clinical Privileges are granted without discrimination, and membership or Clinical Privileges shall not be granted or denied on the basis of age, sex, race, creed, color, national origin, sexual preference**,** or disability.

F. Appointment and reappointment to the Medical Staff shall also be dependent upon the Applicant's qualifications in light of criteria set forth below, relevant to the needs of the community, as well as the Hospital's ability to accommodate the Applicant's expectations of the Hospital Criteria which shall be considered in the evaluation of each application shall include current and expected patient care needs, availability of adequate facilities and supportive services; and actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services, including, but not limited to, long- and short-range development plans in the process of implementation. The proximity of the Applicant's practice and primary patient care community to the Hospital shall be an additional factor, which may be considered in evaluating the application.

G. A Practitioner employed by the Hospital is not automatically granted Medical Staff membership or Clinical Privileges. An employed Practitioner is subject to the qualifications and application process and all other provisions of these Bylaws. A Practitioner's termination of employment by the Hospital for any reason shall automatically result in the contemporaneous termination of Medical Staff membership and Clinical Privileges, without any due process rights under these Bylaws, if the Practitioner's written agreement with the Hospital specifically so provides. A Dependent Affiliate's termination of employment, for any reason, by any Physician Member of the Medical Staff shall automatically result in the contemporaneous suspension of the Affiliate's Clinical Privileges.

4.3 Special Qualifications

In addition to the general qualifications for membership outlined in Section 4.2 above, all Applicants so indicated shall meet the following additional qualifications:

A. Physicians: All Physician Applicants who seek or initially sought appointment to the Medical Staff after April 1, 1995 must meet the initial Board Certification requirements set forth in this Section 4.3A. Physicians whose initial appointment occurred prior to April 1, 1995 shall have complied with the criteria in effect at the time of their initial appointment. Furthermore, all Physician Applicants who seek or initially sought appointment to the Medical Staff after January 1, 2001 (and only such Applicants) must meet the periodic recertification requirements set forth in this Section 4.3A.

1. Except as otherwise provided in this Section, if the Applicant practices in a primary care field, such that only one type of Board Certification is available within the Applicant's practice area, the Applicant must have current Board Certification for the Applicant's practice area. However, if the Applicant is not Board Certified in his/her specialty at the time the application is submitted, the Applicant must be eligible to take the next board examination and such Board Certification must be obtained in the specialty in which the Applicant practices on or before five years from the time of the first opportunity to complete Board Certification after initial admission to the Medical Staff. If the Applicant practices in a specialty that requires periodic recertification to maintain Board Certification, the Applicant shall maintain board certification or board eligibility, provided the maximum period for board eligibility does not exceed three years. If the Applicant fails to comply with the requirements of this paragraph, his/her Medical Staff membership and Privileges will not be renewed at the expiration of the then-current term of appointment; with no due process rights.

2. Except as otherwise provided in this Section, if the Applicant practices a subspecialty within a specialty, the Applicant must have current Board Certification within such subspecialty for the Applicant's practice area. However, if the Applicant is not Board Certified in his/her subspecialty at the time the application is submitted, the Applicant must be eligible to take the next board examination and such Board Certification must be obtained in the subspecialty in which the Applicant practices on or before five years from the time of initial admission to the Medical Staff. If the Applicant practices in a subspecialty that requires periodic recertification to maintain Board Certification, the Applicant shall maintain board certification or board eligibility, provided the maximum period for board eligibility does not exceed three years in order to maintain Medical Staff membership and Clinical Privileges. A Physician who meets all the requirements for Active Privileges who is not board certified in Emergency Medicine but who is board certified in Pediatrics, Internal Medicine, General Surgery or Family Medicine and whose experience and training is deemed appropriate by the Chairman of the Emergency Department may exercise privileges to work in the Emergency Department so long as those privileges are limited to working exclusively in triage / screening or lower-acuity area of the Emergency Department as defined by the Chair of Emergency Medicine. If the Applicant fails to comply with the requirements of this paragraph, his/her Medical Staff membership and Privileges will not be renewed at the expiration of the then-current term of appointment; with no due process rights.

3. Except as otherwise provided in this Section, if the Applicant practices in more than one practice area, the Applicant must have current Board Certification in each field within which he/she practices. However, if the Applicant is not Board Certified in his/her additional specialty at the time the application is submitted, the Applicant must be eligible to take the next board examination and such Board Certification must be obtained in each specialty in which the Applicant practices on or before five years from the time of initial admission to the Medical Staff. If the Applicant practices in a specialty that requires periodic recertification to maintain Board Certification, the Applicant shall maintain board certification or board eligibility, provided the maximum period for board eligibility does not exceed three years in order to maintain Medical Staff membership and Clinical Privileges. If the Applicant fails to comply with the requirements of this paragraph, his/her Privileges in such practice area will not be renewed at the expiration of the then-current term of appointment with no due process rights.

B. Dentists: All Medical Staff Members who meet the requirements of this Section 4.3(B) shall be assigned to the Department of Surgery, sub department of oral surgery, and shall comply with the rules and regulations of that department and sub department. Dentists shall conform to standards established by the Medical Staff in accordance with the Code of Ethics of the American Dental Association. Dentists shall be eligible for Clinical Privileges within their subspecialty who:

1. Have graduated from a college of dental medicine accredited by the American Dental Association;
2. Are licensed to practice dentistry by Maryland State Board of Dental Examiners; and
3. Have demonstrated competence to perform dental surgery or their subspecialty within dentistry.

Dentists who seek Clinical Privileges in oral and maxillofacial surgery must be Board Certified or possess active candidate status by the American Board of Oral and Maxillofacial Surgeons. Written confirmation of Board Certification or active candidate status must be received as part of the application process from the American Board of Oral and Maxillofacial Surgeons. Any Applicant for Clinical Privileges in oral and maxillofacial surgery who receives Privileges but who is not Board Certified at the time Privileges are granted shall obtain Board Certification within five years from the date of completion of his/her residency program. Failure to obtain Board Certification, as described, within the designated time period shall result in termination of all Privileges and membership at the end of the then Medical Staff term of appointment without any right of renewal until Board Certification is achieved and without the right to exercise due process challenges to the termination.

C. Podiatrists: Podiatrists shall conform to standards established by the Medical Staff in accordance with the Code of Ethics of the American Podiatric Medical Association. Podiatrists shall be eligible for podiatric clinical privileges who:

1. Have graduated from a college of podiatric medicine accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
2. Are licensed by the Maryland State Board of Podiatric Medical Examiners; and
3. Have demonstrated competence to perform podiatric surgery.

In addition, Podiatrists must be Board Certified or board qualified by either the American Board of Podiatric Surgery ("ABPS") or the American Board of Multiple Specialties in Podiatry ("ABMSP"). Written confirmation of Board Certification or board-qualified status must be received as part of the application process from either the ABPS or the ABMSP. Any Applicant for Clinical Privileges in podiatry who receives Privileges but who is not Board Certified at the time Privileges are granted shall obtain Board Certification within five years from the date of initial admission to the Medical Staff. Failure to obtain Board Certification, as described, within the designated time period shall result in termination of all Privileges and membership at the end of the then Medical Staff term of appointment without any right of renewal until Board Certification is achieved and without the right to exercise due process challenges to the termination.

D. Psychologists: To be eligible for Clinical Privileges, a psychologist must:

1. Have completed an American Board of Professional Psychologists-accredited program of training and education;
2. Be licensed as a psychologist by the Maryland Board of Examiners of Psychologists;
3. Have demonstrated competence within the field; and
4. Hold a Ph.D. (or its equivalent) in psychology.

E. Physician Assistants:

1. Eligibility: To be eligible for Clinical Privileges, a physician assistant (P.A.) must:

    a. Have completed an American Medical Association-accredited program of training and education;
    b. Be licensed as a Physician Assistant by the Maryland Board of Physicians ("MBP") and provide a copy of the written job description as approved by MBP;
    c. Have demonstrated competence within his/her specialty field;
    d. Be employed by the Hospital or a Physician Member of the Medical Staff with appropriate Privileges within the scope of services to be provided by the P.A.; and

e. Have either been board eligible for not more than three years, or have passed the National Certification Examination for Physician Assistants, or otherwise be a properly qualified Physician Assistant as determined by the Credentials Committee after consultation with the appropriate department of the Medical Staff.

2. Hospital-Employed P.A.'s: In addition to the criteria set forth in Section 4.3(E)(1) above, those P.A.'s employed by the Hospital must:

a. Apply for employment, as do other Hospital employees;
b. Fulfill State registration obligations and submit verification of State requirements; and
c. Submit a list of duties and functions he/she proposes to perform at the Hospital.

3. Physician Supervision: It shall be the responsibility of the supervising Physician designated on the P.A.'s State license to adequately supervise the P.A., to ensure that the P.A. conforms with his/her obligations under State law and regulations, and to ensure that the P.A. does not exceed the scope of his/her State-approved job description.

F. Nurse Practitioners:

1. Eligibility: To be eligible for Clinical Privileges, a nurse practitioner (N.P.) must:

a. Have completed an American Nurses Association-accredited program of training and education;
b. Be licensed as a Nurse Practitioner by the Maryland Board of Nursing and provide a copy of the attestation agreement with a Physician as approved by such Board;
c. Have demonstrated competence within his/her subspecialty N.P. field;
d. Be employed by the Hospital or a Physician Member of the Medical Staff with appropriate Privileges within the scope of services to be provided by the N.P.; and
e. Have either been board eligible for not more than three years, or have passed the National Certification Examination for Nurse Practitioners, or otherwise be a properly qualified Nurse Practitioner as determined by the Credentials Committee after consultation with the appropriate department of the Medical Staff.

2. Hospital-Employed N.P.s: In addition to the criteria set forth in Section 4.3(F)(1) above, those N.P.s employed by the Hospital must:

a. Apply for employment, as do other Hospital employees;

b. Fulfill State registration obligations and submit verification of State requirements; and
c. Submit a list of duties and functions he/she proposes to perform at the Hospital.

3. Physician Collaboration: It shall be the responsibility of the collaborating Physician designated on the N.P.'s State license to adequately supervise the N.P., to ensure that the N.P. conforms with his/her obligations under State law and regulations, and to ensure that the N.P. does not exceed the scope of his/her State-approved written collaboration agreement with the Physician.

G. Nurse Midwives:

1. Eligibility: To be eligible for Clinical Privileges, a certified nurse midwife (CNM) must:

a. Have completed Nurse Midwifery Training according to the American College of Nurse Mid-Midwives;
b. Be licensed as a Nurse Midwife by the Maryland Board of Nursing ;
c. Have demonstrated competence within his/her field;
d. Be employed by the Hospital with appropriate Privileges in OB/GYN;
e. Fulfill State registration obligations and submit verification of State requirements; and
f. Submit a list of duties and functions he/she proposes to perform at the Hospital.

2. Physician Collaboration: It shall be the responsibility of the collaborating Physician designated by the CNM's State license to adequately consult with the CNM , to ensure that the CNM conforms with his/her obligations under State law and regulations, and to ensure that the CNM does not exceed the scope of his/her State-approved delineation of privileges.

H. Nurse Anesthetists:

1. Eligibility: To be eligible for Clinical Privileges, a certified registered nurse anesthetist ("CRNA") must:

a. Have completed a Council on Accreditation of Nurse Anesthetist Educational Programs-accredited program of training and education;
b. Be licensed as a Certified Registered Nurse Anesthetist by the Maryland Board of Nursing and provide a copy of the written collaboration agreement with a Physician as approved by such Board;
c. Have demonstrated competence within his/her field;
d. Be employed by the Hospital or a Physician Member of the Medical Staff with appropriate Privileges in anesthesiology; and

e. Have either been board eligible for not more than three years, or have passed the National Certification Examination for CRNAs, or otherwise be a properly qualified CRNA as determined by the Credentials Committee after consultation with the appropriate department of the Medical Staff.

2. Hospital-Employed CRNAs: In addition to the criteria set forth in Section 4.3(G)(1) above, those CRNAs employed by the Hospital must:

a. Apply for employment, as do other Hospital employees;
b. Fulfill State registration obligations and submit verification of State requirements; and
c. Submit a list of duties and functions he/she proposes to perform at the Hospital.

3. Physician Collaboration: It shall be the responsibility of the collaborating Physician designated on the CRNA's State license to adequately supervise the CRNA, to ensure that the CRNA conforms with his/her obligations under State law and regulations, and to ensure that the CRNA does not exceed the scope of his/her State-approved written collaboration agreement with the Physician.

4.4 Basic Responsibilities of Medical Staff Membership and Clinical Privileges.

A. All Practitioners who apply for and/or are granted Privileges are subject to the particular obligations and limitations of the Medical Staff category to which they are admitted and the Privileges which are granted. All such Practitioners have a continuing obligation to ensure that material information provided in their application for initial appointment and reappointment remains current and shall immediately notify the Medical Staff Office of any changes in such information. Qualifications for Medical Staff Members are continuing and must be fulfilled continuously during the time the Practitioner has Privileges. Failure to continuously comply with these obligations is sufficient cause for suspension of Privileges. If a Practitioner is not in compliance, he/she shall be provided 30 days' notice by the department chair or their designees or Chief Executive Officer or their designee of his/her noncompliance. Failure to cure such noncompliance within the 30-day period shall be reported to the Medical Executive Committee for appropriate action, including suspension of Privileges. Suspension may be initiated under such circumstances prior to MEC action if specified by a policy approved by the MEC. However, for completion of public health requirements (including vaccinations) and training requirements (including requirements for the use of electronic medical records systems) provided that at least 30 days notice of the requirement is given to the medical staff of this requirement via posting in the medical staff lounge, written notice to the physician's address of record, and announced at a quarterly staff meeting, then suspension may occur at the deadline described by the requirement in question and no 30 days of the uncured condition in question need persist prior to suspension commencing.

B. Each Member of the Medical Staff and Practitioner granted Privileges shall:

1. Provide patients with care at the generally recognized professional level of quality and efficiency;
2. Abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, departmental rules and regulations, Hospital bylaws, Hospital Rules and Regulations, policies, procedures and standards**,** including the payment of dues, and fines;
3. Complete such reasonable responsibilities and assignments imposed upon the Practitioner by virtue of Medical Staff membership and/or Clinical Privileges, including committee assignments;
4. Prepare and complete in timely and legible fashion medical records for all patients to whom the Practitioner provides care in the Hospital;
5. Make appropriate arrangements with another Practitioner who possesses substantially comparable Privileges within his/her specialty/subspecialty for coverage for his/her patients in the Practitioner's absence;
6. Participate in continuing education programs, as determined by the Medical Staff;
7. Participate in such emergency and charitable service coverage or consultation as may be required by the Medical Staff;
8. Discharge such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff;
9. Abide by the ethical principles of his/her profession, including but not limited to any ethical prohibitions on fee-splitting or other inducements regarding patient referrals;
10. Maintain confidentiality of patient care;
11. Accept Emergency Department call as requested by his/her department chair;
12. See and write a progress note every day for each of his/her hospitalized patients;
13. Agree~~s~~ to be subject to the directives of the Resource Management Committee of the Medical Staff and abide by and participate in any Performance Improvement Plan imposed by that Committee;
14. Seek consultation whenever necessary and personally contact the consultant when requesting a consultation
15. Explain all treatments, procedures, and tests to patients, to include risks, benefits, and alternatives, in a language the patient can understand (and, if the patient is pregnant, to include the risks, benefits, and alternatives with regard to the fetus).
16. Attest that he or she has had an opportunity to read a copy of the Medical Staff Bylaws, and the Rules and Regulations of the Medical Staff, and agreed to be bound by them.
17. Agree that any misrepresentation or misstatement in, or omission from, an application for appointment or re-appointment, whether intentional or not, may be cause for rejection of the application. In the event that an appointment or reappointment has been granted prior to discovery of the misrepresentation, statement or omission, the discovery of such may be grounds for automatic relinquishment of clinical privileges and medical staff appointment.

4.5 Special Responsibilities.

A. Emergency and Service Care Assignments. Membership on the Medical Staff carries the responsibility for care and service of patients. A patient who requires Hospital admission on an emergency basis may request the services of a particular Physician in the appropriate department or service. However, if the patient does not submit such a request, the Member of the Medical Staff on emergency service call for that department or service will be assigned to the patient. The chair of each department shall be responsible for establishing the service call list and providing a service call schedule for such assignment. The Medical Executive Committee or each department or sub department may require all Members or Members of a designated category of Medical Staff membership to accept Emergency Department roster referrals. Physician's on-call for the Emergency Department are obligated to perform, upon request, in-house consultations in their specialty. The roster shall be devised so that the Medical Staff Members' participation rotates fairly and provides equal access to the roster among those who are deemed qualified and eligible by the CMO or designee, taking into account adherence to the bylaws, rules, policies and regulations of the medical staff and the relevant department. The various rosters maintained by each department or sub department shall be the exclusive source of referrals to Physicians from the Emergency Department. Failure of the Medical Staff Members to comply with this requirement may result in corrective action.

A Physician on call in the Emergency Department must see in his/her office for follow-up care, within a time frame appropriate to the nature of the diagnosis any patient referred to him/her by the Emergency Department regardless of their insurance status or ability to pay. Patients shall not be discouraged from seeking appropriate follow-up care from the Emergency Department for reasons related to insurance status or ability to pay. After the initial evaluation and treatment of the patient, the Physician may recommend to the patient that he/she be followed by another Physician and may so refer the patient.

B. Physician Availability. Each Medical Staff Member shall be responsible for 24-hour coverage of his/her patients and on-call obligations. Each Medical Staff Member must have an answering service and a functional 24-hour paging device, cellular telephone, or some means of contacting the Member at any time. Medical Staff Members are obliged to respond to attempts in a timely fashion to contact them concerning their clinical obligations at the Hospital. In his/her absence, a Physician must sign-out to another Physician with similar Clinical Privileges at the Hospital and must notify his/her answering service of such coverage arrangements. In the case of a Physician's failure to make adequate coverage arrangements, the applicable department chair shall have authority to call any Members of the Medical Staff should he/she consider it appropriate.

In case of mass disaster or activation of the emergency management plan, department chairs (or their assignees) shall have authority to require all Practitioners with Clinical Privileges to perform designated services as appropriate to deal with the mass disaster.

C. Obligation to Report Adverse Events. Any of the following events shall be promptly reported along with the appropriate details by an Applicant or Member to the Medical Staff Office, which will promptly transmit it to the Credentials Committee, CMO or appropriate Department Chairman.:

1. Any charges brought before any state licensing or other registration board (including but not limited to the U.S. Drug Enforcement Administration and/or the Maryland Division of Drug Control);
2. Any previous or currently pending challenges, or any voluntary or involuntary relinquishment, of such licensure or registration;
3. Any limitations, reduction or termination, whether voluntary or involuntary, of medical staff membership or clinical privileges at another hospital or surgery center;
4. Any conviction, indictment, plea of guilty or no contest to, any felony or misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud, or abuse or violence, excluding minor traffic violations, unless the traffic violation involves the use of alcohol or controlled dangerous substances.
5. Any notice of proposed or actual suspensions, exclusions, or debarment from participation in any federally-funded healthcare program, including but not limited to Medicare and/or Medicaid.
6. Any change in status as defined in section 4.3 referring to qualifications of clinical privileges and or medical staff membership of these bylaws (to include Board Certification status).

D. Participation in Quality Assurance, Performance Improvement, Utilization Review and Management, Risk Management, Peer Review, and Credentialing Activities. Recognizing the Medical Staff's responsibility in the areas of quality assurance, performance improvement, risk management, utilization review and management, peer review, and credentialing, the Medical Staff places a high priority on supporting activities relating to clinical aspects of patient care and safety. Based on the need to identify, evaluate and correct potential risks and develop programs to reduce such risks, it is imperative that information derived from the Hospital's risk management, quality assurance and performance improvement committees be shared. All complaints, requests for corrective action, or requests for investigation that are reported to the Medical Staff Quality Improvement Committee or a relevant MEC subcommittee shall, after review, be forwarded to the appropriate committee and department chair. The committee and department chair may, if further action or investigation is deemed useful or necessary, forward the findings to the Medical Executive Committee to ascertain if the alleged activity or conduct is inconsistent with the standards or aims of the Medical Staff or could be deemed to merit corrective action. The concerned Practitioner shall be advised of the complaint and his/her rights, if any, therein.

The Medical Staff shall provide support as appropriate to peer review mechanisms utilized in the Hospital, including participation in patient care issues relating to the review and denial of medical care on a prospective, concurrent and retrospective basis. All such peer review activities must ensure that whatever professional action shall be taken is accomplished:

1. In a reasonable belief that the action was in furtherance of quality care;
2. After reasonable effort to obtain the facts of the matter;
3. After adequate notice and hearing procedures are afforded to the Practitioner involved or after such other procedures are fair to the Practitioner under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts.

E. Malpractice Insurance Purchase Upon Loss of Privileges: In the following instances, the Hospital may require, at its discretion, that any present or former Practitioner purchase additional adequate malpractice insurance to cover malpractice claims arising out of treatment rendered to patients at the Hospital but not asserted until after the cessation of the Practitioner's Privileges at the Hospital (including "tail" and "prior acts" coverage):

1. Voluntary resignation of Clinical Privileges or leave of absence from the Medical Staff;
2. Revocation of Medical Staff membership and/or Clinical Privileges; or
3. Other termination of Medical Staff membership and/or Clinical Privileges.

Such requirement shall be a condition, which the Hospital may enforce by not accepting a tendered voluntary resignation, by taking disciplinary action under the Bylaws, by purchasing such insurance on the Practitioner's behalf, at Practitioner's expense, and/or by judicial process, if necessary.

F. Medical Records Responsibilities.

1. **Record completion**. The attending Physician shall be held ultimately responsible for the preparation of timely, complete, legible and accurate medical record for each patient. In the event of a conflict over the physician responsible for this completion, the relevant department chair shall resolve the conflict. The schedule of completion of various aspects of the medical record shall be defined in the policies and procedures of the medical staff. Medical records are to be completed according to the following schedule:

Histories and Physicals:	A medical history and physical examination be completed and documented 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 examination must be completed by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
Operative Reports:	Must be dictated within 24 hours of surgery; a brief operative report describing techniques, findings, and tissues removed or altered must be written in the chart immediately following surgery and signed by the surgeon if a full operative note containing these details is not otherwise available.
Transfer Summaries:	Prior to transfer.
Discharge Summaries:	Must be dictated within 30 days of discharge unless the provider is subject to another policy authored under a quality improvement process designed to create discharge summaries in a more timely fashion; such policies must be approved by the MEC.

Hospital-based physicians' interpretations of tests performed at BWMC must be completed within 24 hours of completion of the relevant study.

The procedures for penalties and enforcement are determined by the rules and regulations of the MEC.

2. **Daily note**. Attending Physician or relevant affiliate staff must write a progress note each day on every patient.

3. Standing orders / treatment protocols. The Medical Executive Committee, in conjunction with the appropriate Hospital departments, must approve any standing orders and/or treatment protocols, as well as any modifications to same.

4. Documentation of orders. All orders shall be documented. A verbal order shall be considered to be documented if dictated to a Registered Nurse, nursing graduate authorized to practice in this State, Licensed Practical Nurse, or Nurse Practitioner. In addition, certified occupational therapists, certified speech pathologists, Physician, Physician Assistants, pharmacists, physical therapists, respiratory therapists and dieticians may accept orders relevant to their department's duties, and diagnostic studies relevant to their department. Additionally, all verbal or telephone orders given by a member of the medical staff authorized to give orders, must be cosigned within 48 hours after being given. Any physician may administratively cosign a verbal/telephone order for any other physician.

Patients shall be discharged only on order of an appropriate member of the medical staff. At the time of discharge, the patient shall be provided with a written discharge instruction sheet

A chart is considered delinquent if it is not completed within 30 days of the patient's discharge. The procedures for penalties and enforcement are determined by the rules and regulations of the MEC.

5. Access to and treatment of records. All records are the property of the Hospital and shall not be removed from the Hospital without permission of the Chief Executive Officer (or his/her designee). In the case of readmission of a patient, all previous records shall be available for the use of the attending Physician. Unauthorized removal of charts from the Hospital is grounds for suspension of a Physician pursuant to Article XII (Corrective Action) of the Medical Staff Bylaws.

Medical staff members may only review patient records if they participated in the care of that patient. Other medical records may be reviewed provided that this review is done under the auspices of a Medical Review Committee of the medical staff, such as a Peer Review Committee, or for the purposes of privileging / credentialing, under the Maryland Health Occupations Code Annotated § 1-401. Access to all medical records of all patients shall be afforded to Medical Staff Members in good standing for bona fide study and research only, consistent with preserving the confidentiality of personal information concerning individual patients. Access shall be at no cost to the members of the medical staff. Former Members of the Medical Staff shall be permitted access to information from medical records of their patients covering all periods during which they attended such patients in the Hospital upon the authorization of the Chief Executive Officer(or his/her designee).

1. Documentation in electronic medical record systems.

a. **Generally**. The MEC shall approve all policies and procedures defining whether and in what manner clinical documentation (including all documentation referenced in these bylaws) done by the medical staff shall occur in an established medical records system of the hospital. This shall include orders, clinical documentation (including history and physical exams, discharge summaries, progress notes, and all other medical staff documentation), patient specific information (including problems lists), patient instructions (including follow up information, medications, and patient instructions), and any other documentation pertaining to the care of patients at the hospital.

b. **Training**. The MEC shall approve all policies and procedures defining the base training requirements for access to electronic medical records. Any member of the medical staff who does not meet training requirements consistent with these policies and procedures shall be subject to suspension as defined by policies and procedures approved by the MEC.

G. Autopsies. Each Medical Staff Member is expected to be actively interested in securing autopsies. No autopsy shall be performed without consent of the relative or legally authorized agent unless it is required by law. All autopsies shall be performed by the Hospital pathologist or by a Physician delegated this responsibility.

ARTICLE V CATEGORIES OF MEMBERSHIP

5.1 Categories.

The categories of the Medical Staff shall include the following: Active, ~~Associate,~~ Courtesy, Consulting, and Honorary. In addition, there shall be an Affiliate and ~~Adjunct Staff.~~ Determination of each Practitioner's Medical Staff category shall occur at the time of appointment or reappointment, although a Practitioner may request a change in Medical Staff category at any time during his/her term of appointment. The Medical Executive Committee may, on its own or pursuant to a request by a Member, recommend a change in the Medical Staff category of a Member consistent with the requirements of these Bylaws. This recommendation shall be forwarded to the Board of Directors.

5.2 Active Medical Staff.

A. The Active Medical Staff shall consist of Members who:

1. Meets all qualifications as set forth in these Bylaws;
2. Are actively engaged in the practice of their specialty in the Hospital;

3. Are privileged to admit and/or attend to patients in the Hospital; and
4. Assume all Medical Staff functions and responsibilities, including Emergency Department on-call obligations and consultation requests, as required by the CMO or designee.

B. Members of the Active Medical Staff may admit patients to the Hospital and may perform an unlimited number of consultations and procedures. Members of the Active Medical Staff shall serve on call in the Hospital's Emergency Department if so required by the CMO or designee, but shall not be entitled to be placed on such call roster.

C. Members of the active medical staff are expected to attend any scheduled or special meetings of their department as required by their department chair. Attendance at these meetings may be a prerequisite for continued privileges in the department as well as access to the on-call schedule.

D. The Members of the Active Medical Staff are eligible to vote in quarterly Medical Staff and department meetings. They must pay all Medical Staff, department, and sub department dues and fines. They may hold Medical Staff office after they have served at least five years on the Medical Staff. They must serve on committees as appointed or elected; provided, however, to serve on the Medical Executive Committee as an at-large member, they must have been on the Medical Staff at least two years.

5.3 Consulting Medical Staff.

A. The Consulting Medical Staff shall consist of Members who:

1. Meet all qualifications as set forth in these Bylaws;
2. Are privileged to perform consults and/or procedures;
3. Assume certain Medical Staff functions and responsibilities, including Emergency Department on-call obligations and consultation requests, as required by the CMO or designee;
4. Are not privileged to admit patients in the Hospital unless required to have on-call responsibilities by the CMO or designee.
5. House physicians shall not admit patients to their own service or take any Emergency Room call.

B. Members of the Consulting Medical Staff may not have admitting Privileges to the Hospital unless required to take emergency department call responsibilities by the CMO or designee, but they may have an unlimited number of procedures or consults. Members of the Consulting Medical Staff need not serve on call in the Hospital's Emergency Department unless they are required to do so by the CMO or designee, they shall not be entitled to be placed on such call roster.

C. Members of the consulting medical staff are expected to attend any scheduled or special meetings of their department as required by their department chair. Attendance at these meetings may be a prerequisite for continued privileges in the department as well as access to the on-call schedule.

D. Members of the Consulting Medical Staff are not eligible to vote in quarterly Medical Staff, department, or sub department meetings. They may not hold office. They must pay all Medical Staff, department, and sub department dues and fines. They may serve on committees with a vote if so appointed or elected; provided, however, that: 1) to have voting rights on a committee, they must have been on the Medical Staff at least one year; and 2) to serve on the Medical Executive Committee as an at-large member, they must have been on the Medical Staff at least two years.

5.4 Courtesy Medical Staff.

A. The Courtesy Medical Staff shall consist of Members who seek to hold Medical Staff membership but not Clinical Privileges. They shall not provide patient care services at the Hospital. They are not required to demonstrate current clinical competence in the care of patients in a hospital setting.

B. Members of the Courtesy Medical Staff are permitted, but not required, to attend Medical Staff, department, and sub department meetings, but they may not vote at any such meeting. Members of the Courtesy Medical Staff are not eligible to hold office. They may volunteer to serve on committees, except the Medical Executive Committee.; They are obligated to pay all Medical Staff, department, and sub department dues.

5.5 Honorary Medical Staff.

A. The Honorary Medical Staff consists of Members who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences or their previous longstanding service to the Hospital, and who continue to exemplify high standards of professional conduct; or who have retired from the active practice and, at the time of their retirement were Members in good standing of the Active Medical Staff and continue to adhere to appropriate professional standards.

B. Members of the Honorary Medical Staff are ineligible to hold office or admit patients. They have no assigned on-call duties and may not request to be included in the Emergency Department roster. They may volunteer to serve upon committees and may attend Medical Staff, department, and sub department meetings, although they are not required to do so. They may not vote at any committee, Medical Staff, department, or sub department meeting.

5.6 Affiliate Staff.

A. AFFILIATE means those allied health professionals who are authorized to practice at the Hospital and who possess Clinical Privileges. Affiliates are non MD / DO / DAM health care providers that include but are not limited to psychologists, physician assistants, dentists, and nurse practitioners. Affiliates include those who are permitted to provide patient care services independently within the Hospital without direct supervision within the scope of their licensure and designated Clinical Privileges (psychologists) ("Independent Affiliates"), and those who are dependent upon an employment relationship with a Medical Staff Member or the Hospital that requires direct supervision (physician assistants and nurse practitioners) ("Dependent Affiliates").

B. Members of the Affiliate Staff are not required to take Emergency Department call. They may, if they so choose, request to be included on the roster but they are not entitled to be included in response to such a request.

C. Members of the affiliate medical staff are expected to attend any scheduled or special meetings of their department as required by their department chair. Attendance at these meetings may be a prerequisite for continued privileges in the department as well as access to the on-call schedule.

D. The Members of the Affiliate Staff must pay all Medical Staff, department, and sub department dues and fines. They may not hold Medical Staff office. They may serve on committees if so appointed or elected and may vote on such committees.

ARTICLE VI APPOINTMENT AND REAPPOINTMENT

6.1 Condition and Duration of Appointment and Reappointment.

A. The authority to make initial appointments, reappointments and revisions to the Medical Staff and to grant Clinical Privileges rests solely with the Board of Directors. The Board shall act on initial appointments, reappointments, revisions or revocation of appointments only after there has been a recommendation from the Medical Executive Committee.

B. Appointment to the Medical Staff shall confer on the Member only such Clinical Privileges as have been granted by the Board in accordance with these Bylaws.

C. Initial appointment to the Medical Staff shall be for a period of up to two years.. Reappointments shall likewise be for two-year periods. The duration of the appointment may be shortened to a period of less than two years if done so as part of the approval of the application for appointment or reappointment.

D. Applicants shall be assigned to a specific department.

E. Except as otherwise specified herein, no Practitioner shall exercise Clinical Privileges in the Hospital unless and until he/she applies for and receives appointment to the Medical Staff and is granted Privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the Applicant acknowledges responsibility to review the Medical Staff Bylaws, and agrees that throughout any period of membership, he/she will comply with the responsibilities of Medical Staff membership and with the Bylaws, Rules and Regulations of the Medical Staff and the Rules, Regulations and Policies of the Hospital as they exist and as they may be modified from time to time.

F. In connection with all applications for appointment, reappointment, advancement or transfer, the Applicant shall have the burden of producing information for an adequate evaluation of the Applicant's qualifications and suitability for the Clinical Privileges and Medical Staff category requested, of resolving any doubts about these matters, and of satisfying requests for information. The Applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychiatric examination, at the Applicant's expense, if deemed appropriate by the Chair of the department or the Medical Executive Committee, which may select the examining physician.

6.2 Application for Initial Appointment and Reappointment.

A. By applying for appointment or reappointment to the Medical Staff, each Applicant:

1. Signifies his/her willingness to appear for interviews in regard to the application;
2. Authorizes consultation with others who have been associated with him/her and who may have information bearing on his/her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
3. Consents to inspection of records and documents that may be material to an evaluation of his/her qualifications and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations having custody of such records and documents to permit such inspection and copying;
4. Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the Applicant;
5. Consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding his/her professional standing or competence that the hospital, medical staff or any individual may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;
6. Agrees to pay all Medical Staff dues, fines, or other assessments as provided by medical staff rules and regulations or these bylaws,
7. Agrees to submit any reasonable evidence of current ability to competently perform the Clinical Privileges he/she has requested; and
8. Pledges to provide for continuous quality care for his/her patients.

9. An application is considered null and void if it remains incomplete for 240 days from the date of receipt.

B. All applications for the appointment to the Medical Staff shall be submitted on the form prescribed by the Board, completed, signed and dated by the Applicant. The form shall require a disclosure of information required to be collected, verified, reviewed and documented in accordance with all applicable State and federal laws and regulations.

C. When collection and verification is accomplished, all such information shall be transmitted to the appropriate department chair.

D. After receiving the application, the department chair shall review the application and supporting documentation, and may conduct a personal interview with the Applicant at the department chair's discretion. As soon as practicable, but in no event longer than 90 days after his/her initial receipt of a completed application, the department chair will then forward specific written recommendations to the Credentials Committee. For chairperson's applications this function will be provided by the President of the Medical Staff after consultation with the associate chair. If the President of the Medical Staff is the chair of the department, then the Vice President of the medical staff will provide this function.

E. The Credentials Committee shall review the application, evaluate and verify the supporting documentation, and the department chair's report and recommendation. The Credentials Committee may elect to interview the Applicant and seek additional information. As soon as practicable, but in no event longer than 90 days after its initial receipt of a completed application, the Credentials Committee shall transmit to the Medical Executive Committee the written report and its recommendation as to appointment. This recommendation shall include, if appointment is recommended, membership category, department, affiliation, Clinical Privileges to be granted and any special conditions to be attached to the appointment.

F. At its next regular meeting after receiving a Credentials Committee report and recommendation, or as soon thereafter as is practical, the Medical Executive Committee shall consider the report and recommendation. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the Applicant.

G. When the recommendation of the Medical Executive Committee is favorable to the Applicant, it shall promptly forward the recommendations with supporting documentation to the Board of Directors.

H. When the recommendation of the Medical Executive Committee is adverse to the Applicant, the Applicant shall promptly be informed by written notice, which includes the basis for the adverse recommendation. This notice shall be the notice required under Article XIII. The Applicant shall then be entitled to a formal hearing as set forth in

Article XIII.

I. The Board of Directors may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. If the Board of Directors concurs with the recommendation of the Medical Executive Committee, the decision of the Board shall be deemed final. If the Board of Directors does not concur with the recommendation of the Medical Executive Committee, then the matter may be referred to the Joint Conference Committee in accordance with the provisions of Article XIII of these Bylaws.

J. Notice of the final decision shall be given to the Medical Executive Committee, department chair, the Applicant, and the Chief Executive Officer. A decision and notice to appoint or reappoint shall include, if applicable:

1. the Medical Staff category to which the Applicant is appointed;
2. the department to which he/she is assigned;
3. a delineation of the Clinical Privileges granted; and
4. any special conditions attached to the appointment.

K. Complete applications shall be acted upon expeditiously. Processing of applications shall be completed within 270 days of receipt of a complete application, if not sooner, unless any delays are necessitated by the hearing process set forth in Article XIII or if the Practitioner has waived such time frames.

6.3 Reapplication after Adverse Decision.

An Applicant who has received a final adverse decision regarding an application for appointment or reappointment, or whose Privileges have been terminated during their term, shall not be eligible to reapply to the Medical Staff for a period of five years. Any such reapplication shall be processed as an initial application; however, any such Applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision no longer exists.

6.4 Reappointments and Requests for Modifications of Status or Privileges All Practitioners shall be considered for reappointment to the Medical Staff at least every two years. Since no Practitioner may be granted Privileges for longer than two years, an initial term of appointment may be less than two years so that the application for reappointment is due in accordance with such schedule.

A. All applications for reappointment shall be submitted on the form prescribed by the Board, completed, signed and dated by the Applicant. The form shall require a disclosure of information required to be collected, verified, reviewed and documented in accordance with all applicable state and federal laws and regulations.

B. Reappointment applications are due 90 days prior to the expiration of a provider's current period of appointment**.** If the Practitioner fails to submit a completed application for reappointment within 30 days past the date it was due, the Practitioner must submit payment of a fine that has been approved by the Medical Executive Committee with his/her application.

C. When collection and any necessary verification of the application are completed, all such information shall be transmitted to the Credentials Committee and the appropriate department chair. Thereafter, the application shall be processed in the same fashion as an application for initial appointment; provided, however, that the Applicant's performance in the Hospital during prior terms of appointment may also be reviewed and considered.

6.5 Requests for Modification of Status.

A Practitioner who seeks a change in Medical Staff status or modification of Clinical Privileges may submit such a request at any time; except that such application may not be filed within six months of the time of a similar request has been denied.

6.6 Leave of Absence.

At the discretion of the Medical Executive Committee, a Practitioner may obtain a voluntary leave of absence from the Medical Staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed two years under any circumstances. No extension of a leave of absence may be granted. If the Practitioner wishes to remain on a leave of absence beyond two years, he/she must apply as an initial Applicant. During the period of leave, the Practitioner shall not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

At least 30 days prior to the termination of the leave of absence, or at any time earlier, the Practitioner may request reinstatement of Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Practitioner shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the Practitioner’s Privileges and the procedure for reappointment as set forth herein shall be followed.

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and Clinical Privileges. A Practitioner whose Privileges are automatically terminated shall not be entitled to the procedural rights set forth in Article XIII. A request for Privileges subsequently received from a Practitioner so terminated shall be submitted and processed in the manner specified for applications for initial appointments. If a Practitioner's current term of appointment expires while the Practitioner is on a leave of absence, the Practitioner is responsible for submitting a timely application for reappointment.

ARTICLE VII CLINICAL PRIVILEGES

7.1 Exercise of Privileges.

Except as otherwise provided in these Bylaws, a Practitioner providing clinical services at this Hospital, shall be entitled to exercise only those Clinical Privileges specifically granted by the Hospital's Board of Directors. Said Privileges must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical department and the authority of the department chair and the Medical Staff. Duties delegated by a Physician may be performed by an individual authorized to practice a health occupation to the extent that the duty is permitted under applicable rules, regulations and orders of the Maryland Board of Physicians or any other board that regulates such health occupation.

7.2 Delineation of Privileges in General.

A. Requests. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the Applicant. A request by a Practitioner for a modification of Clinical Privileges may be made at any time, but such request must be supported by documentation of training and/or experience supportive of the request. Such request for modification of privileges shall be processed like an initial application.

B. Basis for Privileges Determination. A request for Clinical Privileges shall be evaluated on the basis of the Practitioner’s education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Clinical Privileges take into consideration site-specific criteria.

7.3 Emergency Privileges.

A. Emergency Privileges may be granted by the President of the Medical Staff, the Chief Executive Officer, the Chief Medical Officer, the appropriate Department Chairman or the Chair of Emergency Medicine (or their designee) to Physicians who are not Members of the Medical Staff in case of an emergency upon the recommendation of the department chair and with the approval of the Chief Executive Officer or the Chief Medical Officer (or their designees).

B. A Medical Staff Member may request an expansion of his/her Privileges to the degree permitted by his/her State license and training to permit the Member to provide emergency services to a patient if a current Medical Staff Member with appropriate Privileges is not available to provide the required services. Such expansion of privileges may be granted by the President of the Medical Staff, the Chief Executive Officer, the Chief Medical Officer, the appropriate Department Chairman or the Chair of Emergency Medicine (or their designee). When the emergency no longer exists or when a previously privileged Physician becomes available, the Physician with the emergency Privileges must immediately surrender those Privileges. No hearing or due process rights shall be available for such surrender of Privileges.

C. For purposes of Section 7.3 A and B, an "emergency" is defined as a condition that would result in serious permanent damage 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.

D. In the event of the activation of the emergency management plan, the Chief Executive Officer, Chief Medical Officer, appropriate Department Chairman or Medical Staff President or his or her designee or the Chairman of the Department of Emergency Medicine or his or her designee (Privilegor[s]) has the option to grant emergency privileges.

1. The Privilegor shall be responsible for determining that:
    a) The Emergency Management Plan has been activated,

    b) There is a need for the emergency credentialing of additional medical staff, and
    c) There are specific specialties that need additional qualified persons to be credentialed, and Each Practitioner that has been granted emergency privileges must provide government issued identification and at least one or more of the following at the discretion of the <u>Privilegor:</u>
        i. A current hospital or critical access hospital picture identification card that clearly identifies professional designation.
        ii. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).

iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT8), or other recognized state or federal organizations or groups.

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

v. Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications

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2. The medical staff oversees the professional performance of a volunteer practitioner who has been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision whether the disaster privileges should be continued based on information regarding the professional practice of the volunteer within 72 hours of granting the privileges. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Once the immediate situation has passed and such determination has been made consistent with the institution's disaster plan, the practitioner's disaster privileges will terminate immediately. Any individual identified in the institution's disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

3. Emergency privileges shall be documented in an appropriate manner.

7.4 Interim Privileges.

The CEO (or designee) acting on behalf of the board and based on the recommendation of the president of the medical staff (or designee) and the appropriate Department Chairman, may grant interim privileges provided the medical staff office is able to verify the practitioner's current licensure and competence. Interim privileges may be granted only in two circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the board.

Important patient care, treatment, or service need: Interim privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time not to exceed 120 calendar days, while the practitioner's full credentials information is verified and approved. When granting such privileges, the organized medical staff verifies current licensure and current competence.

Clean application awaiting approval: Interim privileges may be granted for up to 120 calendar days when a practitioner applying for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval from the board. To receive interim privileges under these circumstances, the applicant must provide evidence of the following, which has been verified by the hospital:

- Current licensure
- Education training and experience
- Current competence
- Current Drug Enforcement Agency registration (if applicable)
- Current professional liability insurance in the amount required
- Malpractice history
- One positive reference specific to the applicant's competence from an
  appropriate medical peer
- Ability to perform the privileges requested
- Results from a query to the NPDB

Additionally, the application must meet the criteria for category 1, expedited credentialing consideration, as noted previously in this section.

Termination of interim privileges: The CEO, acting on behalf of the board and after consulting with the president of the medical staff and the appropriate Department Chairman, may terminate any or all of a practitioner's privileges based on the discovery of information or an event that raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may affect the termination. In the event of such a termination, the practitioner's patients will be assigned to another practitioner by the CEO or his or her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner. Rights of the practitioner with interim privileges: A practitioner is not entitled to the procedural rights afforded in the fair hearing plan of these bylaws because his or her request for interim privileges is refused or because his or her interim privileges are terminated or suspended.

7.5 Clinical Privileges for Podiatrists.

A. Admissions. Podiatrists who are Members of the Medical Staff may admit patients and may perform history and physicals. However, the Podiatrist may not assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the Podiatrist's lawful scope of practice.

B. Surgery. Surgical procedures performed by podiatrists shall be under the overall oversight of the chair of the department of surgery or the chair's designee.

7.6 Clinical Privileges for Dentists.

A. Admissions. Dentists who are Members of the Medical Staff may admit patients and may perform histories and physicals of the aspects of the patient's condition to be cared for by the Dentist. However, the Dentist Member may not assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the Dentist's lawful scope of practice.

B. Surgery. Surgical procedures performed by Dentists shall be under the overall oversight of the chair of the department of surgery or the chair's designee.

C. Medical Appraisal. All patients admitted for care to the Hospital by a Dentist, if necessary for the delivery of competent care, shall be evaluated by a Physician Member to determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between the Physician Member and Dentist, based upon medical or surgical factors outside of the scope of licensure of the Dentist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

7.7 Clinical Privileges for Psychologists.

A. Admissions. Psychologists may not admit patients. The psychologist with Clinical Privileges may not assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the psychologist's lawful scope of practice.

B. Treatment. All treatment rendered by the psychologist shall be under the overall oversight of the chair of the department of psychiatry or the chair's designee.

C. Medical Appraisal. All patients who receive Hospital care from a psychologist shall be evaluated by and under the care of a collaborating Physician Member of the Medical Staff who has appropriate Clinical Privileges in the unit where the patient is being treated and who has ongoing responsibility for the patient. Where a dispute exists regarding proposed treatment between the Physician Member and the psychologist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s); provided, however, that if the dispute cannot be resolved in timely fashion, the decision of the collaborating Physician Member shall prevail.

ARTICLE VIII CLINICAL DEPARTMENTS

8.1 Organization of Clinical Departments.

The Medical Staff shall be divided into clinical departments. A department may be further divided, as appropriate, into sub-departments. Each department (and, if applicable, sub-department(s)) shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties and responsibilities as set forth herein. Every Practitioner appointed to the Medical Staff shall be assigned to and have Privileges in a clinical department and sub-department(s), if applicable. The clinical departments and sub- departments are named and organized as follows:

1. Anesthesiology
2. Emergency Medicine
3. Medicine, which includes the following sub-departments:

Allergy/ Immunology	Medical Oncology
Cardiology	Nephrology
Critical Care Medicine	Neurology
Dermatology	Physical Medicine/Rehabilitation
Endocrinology	Pulmonary Medicine
Gastroenterology	Radiation Oncology
Infectious Disease	Rheumatology
Internal Medicine/Family Practice	

4. Obstetrics/Gynecology
5. Pathology
6. Pediatrics
7. Psychiatry
8. Radiology
9. Surgery, which includes the following sub departments:

Critical Care Surgery	Colorectal surgery
Dentistry	Plastic Surgery
General Surgery	Podiatry
Neurosurgery	Ophthalmology
Oral/Maxillofacial Surgery	Surgical Oncology
Orthopedics	Thoracic Surgery
Otorhinolaryngology	Urology
	Vascular Surgery

The chairs of the departments shall appoint an associate chair for each department. The appointments of the associate chairs are not effective until approved by the Medical Executive Committee. The chair of the department may also appoint chairs of the sub departments identified. The appointments of the sub department chairs are not effective until approved by the Medical Executive Committee. Department associate chairs and sub department chairs may be replaced when a new department chair takes office.

8.2 Functions of Departments.

The general functions of each department shall include:

A. conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the Member whose work is subject to such review is a Member of that department.

B. recommending to the Medical Executive Committee guidelines for the granting of Clinical Privileges and the performance of specified services within the department;

C. evaluating and making appropriate recommendations regarding the qualifications of Applicants seeking appointment or reappointment and Clinical Privileges within that department;

D. conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

E. reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures; and (2) sound principles of clinical practice;

F. coordinating patient care provided by the department's Members with nursing and ancillary patient care services;

G. submitting written reports to the Medical Executive Committee concerning:

1. The department's review and evaluating activities, actions taken thereon, and the results of such action; and
2. Recommendations for maintaining and improving the quality of care provided in the department and the Hospital;

H. may meet at least twice per year or more often if necessary at the call of the Department Chair for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and Medical Staff functions;

I. establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

J. taking appropriate action when issues involving clinical performance or opportunities to improve care are identified;

K. accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

L. formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff; and

M. convening, where appropriate, an advisory committee comprised of sub department chairs to help coordinate the functions of the department.

8.3 Appointment of Department Chairs.

A. Qualifications. Each department chair shall be a Member in good standing of the Active Medical Staff who has demonstrated a high level of clinical competency, as well as executive and administrative abilities. Each department chair must be certified by the appropriate specialty board.

B. Term. Each term as chair of a department shall be for five years. Starting approximately 180 days before the end of all five-year periods, there shall be a review of the chair's performance in accordance with Section 8.3(D) below. A chair may not serve more than two consecutive terms, unless an extension occurs through the chair's contracted relationship with the Hospital.

C. Contractual Appointment. If the Board of Directors or it's designee negotiates and executes a written contract with any medical staff member of any clinical department, the terms of the written contract supersede the provisions of these Bylaws. Regardless of such written contract, the Medical Executive Committee reserves the right to ratify or refuse to ratify the chairmanship. If the Committee does not ratify the chairmanship, then the Board of Directors will take action to rectify the situation.

D. Selection and Re-election of Department Chairs by Medical Staff.

1. Initial Selection. If the Board of Directors does not select a department chair, the provisions of this Section 8.3(D) shall apply. Upon a vacancy occurring in a chairmanship, the President of the Medical Staff shall establish a Chairmanship Nominating Committee. This Committee shall be composed of the current President of the Medical Staff (who will chair the committee), the immediate past President of the Medical Staff, the associate chairs of the departments of Medicine and Surgery, three members of the department in question elected by the department's membership, the Chief Executive Officer, and the Chief Medical Officer. If one or more of the Chairmanship Nominating Committee members wishes to be considered for the vacant chairmanship of a department, such Member shall resign from the Chairmanship Nominating Committee and another Physician Member of the Active Medical Staff shall be appointed to the Chairmanship Nominating Committee. If the Committee cannot be completed using these criteria, the President of the Medical Staff shall appoint other Member(s) of the Medical Staff to the Committee, so the number of voting Members shall always be nine. The Chairmanship Nominating Committee, using procedures established by itself, but providing for some method of consulting the Medical Staff, the department involved, and the Hospital's administration, shall nominate a single candidate to fill the vacancy, which candidate shall be recommended to the Medical Executive Committee. The Medical Executive Committee shall accept or reject the candidate. If the Medical Executive Committee rejects the candidate, the Chairmanship Nominating Committee shall nominate a different candidate who shall then be recommended to the Medical Executive Committee. This process shall continue until such nominated candidate is accepted by the Medical Executive Committee. After a candidate has been accepted by the Medical Executive Committee, the Medical Executive Committee shall recommend to the Board of Directors that such candidate be chosen to fill the vacancy. If the Board of Directors does not appoint the candidate recommended by the Medical Executive Committee, the Chairmanship Nominating Committee shall nominate a different candidate and the process shall be repeated until the Board of Directors approves the candidate.

2. Re-election. At least 180 days prior to the end of his/her five-year term, the incumbent must state whether he/she intends to seek the chairmanship for another term. If the incumbent intends to seek another term, he/she will be subject to a review by the Chairmanship Review Committee of the Medical Staff. This Committee shall be composed of the Chairmanship Nominating Committee. This Committee shall conduct its review and either makes a recommendation to the Medical Executive Committee to reappoint the chair or a statement that it is unable to recommend reappointment and its reasons therefore.

The Medical Executive Committee shall deliberate on the recommendations of the Chairmanship Review Committee at the next meeting after receipt of such recommendations.

The Medical Executive Committee shall after deliberation take one of the following actions:

i. Recommend to the Board of Directors that the chair be reappointed;
ii. Recommend to the Board of Directors that the chairmanship be declared vacant, and allow the chair who was reviewed to seek appointment through the Chairmanship Nominating Committee with other interested applicants;
iii. Recommend to the Board of Directors that the chairmanship be declared vacant and that the chair who was reviewed not be reappointed; or
iv. Return the matter to the Chairmanship Review Committee to request further consideration and clarification.

If the Medical Executive Committee elects to return the matter to the Chairmanship Review Committee, it shall specify precisely the issues that need further reconsideration or clarification. The Chairmanship Review Committee shall report to the Medical Executive Committee within 30 days. Upon receipt of the report from the Chairmanship Review Committee, the Medical Executive Committee shall take one of the four actions noted above, except that it may not return the matter to the Chairmanship Review Committee a second time. The Board of Directors may accept or reject the recommendation of the Medical Executive Committee; or, the Board may return the matter to the Medical Executive Committee or take other appropriate action.

3. The Medical Director of Informatics shall be elected by the MEC.

8.4 Duties of Department Chairs.

Each department chair has the following responsibilities:

1. Act as presiding officer at departmental meetings;
2. Report to the Medical Executive Committee and to the President of the Medical Staff regarding all professional and administrative activities within the department;
3. Be a member of the Medical Executive Committee as provided in these Bylaws, be responsible to the Medical Executive Committee, give guidance on the overall medical policies of the Medical Staff and Hospital, and make specific recommendations and suggestions regarding his/her department;
4 Endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within the department;
5. Implement within the department appropriate actions taken by the Medical Executive Committee;
6. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;

7. Select, and, if necessary, remove, associate chairs and sub department chairs in accordance with the provisions of these Bylaws;
8. Perform such other duties commensurate within the office as may from time to time be reasonably requested by the President of the Medical Staff or the Medical Executive Committee.
9. Clinically related activities of the department
10. Administratively related activities of the department, unless otherwise provided by the hospital and agreed to by the relevant chair
11. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
12. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
13. Recommending clinical privileges for each member of the department.
14. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
15. The integration of the department or service into the primary functions of the organization.
16. The coordination and integration of interdepartmental and intradepartmental services.
17. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
18. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
19. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
20. The continuous assessment and improvement of the quality of care, treatment and services.
21. The maintenance of quality control programs, as appropriate.
22. The orientation and continuing education of all persons in the department or service.
23. Recommending space and other resources needed by the department or service.
24. Contributing to the development of the hospital's electronic medical records system and supporting its use and adoption by members of the relevant department.

8.5 Duties of Sub-department Chairs.

Each sub department chair has the following duties:

1. Act as presiding officer at sub departmental meetings;
2. Report to the department chair regarding all professional and administrative activities within the sub department;

3. Generally monitor the quality of patient care and professional performance rendered by Practitioners with Clinical Privileges in the sub department and oversee the patient care, evaluation, and monitoring functions delegated to the sub department by the department;
4. Transmit to the department chair the sub department chair's recommendations concerning Practitioner appointment and classification, reappointment, modifications, monitoring of specified services, and corrective action with respect to persons with Clinical Privileges in the sub department;
5. Endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within the sub department;
6. Implement within the sub department appropriate actions taken by the department;
7. Participate in every phase of administration of the sub department, as appropriate;
8. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the sub department as may be required by the department;
9. Recommend delineated Clinical Privileges for each Practitioner in the sub department;
10. Seek to assure that each Practitioner in the sub department practices within the scope of the Privileges granted;
11. Perform such other duties commensurate within the office as may from time to time be reasonably requested by the department chair, the President of the Medical Staff, or the Medical Executive Committee;
12. Establish criteria, consistent with the policies of the Medical Staff, for the granting of Clinical Privileges within the sub department, as well as determining the qualifications and competence of sub department personnel who are not licensed independent practitioners who provide patient care services;
13. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care services that are not provided by the Hospital or sub department;
14. Seek to coordinate and integrate intra- and inter-sub departmental services;
15. Seek to orient and promote the continuing education of all persons in the sub department; and
16. Recommend space and other resources needed by the sub department.
17. Contributing to the development of the hospital's electronic medical records system and supporting its use and adoption by members of the relevant department.

8.6 Removal of Department, Sub-department, & Associate Department Chairs.

Department chairs selected by the Board of Directors may be removed by the Board of Directors in accordance with the applicable contract. If the Medical Staff selects a department chair in accordance with Section 8.3(D) above, the Medical Executive Committee may recommend, at any time, to the Board of Directors that a department chair be removed. Sub department and Associate department chairs may be removed, at any time, by the department chair with the approval of the Medical Executive Committee. No rights of hearing and appeal exist for any such removal.

ARTICLE IX ORGANIZATION OF THE MEDICAL STAFF

9.1 Officers of the Medical Staff.

The officers of the Medical Staff shall be the President, the Vice President and the Secretary/Treasurer.

9.2 Qualifications.

Officers must be Members of the Active Medical Staff at the time of their nomination and election and must remain Members in good standing during their term of office. Officers may not concurrently serve as a Medical Staff Officer, Corporate Officer, or Department Chair at any other hospital.

9.3 Term.

No officer shall hold the same office for more than two consecutive years. Elections shall be held annually.

9.4 Nominations.

There shall be a Nominating Committee that shall consist of five Members of the Active Medical Staff, and the immediate past President of the Medical Staff, who shall be the chair. The Nominating Committee shall be elected by the Medical Staff at the quarterly March Medical Staff Meeting. The duties of the Nominating Committee are to select a slate of nominees (one for each position) in accordance with the process described herein for the offices of President, Vice President, and Secretary/Treasurer, as well as the at-large Members of the Medical Executive Committee. The nominations must be made and published by notices posted in conspicuous locations at the Hospital at least 15 days in advance of the election.

Nominations for officer candidates and at-large members of the Medical Executive Committee may also be made by a petition signed by at least ten of the Members of the Active Medical Staff submitted to the Medical Staff Office at least 15 days in advance of the election and any such nominations also shall be published by posting notices in conspicuous locations in the Hospital. No nominations may be made except as provided above and no nominations will be accepted from the floor at any Medical Staff Meeting.

At the annual Medical Staff Meeting in June, the officers and committee members shall be elected. Voting shall be by secret ballot (see memo). Ballots will be counted at the June meeting under the supervision of the immediate past President of the Medical Staff, and the results shall be announced immediately.

The recommendations of the nominating committee will be forwarded to the CMO for administrative input; if the CMO objects to the nominating committee's recommendations, he may request that the nominating committee reconvene to consider additional information. Those opinions / recommendations are not binding on the final recommendations of the committee**.**

9.5 Duties of Officers.

A. President of Medical Staff. The President shall serve as chief officer of the Medical Staff. The President will encourage a cooperative and effective relationship between the Medical Staff and the Hospital. He/she shall maintain general supervision over the professional medical services of the Hospital and the Members of the Medical Staff, shall coordinate the work of the various departments and services of the Medical Staff, and shall be directly responsible for same to the Board of Directors. The duties of the President shall include, but not limited to the following:

1. Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
2. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
3. Serving as chair of the Medical Executive Committee;
4. Serving as an *ex officio* Member of all other Medical Staff committees (except the Nominating Committee). As an *ex officio* Member of such committees, the President of the Medical Staff will have no vote, unless his/her membership in a particular committee otherwise is required by these Bylaws.
5. Interacting with the Chief Executive Officer and Board of Directors in all matters of mutual concern within the Hospital and shall represent the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer. The President shall be a voting member of the Board of Directors.
6. Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chair of these committees;
7. Serving as spokesperson for the Medical Staff in external professional and public relations;
8. Performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff, or by the Medical Executive Committee; and
9. Serving on liaison committees with the Board of Directors and Hospital administration, as well as outside licensing or accreditation agencies.

B. Vice President. The Vice President, in the absence of the President, shall assume all duties, authority and responsibility of the President. The Vice President shall also perform such duties as may be delegated to him/her by the President.

C. Secretary/Treasurer. The Secretary/Treasurer shall keep accurate records of the meetings of the Medical Staff and the Medical Executive Committee. The Secretary/Treasurer shall be accountable for all funds entrusted to him/her and shall submit a financial report at each regularly scheduled Medical Executive Committee meeting. The Secretary/Treasurer may fulfill the functions of the President and Vice President to run Medical Staff meetings if both individuals are unavailable, but only if the meeting was previously scheduled. He/she shall perform such other duties as customarily pertain to the office.

D. Vacancy. In the event of a vacancy in the office of President, the Vice President shall automatically become President. The vacancy of any other office will be filled by election of the Medical Staff upon the recommendation of the previous Nominating Committee at the next general Medical Staff Meeting.

E. Removal of Officers. Removal of officers shall be for failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff. Except as otherwise provided, a majority vote of the Medical Executive Committee or a petition signed by at least 1/3 of the Medical Staff Members eligible to vote for officers is needed to initiate the removal of a Medical Staff Officer. Fifteen days notice must be provided to all eligible Medical Staff Members that a special meeting will be held to consider removal of an officer. To take action at the special meeting, a Quorum must be present. Removal of an officer requires a 2/3 majority vote of the Medical Staff eligible to vote for Medical Staff officers and actually voting at the special meeting. Voting may be in person or by mail ballot, but all mail ballots must be received by the date and time of the special meeting. Prior to the initiation of any removal action, the officer in question must be provided with notice of the date of the meeting at which such action shall be undertaken. Notice must be in writing and must be given at least 15 days prior to the date of the meeting. The officer shall be afforded an opportunity to speak to the Medical Executive Committee prior to a vote on such removal being taken.

ARTICLE X MEDICAL STAFF MEETINGS

10.1 Regular Meetings.

Regular Medical Staff Meetings shall be held on the first Wednesday of March, June, September and December. Departmental and sub departmental meetings shall be held regularly in accordance with established departmental/sub departmental procedure.

10.2 Annual Meeting.

The quarterly Medical Staff Meeting in June shall be designated as the annual meeting of the Medical Staff, at which time elections shall be held.

10.3 Special Meetings.

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, upon receipt of a written request of the Board of Directors or the Medical Executive Committee, or upon receipt of a petition signed by 25% of the Members of the Active Medical Staff. The notice of the special meetings shall state the purpose of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The meeting shall be scheduled within 30 days after receipt of such request. No later than ten days prior to the meeting, notice shall be mailed or delivered to the Members of the Medical Staff. The notice must state the purpose of the meeting.

10.4 Quorum.

For all committees, Quorum shall be defined as the group of the voting members of the committee present, unless these Bylaws otherwise specifically provide.

10.5 Conduct of Meetings.

Unless otherwise specified, meetings of the Medical Staff shall be conducted according to Roberts Rules of Order. However, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

10.6 Majority Vote.

Unless otherwise specified in these Bylaws, a majority vote shall prevail for any action taken at any meeting of the Medical Staff or any department/sub department or committee.

10.7 Special Attendance at Meetings.

At the discretion of the department or committee chair, when the practice or conduct of a department or committee member is scheduled for discussion at a regular department, sub- department, or committee meeting, the member may be requested to attend. If a suspected deviation from the standard of care is involved, the notice shall be given at least seven days prior to the meeting and shall include the time and place of the meeting and a general description of the issue involved. Failure of a member to appear at any meeting with respect to which he/she was given such notice, unless excused by the President of the Medical Staff upon a showing of good cause, shall be a basis for corrective action.

ARTICLE XI COMMITTEES

11.1 Authority.

A. Function of Committees. Medical Staff committees shall include but not be limited to the Medical Staff meeting as a committee of the whole, meetings of departments and sub departments, meetings of committees established under Article XI, and meetings of special or *ad hoc* committees created by the Medical Executive Committee or clinical departments of the Hospital. The committees described in this Article shall be the standing committees of the Medical Staff. Special or *ad hoc* committees may be created by the Medical Executive Committee, by the President of the Medical Staff, or by any standing committee to perform specified tasks. Medical Staff committees report to the Medical Executive Committee.

B. Status as Medical Review Committees**.** For purposes of the requirements set forth under these Bylaws and applicable provisions of state and federal laws and regulations, and as approved by the Board of Directors, every committee operating pursuant to these Bylaws, including but not limited to the Credentials Committee, Quality and Safety Committee, the Medical Executive Committee, any hearing committee, or peer review (including **any** peer review process) or standing or special committee or sub-committee formed by the Board of Directors, the Medical Staff, shall be "a Medical Review Committee" within the meaning of Maryland Annotated Code, Health Occupations Article, Section 14-501 [the provision of Maryland law that relates to the confidential nature of the services performed by the Hospital's various peer review committees].

11.2 General Provisions.

A. Selection and Replacement of Committee Members. Unless these Bylaws specifically provide otherwise or if they are serving *ex officio*, Physician committee members may not serve unless and until they are selected by the President of the Medical Staff or the chair of the committee. If a vacancy occurs on a committee, the vacancy shall be filled through the same process. Non-Physician members of committees shall be appointed by the Chief Executive Officer or their designee.

B. Term of Committee Members. Unless otherwise specified, committee members shall be appointed for a term of two years, starting at the beginning of the calendar year that coincides with the beginning of the new term of the President of the Medical Staff. Committee members shall serve until the end of this two-year period or until the member's successor is appointed, unless the member earlier resigns or is removed from the committee.

C. Removal. If a member of a committee ceases to be a Member in good standing of the Medical Staff, suffers a loss or significant limitation of Privileges, or if any other good cause exists, that member may be removed from the committee by the Medical Executive Committee.

D. Vacancies. 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.

E. Meetings. Unless otherwise indicated, all committee meetings shall meet as often as necessary at the call of its chair. Each committee shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

F. Attendance. Each member of a committee may annually attend at least 50% of the committee's meetings in order to maintain membership on that committee, unless excused from such attendance requirement by the President of the Medical Staff or the committee Chairman.

G. Quorum. For all committees, Quorum shall be defined as the group of the voting members of the committee present, unless these Bylaws otherwise specifically provide. The Chairman of the committee can extend voting privileges to the non-voting members of the committee at his/her discretion.

11.3 Medical Executive Committee.

A. Composition. The Medical Executive Committee shall consist of the following persons, with the following voting rights:

Chair: President of Medical Staff

Voting: President of Medical Staff
Vice President of Medical Staff
Secretary/Treasurer of Medical Staff
Chair, Department of Medicine
Chair, Department of Surgery
Chair, Department of Anesthesiology
Chair, Department of Emergency Medicine
Chair, Department of Obstetrics/Gynecology
Chair, Department of Pathology
Chair, Department of Pediatrics
Chair, Department of Psychiatry
Chair, Department of Radiology
Four at-large Members, one of which may be an Advanced Practice Provider.
Medical Director of Informatics.
Immediate Past President of the Medical Staff Chief Medical Officer

When the President of Medical Staff also serves as a Department Chairman, then the Associate Chair for that Department will hold voting privileges.

Non-Voting: Associate Chair, Department of Medicine(votes if department chair is absent)

Associate Chair, Department of Surgery (votes if department chair is absent)
Chief Executive Officer (or his/her designee)
Vice President for Nursing

The Nominating Committee shall strive to seek representation from the various departments of the Medical Staff in preparing slates of the proposed at-large Physician members of the Medical Executive Committee.

Any voting chair member of the MEC may designate a proxy for the purpose of attending and voting at a meeting of the MEC.

B. Meetings. The Medical Executive Committee shall meet as often as necessary, but at least ten times per year, and shall maintain a record of its proceedings and actions.

C. Duties. The Medical Executive Committee is delegated the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by medical staff members with clinical privileges. This authority may be removed by amending these bylaws and related policies. The other duties include, but are not limited to:

1. Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff Meetings, subject to such limitations as may be imposed by these Bylaws;
2. Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
3. Receiving and acting upon reports and recommendations from Medical Staff departments, sub departments, committees, and assigned activity groups;
4. Recommending action to the Board of Directors;
5. Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual Clinical Privileges, the organization of quality assurance activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;
6. Evaluating and improving the medical care rendered to patients in the Hospital;
7. Participating in the development of Medical Staff policies and Hospital policies that affect patient care or physician conduct at the Hospital;
8. Reviewing the qualifications, credentials, performance and professional competence, and character of Applicants and Medical Staff Members and making recommendations to the Board of Directors regarding Medical Staff appointments and reappointments, assignments to departments, Clinical Privileges, and corrective action;

9. Taking reasonable steps to promote professional conduct and competent clinical performance on the part of all Practitioners, including the initiation of and participation in Medical Staff corrective or review measures when warranted;
10 Taking appropriate and reasonable steps to develop continuing education activities and programs for the Medical Staff;
11. Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the President of the Medical Staff;
12. Reporting to the Medical Staff at each regular Medical Staff Meeting;
13. Assisting in the obtaining and maintaining of the Hospital's accreditation;
14. Providing a liaison between the Medical Staff and the Chief Executive Officer;
15. Appointing such special or *ad hoc* committees as may seem necessary or appropriate to assist in the Medical Executive Committee in carrying out its functions and those of the Medical Staff;
16. Reviewing the quality, appropriateness and efficiency of clinical services provided by all physicians; and
17. Referring recommendations to the Joint Conference Committee for study, additional recommendations, approval, confirmation, or disapproval, and transmission thereof to the Board of Directors.
18. Maintains the authority to review and approve all policies, procedures and recommendations relating to the documentation, format and content of patient care related issues; including the paper and electronic medical record. If the organized medical staff disagrees with a policy or procedure enacted by the MEC, it can utilize the conflict resolution mechanism.
19. The MEC will review all rules and regulations proposed by the organized medical staff:

    a. If the MEC approves the proposed rule or regulation, the MEC will forward it to the Board noting approval by both the organized medical staff and the MEC.
    b. If the MEC does not approve the proposed rule or regulation, the MEC will forward it to the Board noting the approval by the organized medical staff and disapproval by the MEC.

D. CONFLICT RESOLUTION

1. **General procedure**.

Any conflict between the medical staff and the Medical Executive Committee (MEC) will be resolved using the mechanisms described in this section.

(a) Any staff member in the Active category may challenge any rule or policy established by the MEC by submitting written notification to the President of the Medical Staff the challenge and basis for the challenge, including any recommended changes to the rule or policy.

(b) The MEC shall discuss the challenge at its next meeting following receipt of the notification and determine if any changes will be made to the rule or policy.

(c) If changes are adopted, they will be communicated to the medical staff, at such time each medical staff member in the active category may submit written notification of any further challenge(s) to the rule or policy to the President of the Medical Staff.

(d) In response to the written challenge, the MEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised.

(e) If a task force is appointed, following the recommendations of such task force, the MEC will take final action on the rule or policy.

(f) Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by twenty-five percent (25%) of the members of the active category requesting review and possible change of a rule, regulation, policy or procedure. Upon presentation of such a petition, the adoption procedure outlined in Article 15 will be followed.

2. **Variance between MEC and medical staff**.

If the medical staff votes to recommend directly to the Board an amendment to the Bylaws or a policy that is different from what has been recommended by the MEC, the following conflict resolution process shall be followed:

(a) The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC and the medical staff, and recommend language to the bylaws or policy that is agreeable to both the medical staff and the MEC.

(b) Whether or not the MEC adopts modified language, the medical staff shall still have the opportunity to recommend directly to the Board alternative language. If the board receives differing recommendations for bylaws or a policy from the MEC and the medical staff, the Board shall also have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints such a task force, the Board shall have final authority to resolve the differences between the medical staff and the MEC.

(c) At any point in the process of addressing a disagreement between the medical staff and MEC regarding bylaws or policies, the medical staff, MEC, or governing Board shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed, is the responsibility of the Board.

E. Quorum for MEC. If any voting member of the MEC requests that a quorum for MEC be required for any vote or action of the MEC, then this section applies. In that circumstance, at least 35% percent of the voting members of the MEC must be present.

11.4 Bylaws Committee.

A. Composition. The Bylaws Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: President of the Medical Staff or Vice President of the Medical Staff
Chair, Department of Medicine
Chair, Department of Surgery
Four at-large Members of the Medical Staff

B. Meetings. The Bylaws Committee shall meet as often as necessary at the call of the Chair. The Bylaws Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Bylaws Committee shall include:

1. Conducting a review of the Medical Staff Bylaws, as well as the Rules and Regulations and forms promulgated by the Medical Staff, its departments and sub departments;
2. Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and
3. Receiving and evaluating for recommendation to the Medical Executive Committee modifications of the Bylaws, Rules and Regulations, and the forms specified herein.

11.5 Cancer Committee.

A. Composition. The Cancer Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Chair, Sub department of Medical Oncology
Additional member, Subdepartment of Medical Oncology
Chair, Sub department of Radiation Oncology
Additional member, Sub department of Radiation Oncology

Liaison Physician to the American College of Surgeons
Chair, Department of Medicine (or his/her designee)
Chair, Department of Surgery (or his/her designee)
Chair, Department of Obstetrics/Gynecology
Chair, Department of Pathology (or his/her designee)
Chair, Department of Radiology (or his/her designee)

Non-voting: Representative, Hospital administration
Representative, Hospital Learning Department
Representative, Hospital Pharmacy
Representative, Hospital Nursing Department
Representative, Hospital Social Services Department
Representative, Hospital Rehabilitative Services Department
Representative, Hospital Quality Management Department
Hospital's Tumor Registrar
Representative, Anne Arundel County Health Department
Representative, Hospital Public Relations Department

B. Meetings. The Cancer Committee shall meet as often as necessary, but at least quarterly. The Cancer Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Cancer Committee shall consist of:

1. Assisting the Hospital's administration in maintaining approval of the American College of Surgeons' Commission on Cancer;
2. Promoting and coordinating a multi-disciplinary approach to patient management at all levels;
3. Assuring that consultative services in all disciplines are available and that education and "tumor conference review" activities cover all major cancer sites and issues of cancer care;
4. Establishing and documenting an active support system for patients, families and Medical Staff members;
5. Initiating patient care audits and reviewing similar data supplied by other Hospital committees; and
6. Supervising the cancer registry and overseeing accurate, timely abstracting, staging and reporting of data.

11.6 Continuing Medical Educational Committee.

A. Composition. The Continuing Medical Educational Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: At least three Physician Members of the Medical Staff

B. Meetings. The Continuing Medical Education Committee shall meet as often as necessary at the call of its chair, but at least six times per year. The Continuing Medical Education Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Continuing Medical Educational Committee shall include:

1. Reviewing clinical department requirements to ensure compliance with applicable state and federal laws, regulations and professional organizations; and
2. Arranging for and sponsoring programs designed to provide the Medical Staff with ongoing medical education.

11.7 Credentials Committee.

A. Composition. The Credentials Committee may consist of the following persons with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Not less than five Members of the Medical Staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties

B. Meetings. The Credentials Committee shall meet as often as necessary at the call of its chair but no less often than monthly. The Committee shall maintain a record of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The Credentials Committee shall:

1. Review and evaluate the qualifications of each Practitioner applying for initial appointment, reappointment, or modification of and for Clinical Privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;
2. Submit to the Medical Executive Committee required reports and information on the qualifications of each Practitioner applying for membership or particular Clinical Privileges, including recommendations with respect to appointment, reappointment, membership category, department affiliation, Clinical Privileges and special conditions;
3. Investigate, review and report on matters referred to it by the President of the Medical Staff or by the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any Applicant or Medical Staff Member when he/she is seeking any change in Privileges; and

4. Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

11.8 Critical Care Committee.

A. Composition. The Critical Care Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Chair, Department of Medicine (or his/her designee)
Chair, Department of Surgery (or his/her designee)
Chair, Department of Anesthesiology (or his/her designee)
Chair, Sub department of Pulmonary Medicine (or his/her designee)
Chair, Sub department of Cardiology (or his/her designee)
Two at-large Members with admitting privileges in the Hospital's Intensive Care Unit/Critical Care Unit

Non-voting: Chief Executive Officer (or his/her designee)
Hospital's Director of Inpatient Nursing
Hospital's Director of Respiratory Care
Nurse Manager(s), All Critical Care and Telemetry Units in Hospital
Nurse Clinical Specialist in Critical Care

B. Meetings. The Critical Care Committee shall meet as often as necessary, but at least six times per year. The Critical Care Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Critical Care Committee shall be to:

1. Develop and maintain policies and procedures governing critical care;
2. Monitor and evaluate the quality of care delivered in the Hospital's critical care units;
3. Provide Medical Staff participation in measuring and improving the delivery of care in critical care areas; and
4. Promote a multidisciplinary approach to critical care patients.

11.9 Infection Control Committee.

A. Composition. The Infection Control Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Representative, Department of Medicine
Representative, Department of Surgery
Representative, Department of Pathology
Representative, Sub department of Infectious Disease

Non-voting: Hospital administration
Hospital nursing service
Hospital Infectious Disease Coordinator
Representative, Employee Health
Representative, Microbiology
Representative, Pharmacy
Director, Perioperative Services

The Infection Control Committee may also include non-voting consultants in microbiology and non-voting representatives from relevant Hospital services as deemed necessary and appropriate.

B. Meetings**.** The Infection Control Committee shall meet as often as necessary at the call of its chair but at least quarterly. The Infection Control Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties**.** The duties of the Infection Control Committee shall include:

1. Developing a hospital-wide infection control program and maintaining surveillance over the program;
2. Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections;
3. Monitor adherence by Physicians to the Hospital's Infection Control Policy.
4. Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
5. Developing written policies defining special indications for isolation requirements;
6. Monitoring findings regarding review of the clinical use of antibiotics; and
7. Developing policy regarding needle stick injuries and exposures.

11.10 Medical Ethics Committee.

A. Composition. The Medical Ethics Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Representative, Department of Medicine
Representative, Department of Surgery
Representative, Department of Anesthesiology
Representative, Department of Emergency Medicine
Representative, Department of Psychiatry

Non-voting: Representative, Sub department of Neurology
Representative, Sub department of Medical Oncology
Chief Executive Officer (or his/her designee)
Hospital Nurse with administrative responsibilities
Hospital Nurse with clinical responsibilities
Social Worker, employed by Hospital
Hospital Risk Manager
Member, Board of Directors
Member, Clergy
Representative, Hospital Sub acute Unit

In addition, a representative of the Department of Pediatrics shall be a voting member of the Committee for any situations that involve pediatric patients.

B. Meetings. The Medical Ethics Committee shall meet quarterly and also shall convene within a reasonable time if requested by any petitioner. The Medical Ethics Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Medical Ethics Committee shall be to:

1. Be available to discuss and advise options for medical care and treatment of an individual with life threatening conditions;
2. Review and recommend institutional policies and guidelines concerning the provision, withholding, and/or withdrawal of medical treatment; and
3. Educate Hospital employees, patients and patients' families concerning medical decision making.

Any Committee member who has any personal knowledge or involvement with the patient whose care is being reviewed shall immediately so advise the Committee chair.

11.11 Health Information Management Committee.

A. Composition. The Health Information Management Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Representative, Department of Medicine
Representative, Department of Surgery
Representative, Department of Emergency Medicine
Representative, Department of Anesthesiology
Representative, Department of Pathology
Physician Member of Medical Staff

Non-voting: Director, Health Information Management Department (or his/her designee)
Additional Representative(s), Health Information Management Department (as selected by Director of Health Information Management Department)
Hospital Nurse with clinical responsibilities
Hospital Nurse with administrative responsibilities
Representative, Hospital's Quality Management Department
Representative, Hospital's Information Systems Department
Representative, Hospital's Learning Department

B. Meetings. The Health Information Management Committee shall meet at least quarterly as called by its chair. The Health Information Management Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Health Information Management Committee shall be to:

1. Review and evaluate medical records, or a representative sample, to determine whether they:
   (a) Properly describe the condition, diagnosis, and progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequately identify individuals responsible for orders given and treatment rendered; and
   (b) Are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the Hospital;
2. Review and make recommendations for Medical Staff and Hospital policies, rules and regulations relating to the format and requirements of both electronic and paper medical records.
3. Maintain a record of all actions taken and submit periodic reports to the Medical Executive Committee concerning medical records practices in the Hospital;
4. Review the quality, accuracy, timeliness and legibility of medical records documentation; and

5. Administratively close, after appropriate review, medical charts of Practitioners who are no longer available to complete their medical records.

11.12 Perioperative Services Committee.

A. Composition. The Perioperative Services Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Chair, Department of Surgery
Associate Chair, Department of Surgery
Chair, Department of Anesthesiology
Associate Chair, Department of Anesthesiology
Chair, Department of Obstetrics/Gynecology
Five additional Physician representatives of the Departments of Surgery**,** Anesthesiology and Obstetrics/Gynecology,

Non-voting: Representative, Hospital administration
Hospital's Director of Perioperative Nursing
Vice President of Nursing
Nurse Manager of Hospital's Operating Room
Nurse Manager of Hospital's Post Anesthesia Care Unit
Nurse Manager of Hospital's Ambulatory Admissions area
Nurse Manager, Pre surgical Testing
Hospital Risk Manager
Vice President for Quality and Patient Safety

B. Meetings. The Perioperative Services Committee may meet monthly at the call of its chair. The Perioperative Services Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Perioperative Services Committee shall consist of:

1. Developing and periodically reviewing Hospital policies and procedures governing the Hospital's provision of Perioperative services, including but not limited to the scheduling of cases, sterile procedures, and staffing procedures;
2. Developing and periodically reviewing standards for pre-operative care of Hospital patients;
3. Providing Medical Staff participation in measuring and improving the delivery of care in Perioperative services; and
4. Evaluating and recommending new equipment, both permanent and disposable, for Perioperative services.

11.13 Pharmacy and Therapeutics Committee.

A. Composition. The Pharmacy and Therapeutics Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Representative, Department of Surgery
Representative, Department of Anesthesiology
Representative, Department of Emergency Medicine
Representative, Department of Obstetrics/Gynecology
Representative, Department of Pediatrics
Representative, Sub department of Internal Medicine
Representative, Department of Psychiatry
Representative, Sub department of Cardiology
Representative, Sub department of Infectious Diseases
Representative, Sub department of Pulmonary Medicine
Representative, Sub department of Medical Oncology
Hospital's Director of Pharmacy Services (or his/her designee)
Hospital pharmacist
Hospital's Director of Nutritional Services (or his/her designee)
Representative of the Hospital's Infectious Diseases Department
Representative, Hospital Administration
Representative, Hospital's Nursing Administration
Representative, Hospital's Learning Department

B. Meetings. The Pharmacy and Therapeutics Committee may meet monthly at the call of its chair. The Pharmacy and Therapeutics Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Pharmacy and Therapeutics Committee shall include:

1. assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to medications in the Hospital;
2. Advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;
3. Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
4. Periodically developing and reviewing a formulary or drug list for use in the Hospital;
5. Evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

6. Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
7. Evaluating the provision and adequacy of patients' oral, enteral, and parenteral nutritional care;
8. Reviewing untoward and/or adverse medication reactions and interactions; and;
9. Reviewing the medical content of any patient educational material regarding medication and nutrition.

11.14 Post Graduate Medical Education Committee

A. Composition. The Post Graduate Medical Education Committee may consist of the following persons with the following voting rights.

Chair — Chief Medical Officer

Voting — Chairs of the Clinical Departments

Non-voting — Coordinator of Graduate Medical Education

B. Meetings. The Post Graduate Medical Education Committee shall meet as often as necessary at the call of its chair. The Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee and the Board of Directors of the Hospital.

C. Duties

1. The Committee shall set standards for the supervision of residents in order to safeguard patients and enhance graduate medical education at Baltimore Washington Medical Center
2. To determine and supervise the implementation of, within, and according to the standards and the criteria of the Council of Medical Education of the American Medical Association and within applicable federal, state and local statutes, laws and ordinances, the medical education programs of the residents at Baltimore Washington Medical Center.
3. To evaluate and seek to improve the qualifications, competence and performance of the residents at Baltimore Washington Medical Center; to assist, when requested by the Director/Coordinator of Graduate Medical Education, in all matters relating to discipline of residents; and to evaluate and seek to improve the quality of health care through medical education programs for the attending staff
4. The Committee shall seek to insure that the Hospital's Policy on the Supervision of Residents is implemented and followed.

11.15 Performance Improvement / Risk Management

A. Composition. The Performance Improvement / Risk Management Committee may consist of the following persons, with the following voting rights:

Chair: Selected by President of Medical Staff from the Physicians who are voting members of the Committee

Voting: Chairs of the Clinical Departments and/or their designees Chief Medical Officer

Non-voting: Chief Operating Officer (or his/her designee)
Hospital's Vice President for nursing services (or his/her designee)
Hospital Risk Manager
Hospital Vice President for Quality and Patient Safety

B. Meetings. The Performance Improvement / Risk Management Committee may meet monthly at the call of its chair. The Performance Improvement / Risk Management Committee shall keep records of its proceedings and actions and shall regularly report to the Medical Executive Committee.

C. Duties. The duties of the Performance Improvement / Risk Management Committee shall be to review overall performance in the provision of patient care in the Hospital and provide a forum to review complaints and problems within the Hospital as they relate to patient care. Specifically, the duties of the Committee shall include:

1. Providing structure for the collection, analysis and reporting of data about the delivery of patient care and collective practitioner performance;
2. Ensuring communication, action and follow-up on the impact of actions taken to improve the delivery of care and patient outcomes;
3. Providing leaders with information about measurement of performance from organization-wide, departmental and individual levels; and
4. Recommending for review by the Medical Executive Committee plans for improving patient care within the Hospital. These may include mechanisms to:

    a. Establish systems to identify potential problems in patient care;
    b. Coordinate with the Hospital’s Risk Manager a formal program for addressing patient complaints;

c. Promptly refer problems for assessment and corrective action to appropriate departments or committees, provided that any complaints or issues regarding individual practitioners should be immediately referred to the appropriate department chair (even if the Performance Improvement / Risk Management Committee continues to investigate these issues) and that, in such event, the applicable department chair and the chair of the Performance Improvement / Risk Management Committee shall promptly apprise each other of their respective dispositions of the matter in question;

d. Monitor and coordinate the results of quality improvement activities throughout the Hospital.

11.16 Resource Management Committee

B. Composition. The Resource Management Committee may consist of the following persons, with the following voting rights:

Chair: Chief Medical Officer or his designee

Voting: President of the Medical Staff (or his/her designee)
Chair, Department of Medicine
Chair, Department of Surgery
Associate Chair, Department of Medicine
Associate Chair, Department of Surgery
Representative of the Department of Medicine
Representative of the Department of Surgery
Chief Medical Officer

Non-Voting: Chief Operating Officer (or his/her designee)
Vice President for Quality and Patient safety
Physician Advisor to Outcomes Management Department

B. Meetings: The Resource Management Committee shall meet as often as necessary. The Committee shall keep records of its proceedings and shall regularly report to the Medical Executive Committee.

C. Duties: It is the Hospital's policy to work with its Medical Staff to identify Physicians whose practice patterns do not comply with statistical norms and to work with them to enhance their efficiency consistent with high quality standards of patient care. For these purposes, the Hospital has established the Resource Management Committee ("Committee"), comprised of representatives of the Medical Staff and Hospital administration.

The Committee will meet periodically to assess statistical data compiled by the Hospital. The source of the data shall be HSCRC discharge data, or its equivalent, by DRG, by Physician. From such data, the Physicians whose data show significant variances from standard indicators, or who have a significant number of physician denied days by payors, shall be noted. The Committee shall attempt to determine whether these data patterns are the result of a Physician's practice patterns or are due to some other factor not unique to the Physician, such as high patient acuity or some other circumstantial factor.

For the Physicians whose practice patterns (e.g., length of stay and resource utilization) may have caused the data variations, the Hospital will work collaboratively with these Physicians, in conjunction with their department chairs or associate chairs, to achieve better practice efficiencies consistent with high quality patient care. These efforts may include requesting that a Case Manager, Utilization Management Coordinator or their administrative equivalent (collectively "clinical coordinators") help the Physician coordinate patient care; encouraging the Physician to seek additional education, where appropriate; and/or meeting periodically with the Hospital's Physician Advisor to discuss case management issues.

As a condition of membership on the Medical Staff, all Physicians are required to cooperate with the Committee to help achieve more efficient practice patterns. As a goal, it is hoped that a Physician working diligently with the Committee to improve his/her practice patterns can achieve a significant improvement within the first quarter, and to approach the peer average for charge/case, length of stay and other indicators (collectively "improvement goals") by the end of the second quarter.

If negative practice pattern indicators by a Physician persist after concerted efforts by the Physician and the Committee to correct them, or if a Physician fails or refuses to engage in constructive efforts to address the practice pattern problems identified, then the Committee may initiate a progressive action plan to correct the practice patterns. The Chief Medical Officer, or his/her designee, shall review the relevant charts of the Physician and identify specific problems contributing to the apparently inefficient practice patterns. These identified problems and charts shall also be reviewed by the appropriate department chair or associate chair, which would then meet with the affected Physician to review the charts.

The Committee shall develop and implement a performance improvement plan, which may have as its components coordination of length of stay and resource utilization with appropriate clinical coordinators. The identified Physician shall be required to participate in the performance improvement plan, which may include some or all of the progressive discipline as set forth below.

* Requiring additional education for clinical and/or utilization management;
* Removing the Physician from the Emergency Department on-call roster;
* Requiring the Physician to meet weekly or otherwise with the Physician Advisor to review all of his/her patients in the Hospital; and/or,
* Requiring the Physician to meet monthly with the applicable department chair or his/her designee to review utilization data and to identify improvements in variances and volume of denied days.

The Committee may recommend to the Medical Executive Committee that the Physician's admitting privileges be limited; that the Physician be required to utilize the Hospital's Inpatient Team or designate another Physician (not currently subject to the performance improvement plan) for some or all admissions; or that any other recommendation be implemented that is appropriate under the circumstances. Upon receipt of such a Committee recommendation, the Medical Executive Committee will consider the recommendation as a formal request for Corrective Action under Article XII of the Medical Staff Bylaws. The Chief Medical Officer, at his/her discretion, shall inform the Board of Directors of the activities of the Committee and the progress of Physician practice patterns, which have become the subject of the Performance Improvement Plan.

11.17 Joint Conference Committee.

A. Composition. The Joint Conference Committee may consist of the following persons, with the following voting rights:

Chair: Chief Executive Officer (without vote)

Voting: Up to seven members of the Hospital's Board of Directors and/or Hospital administration, as selected by the Chair of the Hospital's Board

Up to seven representatives of the Medical Staff: the President of the Medical Staff; the Vice-President of the Medical Staff; the chair of the Department of Medicine; the chair of the Department of Surgery; and three representatives of the Medical Staff that are selected by the President of the Medical Staff and ratified by the Medical Executive Committee, one of whom shall be the immediate past President of the Medical Staff (if available)

The Hospital's Board of Directors and the Medical Staff shall strive to have an equal number of representatives at each meeting of the Committee.

B. Meetings. The Joint Conference Committee shall meet at the call of the President of the Medical Staff, the Chief Executive Officer, or the chair of the Board of Directors. The Joint Conference Committee shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors after each meeting.

C. Duties. The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, goals and objectives, practice, and planning, and a forum for interaction between the Board of Directors and the Medical Staff by providing liaison on such matters as may be referred by the Medical Executive Committee or the Board of Directors. The Joint Conference Committee shall study the matters referred to it and provide additional recommendations as necessary. The Joint Conference Committee shall attempt to resolve conflicts between or among the Medical Staff, the Hospital administration, and/or the Hospital's Board of Directors as they arise and shall exercise other responsibilities set forth in these Bylaws.

11.18 Human Subjects Review Committee

A. Composition. The Human Subjects Review Committee may consist of the following persons with the following voting rights:

Chair: Selected by the President of the Medical Staff from the physicians who are members of the Committee.

Voting: At least four physician members of the medical staff, representing a minimum of three different clinical departments

Non-voting: Representative, Hospital Administration
Representative, Hospital Social Services
Representative, Pharmacy
Representative from the volunteer clergy

Members of other departments may be invited as guests to provide input on a specific subject. The names and qualifications of the members of the committee shall be maintained and be available for review at all times. No individual who is involved in the conduct of the research project under review shall participate in the evaluation or review of the research project.

B. Meetings: The Human Subjects Review Committee shall meet as necessary at the call of the chair and more often as necessary in the discretion of the Chair in order to meet its responsibilities.

C. Duties: The duties of this committee are:

1. The review of every research proposal, including drug trials, request to do, research on hospital charts, or cooperative studies which take place within the hospital
2. To maintain a record of the procedure utilized to obtain informed consent from patients involved in each approved study.

3. To conduct successive reviews and to follow up on all approved studies in progress. The reviews will be conducted at intervals appropriate to the degree of risk, but not exceeding one year, to assure that each research project is being conducted in compliance with the committee's understandings and recommendation.
4. To review the approval of each research project on a requirement that the researcher will report to the committee any emergent problems, serious adverse reactions, or proposed procedural changes which may affect the status of the research. No change in the research project may be made without committee approval except where changes are necessary to eliminate apparent immediate hazards.

11.19 The Medical Staff Departmental Peer Review Committees

A. Composition. The Medical Staff Departmental Peer Review Committees shall be comprised of members appointed by the President of the Medical Staff and shall include the Department Chair and/or his/her designee.

Chair: Selected by the President of the Medical Staff from the physicians who are members of the committee

Voting: All Medical Staff members shall have voting rights.

B. Meetings: The Peer Review Committees shall meet as often as needed at the call of the chair of the committee.

C. Duties: The duties of the Departmental Peer Review Committees shall be to assure the provision of quality patient care within the relevant department through the monitoring and evaluation of the quality and appropriateness of patient care within the Department and to address opportunities to improve patient care.

11.20 Medical Staff Quality Improvement Committee

A. Composition: Medical Staff Quality Improvement Committee shall consist of the following persons with the following voting rights:

Chair: President of the Medical Staff (or designee assigned by the President of the Medical Staff)

Voting: Vice President of the Medical Staff
Medical Staff Departmental Chairmen, or their designees
Infection Control Committee Chairman, or designee
Chief Medical Officer
Medical Staff Director

Non-Voting: Vice President of Quality Improvement
Vice President of Nursing or designee

B. Meetings: The Medical Staff Quality Improvement Committee shall meet as often as needed, at the call of the chair of the committee.

C. Duties: To provide multidisciplinary oversight for all peer review committee activities and measures of physician performance for all medical staff departments. Work in cooperation with medical staff departments to review, analyze, and make recommendations to improve the quality of care.

ARTICLE XII CORRECTIVE ACTION

12.1 Corrective Action.

The provisions of this Article XII shall not apply to routine inquiries and informal peer review, such as department review and discussion of cases handled by department members, requests for further information from various departments or other peer review committees, and routine screening of cases by departments. These matters are handled in the matter described by section 12.6. Rather, the provisions of this Article (Sections 12.1 through 12.5) shall be used when a more serious question has been raised regarding a Practitioner's conduct, performance, or competence while at the Hospital.

A. Criteria for Initiation. Any person may provide information to the President of the Medical Staff about the conduct, performance, or competence of any Practitioner with Clinical Privileges at the Hospital. When reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct, reasonably likely to be:

1. detrimental to patient safety or to the delivery of patient care within the Hospital;
2. contrary to the Medical Staff Bylaws, Rules and Regulations; and/or
3. below applicable professional standards,

a request for an investigation or action against such Practitioner may be initiated by the President of the Medical Staff, the Chief Executive Officer or his/her designee, a department chair, or the Medical Executive Committee. A request for an investigation and corrective action must be in writing, signed by the complainant, submitted to all members of the Medical Executive Committee, and supported by reference to specific activities or conduct alleged.

B. Investigation. The Medical Executive Committee, after deliberation at the first meeting of the Committee after receiving the request, may decide to act immediately or it may initiate an investigation. If the Medical Executive Committee concludes that no investigation and/or further action is warranted, then it shall send a copy of the complaint to the Practitioner and advise the Practitioner of the Committee's decision, and no further action shall be taken.

However, if the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation be undertaken. The Medical Executive Committee may assign the task to an officer, department, ad hoc committee, or standing committee of the Medical Staff. If by ad hoc committee, the President of the Medical Staff shall select an ad hoc committee of at least three Members of the Active Medical Staff to conduct the investigation. The President of the Medical Staff shall designate one Member to serve as chair. The investigating body shall initiate such investigation as is warranted within a reasonable time frame to assure a fair and comprehensive investigation but not to exceed 30 days. When there is an insufficient number of qualified specialists to review the actions of the Practitioners, or the qualified specialists on the Medical Staff have a conflict of interest, the MEC or investigating body may engage qualified external specialists or experts to review and report on the actions of the Practitioner. The Practitioner shall promptly be notified that an investigation is being conducted, must be interviewed by the investigating body, and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The investigating body shall conduct interviews with persons involved, including the Practitioner; however, such investigation shall not constitute a "hearing" as that term is used in Article XIII, nor shall the procedural rules with respect to hearings apply. Upon conclusion of its investigation, the investigating body shall submit a written report of its findings to the Medical Executive Committee. The report may include recommendations for appropriate corrective action. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

C. Medical Executive Committee Action. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall review the investigating body's report and any related recommendations. The Medical Executive Committee may grant the Practitioner an informal opportunity to appear before the Medical Executive Committee; however, such investigation shall not constitute a "hearing" as that term is used in Article XIII, nor shall the procedural rules with respect to hearings apply. Thereafter, the Medical Executive Committee shall take action that may include, without limitation:

1. Determining that no corrective action need be taken;
2. Deferring action for a reasonable time where circumstances warrant;
3. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action in this Article. In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in the Practitioner's file;
4. Imposing requirements for continuing medical education;
5. Imposing requirements for physical and/or psychiatric examination;

6. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership and/or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;
7. Recommending reduction, modification, suspension or revocation of Medical Staff membership and/or Clinical Privileges; and
8. Taking other actions deemed appropriate under the circumstances.

D. Subsequent Action.

1. If corrective action is recommended by the Medical Executive Committee, that recommendation shall be transmitted in writing to the Practitioner. The Practitioner shall then be entitled to a formal hearing as set forth in Article XIII.
2. After the conclusion of any formal hearing, or if the Practitioner has waived his/her rights to a hearing, the Medical Executive Committee shall reconsider its recommendation in light of the report and recommendation of the hearing panel.
3. If the Medical Executive Committee continues to recommend adverse action regarding the Practitioner, it shall forward its recommendation to the Board of Directors, along with a copy of the hearing committee's report and recommendation. However, if the Medical Executive Committee determines that no further action is warranted, it shall notify the Practitioner and forward him/her a copy of the hearing panel's report and recommendation, and no further action shall be taken.
4. If the Board of Directors concurs with the recommendation of the Medical Executive Committee, the decision of the Board shall be deemed final action, subject to the appellate rights set forth in Article XIII. If the Board of Directors does not concur with the recommendation of the Medical Executive Committee, then the matter shall be referred to the Joint Conference Committee for consideration within 30 days and such committee shall have access to all records in connection with the investigation, recommendation and decision. The decision of the Joint Conference Committee shall be in writing within 30 days of receipt of the matter unless extended by that committee for good cause. The decision and findings of the Joint Conference Committee shall be submitted to the Board of Directors for final action.

12.2 Summary Restriction or Suspension.

A. Criteria for Initiation. Whenever a Practitioner's conduct appears to require that immediate action be taken to protect the life or wellbeing of patient(s) or wherever the Practitioner's conduct presents a danger of immediate and serious harm to the life, health, safety of any patient, prospective patient, or other person, the Chief Executive Officer, the President of the Medical Staff**,** the Chief Medical Officer, the Medical Executive Committee, or the chair of the department in which the Practitioner holds Privileges may summarily restrict or suspend the Medical Staff membership and/or Clinical Privileges of such Practitioner. Unless otherwise stated, such summary restriction or suspension shall

become effective immediately upon imposition and the person or body responsible shall promptly give written notice to be Practitioner, the Board of Directors, the Medical Executive Committee and the Chief Executive Officer. The summary restriction or suspension shall be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Practitioner by the department chair or by the President of the Medical Staff, considering where feasible, the wishes of the patient in the choice of a substitute Practitioner.

B. Medical Executive Committee Action. Upon written request by the affected Practitioner, which request shall be delivered to the President of the Medical Staff or Chief Executive Officer, the Medical Executive Committee shall convene within a reasonable time, but not less than five business days after the written request is made, to review and deliberate on the summary suspension. The Practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee, with or without the Practitioner, constitute a "hearing" within the meaning of Article XIII. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the Practitioner with notice of its decision. If the decision is adverse to the Practitioner, this notice shall be the notice required under Article XIII.

C. Procedural Rights. Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the Practitioner shall be entitled to the procedural rights afforded by Article XIII.

12.3 Automatic Suspension or Limitation.

In the following instances, a Practitioner's Privileges and, if applicable, Medical Staff membership may be suspended or limited as described, which action shall be final without a right to hearing under Article XIII or further review:

A. Licensure. If a Practitioner's license to practice in the State of Maryland is revoked, restricted or suspended by the applicable licensing or certifying authority, the Practitioner's Clinical Privileges and, if applicable, Medical Staff membership shall be automatically revoked, suspended or restricted, as the case may be. If the Practitioner's license is revoked or suspended for 180 days, such Practitioner's Privileges shall be automatically terminated. If the Practitioner thereafter wishes to again be granted Clinical Privileges at the Hospital, he/she must apply as an initial Applicant.

B. Criminal Conviction. Upon conviction of a felony crime in any federal or state court in the United States, the Practitioner's Clinical Privileges and, if applicable, Medical Staff membership shall automatically be suspended for the duration of the then-current term of appointment.

C. Controlled Substances.

1. Whenever a Practitioner's DEA certificate or prescribing authority is revoked, limited, or suspended, the Practitioner shall automatically and correspondingly be divested or the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term; and

2. Whenever a Practitioner's DEA certificate or prescribing authority is subject to probation, the Practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

D. Loss of Insurance. A Practitioner who fails to maintain professional liability insurance as required under these Bylaws shall be automatically suspended, effective upon the date of failure to maintain such insurance. Such suspension shall remain in effect until the Practitioner provides evidence of coverage that is satisfactory to the President of the Medical Staff and Chief Executive Officer.

12.4 Impaired Practitioners.

It is the policy of the Medical Staff to assist Practitioners who may be impaired, so long as reasonable measures can be implemented without presenting a threat to patients. If it is known or suspected that a Practitioner is impaired or if a Practitioner self-reports an impairment, the following procedures shall be followed:

1. The initial response to any concerns that a Practitioner may be or is impaired shall be an oral or written report to the relevant Department Chair and the President of the Medical Staff. The Department Chair shall undertake such informal investigation, as he/she may deem appropriate under the circumstances, to evaluate the credibility of the complaint, allegation or concern.

2. The Department Chair, under the direction of the President of the Medical Staff, shall discuss with the Practitioner that concerns were expressed regarding his/her behavior, as well as any other relevant information that may be available. The confidentiality of the practitioner seeking referral or referred for assistance shall be maintained, except as limited by law, ethical obligation when the health and safety of a patient of a patient is threatened.

   Based on self-referral or credibility of the complaint, allegation, or concern, the Department Chair may refer the Practitioner to the MedChi Physician Rehabilitation Committee and/or such other counseling or treatment services as may be appropriate under the circumstances. The Department Chair shall document the available facts and the Practitioner's response in a memorandum to

be placed in the Practitioner's Peer Review file. Once the Practitioner has entered treatment or counseling services, the Practitioner's Department Chair, under the direction of the President of the Medical Staff, shall monitor the affected Practitioner and the safety of the patients until the rehabilitation or any disciplinary process is complete and periodically thereafter, if required. The purpose of this process is to help with rehabilitation rather than discipline, to aid a practitioner in retaining and regaining professional functioning that is consistent with protection of patients.

3. The President of the Medical Staff shall establish and maintain an educationalprocess for licensed independent practitioners and other staff about illness and impairment recognition issues specific to licensed independent practitioners that includes at risk criteria.

4. If the Practitioner is believed to have been abusing drugs (whether prescription or otherwise), the Department Chair shall contact the Hospital Risk Manager to determine whether referral to the DEA, and/or other law enforcement agency may be appropriate or necessary

5. Reporting to the medical staff leadership any instances in which a Licensed Independent Practitioner is providing unsafe treatment is mandatory.

6. If additional report(s) is/are received regarding the potential impairment of a Practitioner, the provisions of this Section 12.4 shall govern.

Notwithstanding the foregoing, it is not intended that this Section 12.4 supersede any other provision of these By-Laws. If deemed appropriate by the President of the Medical Staff and/or the appropriate Department Chair, the provisions of the corrective action Proceedings set forth in Section 12.1 above may be pursued in addition to, or in lieu of, The provisions of this Section 12.4.

12.5 Reporting Obligations.

Any loss and/or reductions in Privileges shall be reported by the Hospital to the Board of Physiciansor other appropriate State licensing board and/or the National Practitioner Data Bank as required by State and/or Federal law.

12.6 Collegial Action and non-reviewable Probationary Status/ Code of Conduct

A. Collegial, educational and / or informal proceedings

1. To the extent possible, routine questions or concerns that are raised about a Member of the Medical Staff shall be addressed initially by the relevant Department Chair or the President of the Medical Staff.

2. In addressing routine questions or concerns, collegial, educational and/or informal efforts shall be employed. The goal of such efforts is to arrive at voluntary, responsive action by the individual without having to resort to a formal investigation. The relevant Department Chair or President of the Medical Staff shall determine whether it is appropriate to include documentation of these efforts in an individual's confidential peer review file.

3. If the relevant Department Chair or President of the Medical Staff decides to document remedial efforts undertaken, the affected individual should be afforded an opportunity to review the documentation and respond in writing. Any response shall be maintained in the individual's confidential peer review file along with the original documentation.

4. All efforts in this regard are intended to be, and are, part of the Hospital's performance improvement professional review activities. These collegial efforts may involve monitoring and/or counseling. Additionally, the Department Chair or President of the Medical Staff may also recommend additional training or education to address questions that have arisen concerning an individual's clinical practice or professional conduct.

5. Serious questions or concerns or those that have arisen on a recurring basis, shall, in the discretion of the relevant Department Chair or the President of the Medical staff, be reported to the Medical Executive Committee for investigation.

B. The president of the Medical Staff, department chair, CMO or the MEC may place a Medical Staff Member on probationary status because of the need for frequent reviews of clinical, behavioral or ethical performance. A Medical Staff Member who is on probationary status may receive a requirement for proctoring, clinical or behavioral evaluation, assessment of moral or ethical conduct, or any other conditions which do not constitute a reduction or restriction on Medical Staff privileges.

1. Probationary status does not restrict current clinical privileges, but a Medical Staff Member on probationary status may not apply for additional clinical privileges until the probationary status has been removed.

2. The duration of probationary status will be for a period of one year or until the current clinical appointment expires, whichever comes first. At the end of this probationary period, a determination will be made to reduce, or revoke or extend the probationary status or to refuse to renew Medical Staff privileges. Any reduction, revocation or refusal to renew Medical Staff privileges shall entitle the Medical Staff Member to a hearing in accordance with article XIII.

3. A Medical Staff Member may apply to the MEC for removal of probationary status after fulfilling any requirements placed on the Medical Staff Member by the Board of Directors or after three months if no specific requirements or

expiration have been provided. Requests for removal of probationary status after a denial cannot occur any sooner than three months after the previous denial other request for removal.

ARTICLE XIII HEARINGS AND APPELLATE REVIEWS

13.1 General Provisions.

A. Exhaustion of Remedies**.** An Applicant or Member must exhaust all remedies afforded by these Bylaws before resorting to legal action.

B. Application of Article. For purposes of this Article, the term "Member" may include "Applicant," as applicable under the circumstances. The term "recommendation" may include "action" as applicable under the circumstances. Procedures and protections set forth herein shall generally apply, except as reasonably modified.

C. Definitions. For the purposes of this article, the following definitions shall apply:

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

13.2 Grounds for Hearing.

A. Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed to be an adverse action and constitute grounds for a hearing.

1. Denial of Medical Staff membership;
2. Denial of requested change in Medical Staff membership status or category;
3. Denial of Medical Staff reappointment;
4. Involuntary change Medical Staff category or membership status;
5. Suspension of Medical Staff membership (excluding automatic suspensions implemented pursuant to Section 12.3 of these Bylaws);
6. Revocation of Medical Staff membership;
7. Denial of requested Clinical Privileges (excluding Interim Privileges);
8. Involuntary reduction, suspension, or termination of current Clinical Privileges (excluding Interim Privileges and automatic suspensions implemented pursuant to Section 12.3 of these Bylaws); and

9. Involuntary imposition of consultation, co-admission or monitoring requirements (excluding involuntary imposition of requirements of additional education or personal counseling);

13.3. Requests for Hearing.

A. Notice of Action or Proposed Action. In all cases in which a recommendation has been made or an action proposed to be taken that would entitle a Practitioner to due process rights under these Bylaws, the President of the Medical Staff, through the Medical Staff Office, shall give the Practitioner prompt written notice. Said notice shall contain the following information:

1. A description of the recommendation made or an action proposed to be taken;
2. The basis for the recommendation or action proposed to be taken, including the acts or omissions with which the Practitioner is charged and a list of charts in question, where applicable;
3. The right of the Practitioner to request a hearing within 30 days following receipt of the notice of such recommendation; and
4. A summary of the rights in the hearing as set forth in Article XIII.

B. Request for Hearing; Waiver of Hearing. The Practitioner shall have 30 days following receipt of notice of such action or recommendation to request a hearing. The request shall be in writing addressed to the President of the Medical Staff (through the Medical Staff Office), with a copy to the Chief Executive Officer and shall conform to the definition of "written notice" in 13.1.C. In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and to have accepted the recommendation involved. Any request by the Practitioner to extend the time in which the request for a hearing must be submitted must be approved by the Medical Executive Committee.

C. Notice of Hearing. Upon receipt of a request for hearing, the President of the Medical Staff shall schedule a hearing and shall give the Practitioner at least 30 days' notice of the time, place and date of the hearing. The notice of the hearing shall include a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee.

D. Time for Hearing. Unless extended by the hearing officer or waived by both parties, the date of the commencement of the hearing shall not be less than 30 days, nor more than 90 days, from the date of receipt of the Practitioner's request for a hearing by the President of the Medical Staff. However, when the request is received from a Practitioner who is under summary suspension, the date of the commencement of the hearing shall not be less than 30 days, nor more than 45 days, from the date of receipt of the Practitioner's request for a hearing by the President of the Medical Staff.

E. Hearing Committee. When a hearing is requested, the hearing will be held before an impartial hearing committee appointed by the President of the Medical Staff. The hearing committee shall be composed of not less than five Members of the Medical Staff who shall not have actively participated in the matter leading up to the recommendation or action nor be in direct economic competition with the affected Practitioner. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the hearing committee. The President of the Medical Staff shall designate one committee member as chair. A Practitioner may waive these requirements to permit the hearing committee to be comprised of Medical Staff Members who are or may be in direct economic competition with the Practitioner.

F. Failure to Appear or Proceed. Failure without good cause of the Practitioner to personally attend shall be deemed to constitute voluntary acceptance of the recommendations or actions involved, and a waiver of the right to a hearing.

G. Postponements and Extension. Once a request for hearing is initiated, postponements and extension of time beyond the times permitted in these Bylaws may be permitted by the chair of the hearing committee, within his/her discretion on a showing of good cause.

13.4 Hearing Procedure.

A. Prehearing Procedure.

1. If the chair of the hearing committee or the hearing officer requests in writing a list of the Practitioner's witnesses, the Practitioner shall furnish a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who may give testimony or evidence in support of the Practitioner at the hearing. Such list shall be submitted by the Practitioner to the requesting party at least 15 days before the anticipated commencement date of the hearing. While neither side in a hearing shall have any right to the discovery or documents or other evidence in advance of the hearing, the hearing officer may confer with both sides to encourage an advance mutual exchange of documents that are relevant to the issues to be presented at the hearing.

2. It shall be the duty of both the Practitioner and the Medical Executive Committee to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre hearing decisions may be made succinctly at the hearing.

3. A court reporter shall be present to make a verbatim record of the pre-hearing and hearing proceedings. The costs of the reporter shall be borne by the Hospital, but the costs of any transcript produced after the hearing shall be borne by the person requesting it.

B. Hearing Officer. The Medical Executive Committee acting on behalf of the Hospital shall appoint a hearing officer to preside at the hearing. The hearing officer may be an attorney at law, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as the hearing officer. The hearing officer shall not be in direct economic competition with the Practitioner. The hearing officer must not act as a prosecuting officer or as an advocate.

Both the practitioner and the hearing committee and/or hearing officer may have available the services of attorneys who may sit in the proceedings and provide advice as to the legal rights and appropriate procedures under these Bylaws. The hearing officer shall endeavor to assure that all participants in the hearing have reasonable opportunity to be heard to present relevant oral or documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained.

The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances.

C. Rights of the Parties. Both the Practitioner and the Medical Executive Committee have the right:

1. To be represented at any phase of the hearing or preliminary procedures by an attorney at law or by any other person of that party's choice;
2. To have a copy of the transcript of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
3. To call, examine, cross-examine, and impeach any witnesses for relevant testimony, and the Medical Executive Committee may call the Practitioner as if under cross-examination;
4. To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
5. To submit a written statement at the close of the hearing.

In addition, the Medical Executive Committee, when its recommendation has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses.

D. Oath. The hearing officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

E. Miscellaneous Rules. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely upon in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The hearing officer may interrogate the witnesses or call additional witnesses if he/she deems such action appropriate.

F. Burden of Presenting Evidence and Proof. At the hearing, unless otherwise determined for good cause, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Practitioner shall be obligated to present evidence in response. Throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the hearing committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

G. Adjournment and Conclusion. The hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if they are to be submitted, the hearing shall be closed.

H. Basis for Decision. The decision of the hearing committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the hearing committee shall be final, subject to the provisions of Section 13.5 of these Bylaws.

I. Decision and Report of the Hearing Committee. Within 30 days after final adjournment of the hearing, the hearing committee shall render a decision, which shall be accompanied by a report in writing stating the basis of the decision and reasons for the recommendations and determinations. If the Practitioner is currently under suspension, however, the time for the decision and report shall be 15 days. Upon the request of the hearing committee, the hearing officer may assist in preparation of the hearing committee's report. The decision and report shall be delivered to the Medical Executive Committee and the Practitioner. A copy of said decision and report shall also be forwarded to the Chief Executive Officer and the Board of Directors. The report shall contain a concise statement of the reasons in support of the recommendations.

J. Medical Executive Committee Action. The Medical Executive Committee shall consider the hearing committee's report and recommendation at its next regularly scheduled meeting and, upon consideration of same, make a recommendation to the Board of Directors. The Practitioner shall be notified of the Medical Executive Committee's recommendation.

13.5 Board of Directors Action and Appeals.

A. Board of Directors Action. The Board of Directors shall consider the Medical Executive Committee's recommendation at its next regularly scheduled meeting. If the Board of Directors votes to take action that is inconsistent with the Medical Executive Committee's recommendation, the President of the Medical Staff shall be immediately so notified, whereupon a meeting of the Joint Conference Committee may be convened in accordance with the provisions of Section 11.18(B) of these Bylaws. If a meeting of the Joint Conference Committee is convened, it shall make a recommendation to the Board of Directors, which shall take action upon the recommendation at its next meeting.

If the Board of Directors decides not to take adverse action regarding the Practitioner, both the Medical Executive Committee and the Practitioner shall be promptly so notified by the Board's Secretary. That decision shall become final.

If the Board's decision is adverse to the Practitioner, the Practitioner shall have such rights of appeal as are set forth in this Section 13.5.

B. Time for Appeal. Within 15 days after receipt of notice of the Board's initial decision, the Practitioner may request an appellate review. A written request for such review shall be delivered to the Chief Executive Officer, with a copy to the President of the Medical Staff. If a request for appellate review is not received within such period, that action or recommendation shall become final.

C. Grounds for Appeal. A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal shall be:

1. Substantial non-compliance with the procedure set forth under these Bylaws or applicable law which has created demonstrable prejudice; or
2. The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 13.4.

D. Appeal Board. The Board of Directors may function as the appeal board, or it may appoint an appeal board, which shall be composed of not less than three members of the Board of Directors. The Chair of the Board of Directors shall designate one appeal board member as the chair. Knowledge of the matter involved shall not preclude any person from serving as member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, including advice regarding appropriate procedures under these Bylaws, but that attorney shall not be entitled to vote with respect to the appeal.

E. Time, Place and Notice. If an appellate review is to be conducted, the appeal board shall, within 15 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. When a request for appellate review concerns a Member who is then under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 15 days from the date of notice; otherwise, the date of appellate review shall not be less than 30 nor more than 60 days from the date of such notice. The time for appellate review may be extended by the appeal board for good cause.

F. Appeal Procedure. The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the prior hearing; provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the prior hearing committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the prior hearing. Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of its position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral arguments. The appeal board may conduct deliberation outside of the presence of the parties and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Board's preliminary decision.

G. Decision.

1. Except as otherwise provided herein, within 30 days after the conclusion of the appellate review proceeding, the Board of Directors shall render a decision in writing and shall forward copies to each side involved in the appeal.
2. The Board of Directors may affirm, modify, or reverse its preliminary decision. If the Board of Directors concludes that the proceedings to date suffered from a procedural defect or from a material defect in the evidence, it may remand the matter to the Medical Executive Committee for further consideration; in such event, the Medical Executive Committee shall consider the matter at its next meeting and may revise its recommendation to the Board of Directors for consideration at its next meeting. In either event, the resulting decision of the Board of Directors shall be final.

H. Right to One Hearing. No Practitioner shall be entitled to more than one evidentiary hearing on any matter, which shall have been the subject of adverse recommendation.

ARTICLE XIV CONFIDENTIALITY, IMMUNITY AND RELEASE

14.1 Authorization and Conditions.

By applying for or exercising Clinical Privileges within this Hospital, an Applicant:

1. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualification;
2. Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff; and
3. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and the exercise of Clinical Privileges at this Hospital.

14.2 Confidentiality of Information.

A. General. Medical Staff, department, sub department, or committee minutes, files, and records, including information regarding any Member or Applicant to this Medical Staff, shall be confidential as set forth by Md. Ann. Code, Health Occupations Article, § 14-501 *et seq*. Dissemination of such information and records shall only be made where expressly required or permitted by law, subject to the other provisions of this Article XIV.

B. Breach of Confidentiality. Because effective peer review and consideration of the qualifications of Practitioners and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, sub departments, or committees is outside appropriate standards of conduct for this Medical Staff and may violate provisions of State and federal laws and regulations. Confidential peer review matters may only be discussed within the context of peer review within the Hospital, professional society peer review, and appropriate professional licensing authorities. If it is determined that a breach of confidentiality has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

C. Immunity from Liability.

1. For Action Taken. Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an Applicant or Practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of his/her duties as a representative of the Medical Staff or Hospital.

2. For Providing Information. A person is not civilly liable for giving information if the person gives the information in good faith and with the intention of aiding in the evaluation of the qualifications, fitness or character of a physician and the person does not represent as true any matter that the person does not reasonably believe to be true.

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, as mandated by Md. Ann. Code, Health Occupations Article, §14-401 *et seq.* and 42 U.S.C. §11101 *et seq.*, from liability to an Applicant or Practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member of the Medical Staff or who did, or does, exercise Clinical Privileges or provide services at this Hospital.

14.3 Medical Staff Files

One credentials file shall be established for each Practitioner. The content of such file shall include information related to that Practitioner's quality of care, ethical issues, utilization review information and other economic data, Medical Staff matters, disciplinary issues, committee minutes that pertain to the Practitioner, service on committees, and other issues deemed appropriate by the Medical Staff to carry out peer review and credentialing functions.

Credentials files may only be accessed in accordance with legitimate peer review and credentials activities. Access to credentials files shall be carefully monitored by the President of the Medical Staff and each department chair. A Practitioner may review his/her file, upon request, in the presence of at least one authorized member of the Hospital's administration and at least one authorized Member of the Medical Staff (i.e., a Medical Staff officer or the appropriate department chair). Practitioners are encouraged to review their own files prior to submitting applications to renew their privileges. Practitioners are permitted to insert rebuttal or explanatory material into their files, so long as it is identified as being submitted by the Practitioner.

14.4 Activities and Information Covered.

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

1. Applications for appointment, reappointment, or Clinical Privileges;
2. Corrective action;
3. Hearings and appellate reviews;
4. Utilization reviews;

5. Other department, sub department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
6. Peer review organizations, requirements of the Board of Physicians and similar reports.

14.5 Releases.

Each Applicant or Practitioner shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XV ADOPTION AND AMENDMENT OF BYLAWS, RULES & REGULATIONS

15.1 Procedure.

The Medical Staff shall adopt rules and regulations as may be necessary for the proper conduct of its work, including departmental rules and regulations. The Medical Executive Committee's prerogative with respect to departmental rules and regulations is to accept or reject those proposed by the department. Such rules and regulations shall be part of these bylaws, except that they may be amended at any regular meeting of the Medical Executive Committee by a two-thirds vote of the total members present. Such amendments and rules and regulations shall become effective when approved by the Board of Directors.

Upon the request of the Bylaws Committee or the Medical Executive Committee or upon timely written petition signed by at least 10% of the Members of the Active Medical Staff, consideration shall be given to the amendment or repeal of these Bylaws All proposed amendments to the Bylaws must either: be recommended by the Bylaws Committee and the Medical Executive Committee; OR be requested in writing by at least 25% of the Active Medical Staff. When proposed by the organized medical staff, there will be communication of the proposed amendment to the MEC. If the MEC does not pass the proposed amendment to the policies, the organized medical staff can ask for a medical staff vote using the mechanisms noted in the conflict resolution process. All such proposed changes must be mailed to the Medical Staff at least four weeks prior to any regular or special Medical Staff meeting at which they are to be voted upon. The notice of such proposed changes must include the exact wording of the existing Bylaws language, if any, and the proposed change(s).

15.2 Medical Staff Action on Proposed Change.

If a Quorum is present for the purpose of enacting a proposed change to the Bylaws , the change shall require an affirmative vote of 51% of the Active Medical Members voting in person at the meeting or by written ballot.

15.3 Approval.

Amendments to the Bylaws shall become effective when approved by the Board of Directors.

15.4 Exclusivity.

These Bylaws, when approved by the Board of Directors, shall constitute the sole source of the relationship between the Hospital and those Practitioners permitted to exercise Privileges at the Hospital and shall supersede all prior Bylaws, Rules, Regulations, and policies governing the Medical Staff. All policies that affect Practitioners' rights to exercise Privileges at the Hospital shall be adopted as part of these Bylaws or the Rules and Regulations. The mechanism described in this Article shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws

15.5 Board Authority.

The Board of Directors specifically reserves the authority to take any direct action that is necessary or appropriate with respect to any individual appointed to the Medical Staff or given Clinical Privileges or the right to practice in the Hospital if it is imperative to do so without following the procedures set forth in these Bylaws. Actions taken by the Board of Directors may, but need not, follow the procedures outlined in these Medical Staff Bylaws. Any action by the Board, which results in an adverse action, as that term is defined in § 13.2, shall entitle that Practitioner to the provisions of Article XIII.