

**UNIVERSITY OF MARYLAND
MEDICAL CENTER**

MEDICAL STAFF BYLAWS

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DEFINITIONS

1. The term "Applicant" means or refers to a practitioner who has formally applied to be a member of the Medical Staff.
3. The term "Chief of Service" means the member of the Active Medical Staff appointed to be the administrative head of a clinical service.
2. The term "Clinical Privileges" means the authorization by the Governing Body to a practitioner for the provision of health care services according to the provisions of the Medical Staff Bylaws of the Hospital.
4. The term "Corporation" means the University of Maryland Medical System Corporation.
5. The term "Emergency" means a condition in which a patient has substantial risk of death or immediate and serious harm and any delay in administering treatment would add to that danger.
6. The term "Good Standing" means the practitioner in question, at the time the issue is raised, has privileges which are in full force and effect, has met applicable Medical Staff attendance requirements during the prior twelve (12) months, is not in arrears in dues payments, and has not experienced a suspension or curtailment of clinical or admitting privileges at the Hospital during the prior twelve (12) months, other than for medical record completion delinquency.
7. The term "Governing Body" means the Board of Directors of the University of Maryland Medical System Corporation.
8. The term "Hospital" means the University of Maryland Medical Center.
9. The term "Hospital Chief Executive Officer" or "Hospital CEO" means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.
10. The term "Management" means the administrative organization, headed by the Hospital CEO, which is charged by the Governing Body with the responsibility for the overall day-to-day operation of the Hospital.
11. The term "Medical Executive Committee" means a committee comprised of Members of the Medical Staff as voting members, which shall organize and conduct the activities of the Medical Staff pursuant and subject to the terms of these Medical Staff Bylaws.

12. The term "Medical Staff" shall be interpreted to include all eligible practitioners granted a Medical Staff appointment according to the provisions of the Medical Staff Bylaws of the Hospital.
13. The term "Member" or "Members of the Medical Staff" refers to practitioners appointed to the Medical Staff.
14. The term "Physician" means a doctor of medicine or a doctor of osteopathic medicine who is licensed in Maryland.
15. The term "Practitioner" means a medical professional who has a license to practice his or her profession in Maryland and who is otherwise eligible for appointment to the Medical Staff.
16. The term "President of the Medical Staff" means the member of the Active Medical Staff elected or confirmed to serve as chief administrative officer of the Medical Staff.
17. The term "School of Dentistry" means the University of Maryland School of Dentistry.
18. The term "School of Medicine" means the University of Maryland School of Medicine.

ARTICLE 1. NAME, DESCRIPTION & MISSION

The name of the Medical Staff shall be called the Medical Staff Organization of the University of Maryland Medical Center.

The Medical Staff Organization shall consist of practitioners who have been granted the right to exercise clinical privileges within the hospital. Subject to approval by the Board of Directors, the Medical Staff Organization shall adopt such Medical Staff Bylaws and procedures as may be necessary to meet the goals of the Mission Statement as well as remain in compliance with standards of the Maryland Board of Physicians, the Maryland Department of Health & Mental Hygiene, Joint Commission on Accreditation of Healthcare Organizations, the US Department of Health & Human Services and other appropriate agencies as identified from time to time by the Hospital.

Mission Statement

To provide and promote quality health care, emphasizing professionalism, respect and cultural sensitivity, we, the Medical Staff of the University of Maryland Medical Center:

- (1) *Educate* medical students, residents, fellows, and students from other health care professions;
- (2) *Treat* patients, providing care that is effective, efficient, timely, safe, equitable and patient-centered;
- (3) *Learn* continuously by conducting research that promotes the development and dissemination of better treatments to improve health outcomes;
- (4) *Collaborate* as full members of the health care team at the Medical Center, promoting professionalism, respect and customer service among all members of our health care community.

ARTICLE 2. PURPOSE AND AUTHORITY

2.1 PURPOSES OF THE MEDICAL STAFF

2.1-1 ENUMERATED PURPOSES

- (a) To organize the activities of practitioners in the Hospital in order that they may carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the Governing Body;
- (b) To endeavor to provide that all patients receive safe medical care regardless of race, color, religion, national origin, sex, age or disability;
- (c) To strive to maintain and enhance the professional performance of all Members of the Medical Staff through an ongoing review and evaluation of the clinical performance of each Member of the Medical Staff in the Hospital;
- (d) To provide an appropriate educational setting that will maintain scientific standards and that will lead to a continuous advancement in professional knowledge, skill and training;
- (e) To initiate, maintain and enforce bylaws, rules, regulations and policies for the internal governance of the Medical Staff, which are consistent with sound professional practices, organizational principles and legal, regulatory and accreditation requirements;
- (f) To provide a means whereby issues concerning the Medical Staff and the Hospital may be directly discussed by the Medical Staff with the Governing Body and the Management, with the understanding that the Medical Staff is subject to the ultimate authority of the Governing Body and that the cooperative efforts of the Medical Staff, the Hospital CEO and the Governing Body are necessary to fulfill the purposes of the Corporation; and
- (g) To serve as the primary means for the Medical Staff's accountability to the Governing Body for the quality, appropriateness of the professional performance of practitioners and their ethical conduct and cost effectiveness.

2.2 AUTHORITY OF THE MEDICAL STAFF

Subject to the authority and approval of the Governing Body, the Medical Staff shall have and exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the bylaws of the Corporation including, without limitation, the authority to formulate and recommend Medical Staff policies, professional education requirements, clinical coverage requirements, medical malpractice insurance requirements, supervision of trainees, committee assignments, service rules and regulations, criteria for the

granting of Medical Staff appointment and clinical privileges, attendance requirements, office location, residence and response time requirements and the authority to levy dues and assessments, impose fines and use outside consultants when performing peer review activities.

The Medical Staff may enter into arrangements with other System Members to assist it in credentialing activities. This may include, without limitation, relying on information in other System Members' credentials and peer review files in evaluating applications for appointment and reappointment, and utilizing the other System Members' medical or professional staff support resources to process or assist in processing applications for appointment and reappointment.

Medical Staff bylaws and rules and regulations are adopted by the Medical Staff and approved by the Governing Body before being deemed effective. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff bylaws or rules or regulations.

Administrative Procedures described herein for the credentialing and privileging are further described in the Credentials Procedures Manual. This document will also be submitted for review and approval by the Governing Body.

ARTICLE 3. MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No practitioner shall admit patients to the Hospital unless he or she is a Member of the /Medical Staff and has been granted clinical privileges in accordance with the procedures set forth in these bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

- (a) Only practitioners, except for honorary staff, who:
 - (i) document or provide evidence of (1) current and appropriate licensure, (2) adequate experience, education and training, (3) current professional competence, (4) judgment and (5) ability to perform, in relation to the clinical privileges requested, and who can demonstrate to the satisfaction of the Hospital that they are professionally competent and that patients treated by them can reasonably expect quality medical care;
 - (ii) hold faculty appointments at the School of Medicine or the School of Dentistry;
 - (iii) are board certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association (other specialty boards may be considered by the Service Chief and Medical Executive Committee), or present evidence of equivalent training and experience, or are in preparation for meeting board certification requirements in the specialty in which clinical privileges are requested;
 - (iv) retain current and effective medical malpractice insurance coverage by a carrier approved by the Maryland Medicine Comprehensive Insurance Program that meets or exceeds the requirements established by the Governing Body;
 - (v) are eligible to participate as providers for Medicare and Medicaid;
 - (vi) demonstrate a willingness and an ability to work cooperatively with other practitioners in a professional manner; and
 - (vii) are willing to discharge properly the responsibilities established by the Hospital,

shall be deemed to possess the basic qualifications for membership in the Medical Staff, except for the Honorary Staff category in which case these criteria shall only apply as deemed individually applicable by the Hospital.

3.2-2 PARTICULAR ELIGIBLE LICENSES

- (a) Physicians. A physician applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a degree of doctor of medicine or doctor of osteopathic medicine issued by a medical or osteopathic school and must also hold a valid and unsuspended certificate to practice medicine or surgery or osteopathic medicine and surgery issued by the appropriate licensure board of the State of Maryland.
- (b) Dentists. A dentist applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a doctor of dental surgery, dental medicine or equivalent degree issued by a dental school and must also hold a valid and unsuspended certificate to practice dentistry issued by the appropriate licensure board of the State of Maryland.
- (c) Podiatrists. A podiatrist applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a degree of Doctor of Podiatric Medicine conferred by a college of podiatry and must hold a valid and unsuspended certificate to practice podiatry issued by the appropriate licensure board of the State of Maryland.
- (d) Clinical Psychologists. A psychologist applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a doctoral degree in psychology issued by an educational institution and must hold a valid and unsuspended certificate to practice psychology issued by the appropriate licensure board of the State of Maryland.

3.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership on the Medical Staff or clinical privileges merely because he or she holds a certain degree, is licensed to practice in this or in any other State, is a member of any professional organization or on any professional school faculty (medical, dental or otherwise), is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at the Hospital or at another health care facility, or holds a contract with the Hospital. Allied Health Care Practitioners and House Staff Physicians are not members of the Medical Staff and do not have procedural rights or clinical privileges under these Medical Staff Bylaws.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, religion, color or national origin, sexual orientation, or type of procedure or patient in which the practitioner specializes e.g. Medicaid.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the ongoing responsibilities of each member of the Medical Staff include:

- (a) providing patients, in an efficient manner, with safe care that meets generally recognized professional standards.
- (b) abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, Medical Policies and the Hospital Bylaws and Policies.
- (c) completing such reasonable responsibilities, assignments and rotations imposed upon the Member by virtue of Medical Staff membership, including committee assignments, monitoring of practitioners, and accreditation requirements.
- (d) participating on, with or in Hospital or multi-disciplinary committees, teams or programs dealing with the overall medical environment at the Hospital including, without limitation, such functions as medical records, performance improvement, utilization review, practice guidelines, blood usage/transfusion review, transplant procedures, nursing services, drug usage and formularies, infection control, radiation safety, risk management, surgical case review, general safety and patient care policies.
- (e) preparing and completing in timely fashion all medical records (including the use of electronic or computer transmissions and authentications) for the patients to whom the Member provides care in the Hospital.
- (f) aiding and participating in approved educational programs for medical students, interns, resident physicians, resident dentists, physicians and dentists, podiatrists, clinical psychologists, nurses and other personnel; Adhering to institutional and department-specific policies regarding resident supervision.
- (g) making appropriate arrangements for coverage of his or her patients.
- (h) refusing to engage in improper inducements for patient referral or other unethical behavior.
- (i) participating in continuing education programs as determined by the Medical Executive Committee.
- (j) participating in such emergency service coverage or consultation panels as may be determined by the Medical Executive Committee or Service Chief.
- (k) maintaining personal medical malpractice insurance coverage as determined by the Medical Executive Committee.
- (l) informing the Medical Staff Office, in a timely manner, of any action taken, or formal action initiated, that could result in a change of license, DEA registration,

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP (continued)

participation in any program or plan for the reimbursement of services, professional liability insurance coverage, membership or employment status or clinical privileges at other health care institutions or affiliations and the initiation, status and resolution of malpractice claims.

- (m) working with other individuals and organizations in a cooperative, professional and civil manner and refraining from activity that is disruptive of Hospital operations.
- (n) adhering to the ethical standards generally applicable to his or her licensure.
- (o) performing a significant number of procedures, managing a significant number of cases and having sufficient patient care contact within the practitioner's practice to permit the Hospital to assess the practitioner's current clinical competence for any clinical privileges, whether being requested or already granted.
- (p) cooperating in any relevant or required review of a practitioner's (including one's own) credentials, qualifications or compliance with these bylaws and refraining from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities or otherwise.
- (q) cooperating with, and participating in, the Hospital's risk management/malpractice prevention program, performance improvement/utilization review program and peer review activities, whether related to oneself or others, including active participation on, or with, Hospital Committees, teams or other programs dealing with these subjects.
- (r) seeking consultation in the following circumstances:
 - i. all non-emergency cases whenever requested by the patient or patient's personal representative if patient is incompetent;
 - ii. the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - iii. there is doubt as to the choice of therapeutic measures to be utilized;
 - iv. unusually complicated situations are present that may require specific skills of other practitioners;
 - v. the patient exhibits severe symptoms of mental illness or psychosis.
- (s) completion of history and physical examinations in the following manner:
 - i. a medical history and physical exam (H&P) must be completed on all patients within 24 hours of admission. A comprehensive H&P will be done for every patient prior to surgery (except emergencies). An abbreviated system-focused H&P will be completed for patients scheduled for specific

treatment or diagnostic procedure, including but not limited to cardiac catheterization, colonoscopy, bronchoscopy or presenting for initial visit to an ambulatory care site.

- ii. an H&P completed 30 days prior to admission, readmission or scheduled surgery/procedure/treatment is acceptable with documentation that the practitioner reviewed and updated the H&P on the day of admission or scheduled surgery/procedure/treatment. It must be completed by a physician, oral and maxillofacial surgeon, podiatrist, or other licensed practitioner in accordance with hospital policy.
 - iii. the content of a completed and focused H&P is delineated in hospital policy MOI-022.
- (t) Completing such health requirements as may be set and approved by the Medical Executive Committee.
 - (t) interacting with other health care professionals, administrative personnel, and non-professional employees of the Medical Center in a constructive and collegial manner. It is expected that interactions at no time shall compromise or adversely affect patient care. Expected professional conduct shall also include each individual's obligation to ensure that he/she is physically and mentally capable of providing safe and competent care to patients.
 - (u) maintain and preserve the confidentiality of patient information in accordance with applicable law and UMMC's policies and procedures;
 - (v) discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff, the Medical Executive Committee or the Governing Body.

ARTICLE 4. CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, and honorary. At the time of appointment and reappointment, the Member's Medical Staff category shall be determined.

4.2 ACTIVE MEDICAL STAFF

4.2-1 QUALIFICATIONS

The Active Staff shall consist of practitioners who:

- (a) meet the general qualifications for membership set forth in these Medical Staff Bylaws and specifically in Article 3;
- (b) have offices or residences which, in the opinion of the appropriate Chief of Service, are located closely enough to the Hospital to provide adequate continuity of care;
- (c) meet criteria established by the service to which appointment is made for minimum levels of clinical and teaching activity for Active Staff status.

4.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Active Medical Staff Member in good standing shall be to:

- (a) admit patients (except for clinical psychologists) and exercise such clinical privileges as are granted pursuant to Article 6.
- (b) attend and vote (except as otherwise provided for herein) on matters presented at general and special meetings of the Medical Staff and of the services and committees of which he or she is a member.
- (c) hold Medical Staff or service office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or a duly authorized representative thereof.

4.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive years in which a Member of the Active Medical Staff fails to regularly care for patients in this Hospital, satisfy attendance requirements or be regularly involved in Medical Staff functions as determined in these bylaws, by the Medical Staff Rules and Regulations or Medical Staff Policies, or by the Hospital, that Member shall, upon such a finding by the Medical Executive Committee and the approval of the Governing Body, automatically be transferred to the appropriate category, if any, for which the Member is qualified without any procedural rights under Article 12.

4.3 THE COURTESY MEDICAL STAFF

4.3-1 QUALIFICATIONS

The Courtesy Staff shall consist of members who:

- (a) meet the general qualifications set forth in Article 3.
- (b) do not regularly care for patients in the Hospital or are not regularly involved in Medical Staff functions, as determined by the Medical Staff.

4.3-2 PREROGATIVES

Except as otherwise provided, a Courtesy Staff Member in good standing shall be entitled to:

- (a) admit patients (except for clinical psychologists) to the Hospital and exercise such clinical privileges as are granted pursuant to Article 6.
- (b) attend meetings of the Medical Staff and the service of which he or she is a member, including committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Courtesy Staff Members shall not be eligible to hold office in the Medical Staff or to vote on Medical Staff matters.

4.4 ASSOCIATE MEDICAL STAFF

4.4.1 QUALIFICATIONS

The Associate Medical Staff shall consist of practitioners who:

- (a) meet the general qualifications for membership set forth in these Medical Staff Bylaws and specifically in Article 3;
- (b) wish to be affiliated with the Medical Center and refer patients to members of the Active and Courtesy Staff, but who do not admit or treat

patients in the Medical Center.

4.4.2 PREROGATIVES

Appointees of this category shall:

- (a) relate to the hospital primarily through the direct referral of patients to the attending medical staff for admission and/or evaluation;
- (b) be permitted to visit patients, review medical records, but shall have no admitting privileges nor be permitted to write inpatient orders, progress notes or participate actively in the direct provision of inpatient care.
- (c) be eligible for University of Maryland Medical Center outpatient clinical privileges at the discretion of the Chief of Service at University of Maryland Medical Center;
- (d) be eligible to serve special purpose functions, serve on medical staff committees (as a non-voting member) and attend staff and continuing education meetings at the discretion of the appointing medical department; and
- (e) have fair hearing rights as specified in Article 11 of these bylaws.

4.5 HONORARY MEDICAL STAFF

4.5-1 QUALIFICATIONS

The Honorary Staff shall consist of individuals 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.

4.5-2 PREROGATIVES

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in the Medical Staff, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff and service meetings, including committee meetings and educational programs.

4.5-3 APPOINTMENT

Appointment to the Honorary Staff is made by the Medical Executive Committee upon the recommendation of the appropriate Chief of Service.

4.6 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Medical Staff Bylaws and by the Medical Staff Rules and Regulations. Subject to approval by the Governing Body, Honorary Staff membership may be revoked by

a two-thirds vote of the Medical Executive Committee, without any procedural rights under Article 12.

4.7 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member, consistent with the requirements of these bylaws, to the Governing Body.

4.8 OUTSIDE CONSULTATION FOR PEER REVIEW

When an outside consultation is necessary to conduct peer review activities, the Medical Executive Committee may, with the approval of the Governing Body, admit a practitioner or other individual to the Medical Staff for a limited period of time. Such membership shall be solely for the purpose of conducting peer review in a particular case or situation, and this temporary membership shall automatically terminate upon the Member's completion of duties in connection with the peer review matter with no procedural rights under Article 12.

ARTICLE 5. MEDICAL STAFF APPOINTMENT

5.1 GENERAL

Except as otherwise specified herein, no practitioner (including practitioners engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until he or she applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws, and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the bylaws, rules and regulations and policies of the Medical Staff and the Corporation as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, modification of clinical privileges or transfer, the applicant shall have the burden of timely producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges, service(s) and the Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying reasonable requests for information. The applicant's failure to sustain this burden in a timely fashion shall be grounds for denial of the application, which shall be considered as voluntarily withdrawn, without any procedural rights under Article 12. This burden may include submission to a medical or psychiatric examination at the applicant's expense, if deemed appropriate for the clinical privileges requested and the Chief of Service or the Medical Executive Committee will select the examining physician.

5.3 APPOINTMENT AUTHORITY

Appointments, denials, suspensions and revocations of appointments to the Medical Staff shall be made as set forth in these bylaws, provided the Governing Body may act directly if the Medical Staff refuses to act on an application or unreasonably delays (failure to make a recommendation to the Governing Body within one hundred forty (140) days of the receipt of a completed application) acting on an application.

5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the Medical Staff shall be for a period of two (2) years. Reappointments shall be for a period of up to two (2) years beginning with the date of initial appointment, and shall occur every two (2) years thereafter.

5.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

5.5-1 APPLICATION FORM

Application forms (which may include a pre-application) shall be developed by the Medical Executive Committee. The form shall require detailed information which may include, but not be limited to, information concerning:

- (a) the applicant's qualifications, including, but not limited to, professional training and clinical experience, judgment, current licensure, professional liability insurance, current DEA registration, verbal and written English language proficiency, and continuing professional education information related to the clinical privileges requested by the applicant.
- (b) a minimum of two peer references familiar with the applicant's professional competence (preferably one reference on professional competence should be from someone of the same specialty or training) and character during the prior five years.
- (c) membership categories, services, and clinical privileges requested by the applicant.
- (d) previous, and currently pending, professional disciplinary actions, or licensure limitations, irrespective of reinstatement.
- (e) voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, suspension, reduction or loss of clinical privileges at another hospital or health care entity, irrespective of reinstatement or voluntary or involuntary relinquishment of a medical license or controlled dangerous substance registration.
- (f) ability to perform as it relates to the clinical privileges requested.
- (g) final judgments or settlements, together with all pending actions, against the applicant in professional liability actions and current professional liability insurance in such amounts and types as are required by the Hospital or Medical Executive Committee.
- (h) reports to the National Practitioner Data Bank involving the applicant.
- (i) applicant's Peer Review Organization (PRO) history.
- (j) any criminal convictions, involving any felony and any misdemeanor, provided the misdemeanor involved professional activity or a crime of moral turpitude.
- (k) sequential history of professional career, accounting for every year and partial year since graduation from professional school.

- (l) any administrative, civil or criminal complaint or investigation regarding sexual misconduct or child abuse.
- (m) Volunteer faculty for whom the Hospital has no quality assessment data will be required to submit along with their reappointment application a copy of Quality Improvement data, or a list of current clinical privileges granted, from the facility where most procedures are performed.
- (n) whatever additional reasonable information the Hospital or the Medical Executive Committee deems relevant.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed forms with all provisions completed (or accompanied by acceptable explanations of why answers are unavailable), and signed by the applicant ("completed application"). When an applicant receives an application form, he or she shall be given a copy of these bylaws, the Medical Staff Rules and Regulations and summaries of other applicable policies related to clinical practice in the Hospital, if any.

5.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in this Article 5, by applying for appointment to the Medical Staff each applicant:

- (a) signifies his or her willingness to appear for interviews in regard to the application.
- (b) authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications and performance and authorizes such individuals and organizations to candidly provide all such information.
- (c) consents to inspection and copying of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying.
- (d) 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.
- (e) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.
- (f) consents to the disclosure to other hospitals, professional associations, managed care organizations, and licensing boards, and to other similar organizations as required by law, any information regarding his or 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.

- (g) if a requirement exists or is established for Medical Staff dues and assessments, acknowledges responsibility for timely payment.
- (h) pledges to provide for continuous quality care in a cost efficient manner for his or her patients.
- (i) agrees to exhaust all remedies available under these Medical Staff Bylaws before commencing a legal action against the Medical Staff or any service, committee or Member of the Medical Staff, or against the Hospital for any investigation or action taken in accordance with the provisions of these Medical Staff Bylaws, the Medical Staff Rules and Regulations or the Bylaws of the Corporation.
- (j) agrees to immediately inform the Hospital of any changes or developments affecting or changing the information provided in or with his or her initial application and any application for reappointment or additional clinical privileges.
- (k) attests to the correctness and the completeness of the information provided and acknowledges that any misstatement, misrepresentation or omission will constitute grounds for denial of appointment and privileges or for the immediate revocation of same.
- (l) acknowledges that a failure by the applicant to complete an application form timely, the withholding of requested information, or the providing of false or misleading information shall, by itself, constitute a basis for the denial or revocation of Medical Staff membership and/or clinical privileges.
- (m) agrees to participate with the hospital as an Organized Health Care Arrangement under HIPAA as to Hospital patients, and to comply with the Hospital's policies on protected health information and its Notice of Information Privacy Practices as to Hospital patients.

5.5-3 VERIFICATION OF INFORMATION

The applicant shall submit a completed application to the Medical Staff Office as soon as possible but no later than ninety (90) days from the date the application is mailed to the applicant. A failure to do so, without good cause, will terminate the application without any procedural rights under Article 12. The Credentials Committee, through the Medical Staff Office, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application, from primary sources as required by State law. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information in a timely manner and a failure to do so shall be considered a voluntary withdrawal of the application, which is not subject to the procedural rights otherwise available under Article 12. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s). As part of this process, inquiries shall be made to the National Practitioner Data Bank, and to other sources such as the American Medical Association Physician Master File and the Federation of State Medical Boards as deemed necessary.

5.5-4 SERVICE ACTION

After receipt of the completed and verified application, the chief of each service to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The chief shall evaluate all matters deemed relevant to recommendation, including information concerning the applicant's provision of services within the scope of clinical privileges requested, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to Medical Staff category and service, clinical privileges to be granted, and any special conditions to be attached.

5.5-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, evaluate and verify, as needed, the supporting documentation, the service(s) chief's report and recommendations, and other relevant information. The Credentials Committee shall transmit to the Medical Executive Committee a written report (including the recommendation of the service(s) and) and its recommendations as to appointment and, if appointment is recommended, as to Medical Staff category, service(s), clinical privileges to be granted, and any special conditions to be attached to the appointment.

5.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information or return the matter to the Credentials Committee for further investigation.

- (a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, to the Governing Body.
- (b) Adverse Recommendation: 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 first notice required under Article 12. The applicant shall then be entitled to procedural rights under Article 12.

5.5-7 ACTION ON THE APPLICATION

The Governing Body 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. The decision of the Governing Body shall be final subject to the procedural rights under Article 12.

5.5-8 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be promptly given to the President of the Medical Staff, the Medical Executive Committee and the Credentials Committee, the chairman of each service concerned, the applicant, and the Hospital CEO.
- (b) 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 service(s) to which he or she is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

5.5-9 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one year from the date of the final decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

5.5-10 TIMELY PROCESSING OF APPLICATIONS

Applications for Medical Staff appointment shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

- (a) evaluation, review, and verification of application and all supporting documents under Section 5.5-3 within ninety (90) days from receipt of a completed application by the Medical Staff Office.

- (b) review and recommendation by service(s) within twenty (10) days after receipt of a completed application from the Medical Staff Office.
- (c) review and recommendation by Credentials Committee within sixty (60) days after receipt of a completed application from the Medical Staff Office.
- (d) review and recommendation by Medical Executive Committee within thirty (30) days after receipt of the recommendation of the Credentials Committee.
- (e) final action by the Governing Body at its next meeting after receipt of the recommendation of the Medical Staff Executive Committee or conclusion of hearings.

5.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION FOR NEW PRIVILEGES

5.6.1 The Service Chief of the applicant's primary service will define circumstances that require monitoring and evaluation of the clinical performance of each practitioner following his or her initial granting of clinical privileges. Such monitoring may utilize a range of techniques, including but not limited to: chart review, the tracking of performance monitors/indicators, proctoring, external peer review, morbidity/mortality reviews, and discussion with other colleagues. The Focused Professional Practice Evaluation Process outlined in the Credentialing Procedures Manual provides further guidance as to type of evaluation and time frame to be followed.

5.7 ONGOING MONITORING OF PRACTITIONER PERFORMANCE

- 5.7.1 Ongoing evaluation is factored into the decision to maintain an existing privilege, revise an existing privilege, or revoke an existing privilege. Practitioner-specific quality profiles using indicators approved by the Medical Executive Committee will be completed a minimum of every nine (9) months. For any medical staff member without sufficient reviewable volume at the University of Maryland Medical Center, the member will be asked to supply similar data from their primary facility. Areas to be considered include patient care, medical knowledge, practice-based learning and improvement, interpersonal skills and communication, professionalism and systems-based practice.
- 5.7.2 Medical Staff Services will coordinate the collection and review of profiles for the individual practitioners. The profiles will be forwarded to the appropriate Service Chair or Section Chief for completion which will include a recommendation as to whether privileges are to be maintained, revised or revoked. The decision will be documented in the practitioner's credentials file in the Medical Staff Services Department. Recommendations other than maintenance of privileges will be communicated to the medical staff member.

5.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

5.6-1 APPLICATION

- (a) At least one hundred and eighty (180) days prior to the expiration date of the current Medical Staff appointment ("Reapplication Due Date"), a reapplication form developed by the Medical Executive Committee, shall be mailed or delivered to the Member and an inquiry will be made to the National Practitioner Data Bank. The completed re-application form for renewal of appointment to the Medical Staff for the coming year, and for renewal or modification of clinical privileges shall be returned to the Medical Staff Office within 30 days of receipt.
 - (i) The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 5.5-1, as well as other relevant matters. All provisions of the reapplication form must be completed (or accompanied by acceptable explanations of why answers are unavailable) and signed by the applicant, with all fees (including medical staff dues) paid, ("completed application"). Upon receipt of the completed application, the information shall be processed as set forth in Article 5, commencing at Section 5.5-3.
 - (ii) If an application for reappointment is not received at least one hundred twenty (120) days prior to the Reapplication Due Date, written notice by certified mail, return receipt requested, shall be promptly sent to the Member advising that the application has not been received and further explaining that a failure to submit a fully completed reapplication form within (90) days of the Reapplication Due Date shall be deemed a voluntary resignation from the Medical Staff as described in Section 5.6-5 below.
- (b) A Medical Staff Member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, and properly completed, except that such application may not be filed within six (6) months of the time a similar request has been denied. The Credentials Committee, through the appropriate Chief of Service, will verify that appropriate training or experience has occurred to enable the Medical Staff Member to properly exercise the requested clinical privileges. If the request is approved by the Governing Body, the Chief of Service shall set up a provisional period for the requested privileges which shall be processed as set forth in Article 4, commencing at Section 4.7-5.

5.6-2 EFFECT OF APPLICATION

The effect of the application for reappointment or modification of Medical Staff status or privileges is the same as that set forth in Section 5.5-2.

5.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a Medical Staff Member submits the first application for reappointment, and every two years thereafter, or when the Member submits an application for modification of Medical Staff status or clinical privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Section 5.5-3 through 5.5-10. This review will include inquires regarding ability to perform professional duties, judgment, clinical skills, and competence, and may require submission of reasonable evidence of his or her ability to perform professional duties. In the event that the University of Maryland Medical Center is not the Medical Staff Member's primary admitting institution, the applicant will be asked to provide a report issued from that institution summarizing their clinical activity. The information discovered upon review will be included in the Provider Quality Profile to be submitted for review and consideration by the appropriate Department Chairman at the time of the Member's transition from Provisional to Active status and at subsequent reappointment.

5.6-4 IN THE EVENT OF PROCESSING DELAY

If the Medical Staff Services Department anticipates that it will not complete its review of an application for reappointment by the expiration date of the Member's current appointment, and the application appears otherwise in order, the Medical Staff Services will notify the Service Chief at least 30 days before the expiration of the member's current appointment. The Service Chief may request Temporary Privileges for a limited period of time, not to exceed 120 days, while the full credentials information is verified and approved. This request may only be made for an important patient care need (such as for urgent staff coverage or specialty need). Such a request is not effective unless it is reviewed and approved by a Member of the Credentials Committee and the President of the Medical Staff and they are satisfied that the temporary privileges are acutely needed. Such temporary privileges shall not be routinely approved. Any temporary privileges pursuant to this Section do not create a vested right in the Member for continued appointment through the entire next term but only until such time as processing of the application is concluded. If no request for temporary privileges is received, the member will be notified by certified mail that his/her current appointment will expire.

5.6-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure, without good cause as determined in good faith by the Medical Executive Committee, to file timely a completed application for reappointment at least 90 days prior to the Reapplication Due Date as defined in Section 5.6-1 (a) above, shall result in the automatic lapse of the Member's clinical privileges and prerogatives at the end of the current Medical Staff appointment, unless the application is completed and approved prior to the expiration date. The Member shall be notified of the pending lapse in clinical privileges by certified mail return receipt requested at least 30 days before the expiration of the current appointment. The Medical Staff Services Department will also notify the Service Chief. The Service Chief may request Temporary Privileges for a limited period of time, not to exceed 120 days, while the full credentials information is verified and approved.

This request may only be made for an important patient care need (such as for urgent staff coverage or specialty need). Such a request is not effective unless it is reviewed and approved by a Member of the Credentials Committee and the President of the Medical Staff and they are satisfied that the temporary privileges are acutely needed. Such temporary privileges shall not be routinely approved. Any temporary privileges pursuant to this section do not create a vested right in the member for continued appointment through the entire next term, but only until such time as processing and the application is approved or disapproved. The lapse in clinical privileges will terminate following completion of the reappointment process. If the reappointment is not completed within 60 days after the expiration date, medical staff membership and privileges will terminate, and the practitioner will be required to reapply if desired. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article 12 shall not apply.

5.7 LEAVE OF ABSENCE

5.7-1 LEAVE STATUS

A Medical Staff Member in good standing may take a leave of absence upon thirty (30) days prior written notice to the Medical Executive Committee stating the actual period of the leave desired, which may not exceed twelve (12) months or be less than thirty (30) days, the reason for the leave and a description of the activity that will occur during the leave. During the period of the leave, the Member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues and assessments, if any, shall continue, unless waived by the Medical Staff. The foregoing notwithstanding, prior to taking leave, the Member must make appropriate arrangements to ensure that any then existing administrative or clinical responsibilities will be properly discharged during the period of his or her leave.

5.7-2 TERMINATION OF LEAVE

At least 10 days prior to the termination of the leave of absence, the Medical Staff Member will provide written notice to the Medical Executive Committee of his or her return from leave. If the Member's appointment has expired during the leave of absence, he or she will be deemed to have voluntarily resigned from the Medical Staff with no applicable due process rights under Article 12 hereof and shall be required to reapply.

5.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause as determined in good faith by the Medical Executive Committee, to request reinstatement within forty-five (45) days of a leave's termination shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership, clinical privileges, and prerogatives. A Member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article 12 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable. A request for Medical Staff membership subsequently received from a Member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

5.8 RESIGNATION

Medical Staff Members in good standing who wish to resign from the medical staff must submit to their Service Chiefs a written statement indicating the reason for the resignation and effective date of resignation. Completion of obligation, including transfer of patient care responsibilities, completion of medical records, and transfer of administrative duties (if applicable), is required in order for a medical staff member to be considered "in good standing" at the time of resignation.

ARTICLE 6. CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a Member of the Medical Staff with clinical privileges at this Hospital shall have access to the Hospital to exercise only those clinical privileges specifically granted. Said clinical 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 service and the authority of the Chief of Service and the Medical Staff. Each practitioner shall be assigned to the primary service in which clinical privileges are granted.

Clinical privileges in an additional service(s) may be requested. The Chiefs of each Service will coordinate appraisals for the granting and renewal of clinical privileges when a practitioner holds or applies for clinical privileges that are provided in more than one service.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff, or for temporary privileges, or a new experimental activity (see section 6.8), must contain a request for the specific clinical privileges desired by the applicant. A request by a Member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. Clinical privileges for procedures shall be recommended by the Chief of the service except when the Medical Executive Committee determines that certain privileges also require the recommendation of the Chief of another service.

6.2-2 BASES FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the Member's prior and continuing education, training, experience, demonstrated current professional competence and judgment, clinical performance, utilization practice patterns, ability to perform, Hospital's capability (physical plant, equipment and personnel) to support the privileges requested, adequate professional liability insurance coverage, and the documented results of patient care and other quality review, risk management and monitoring which the Medical Executive Committee deems appropriate. Clinical privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Member exercises, or exercised, clinical privileges.

6.3 CONDITIONS FOR PRIVILEGES OF DENTISTS

6.3-1 ADMISSIONS

Dentists who are Members of the Medical Staff may admit patients, if a physician Member of the Medical Staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry). The member physician will assume responsibility for problems, present at the time of the admission or which may arise during hospitalization, which are outside of the dentists' scope of practice. An oral-maxillofacial surgeon may perform the admitting history and physical examination and assess the medical risk of a proposed procedure if they are privileged to do so, and only when the oral-maxillofacial surgeon's examination of the patient and review of the medical records supports the conclusion that the patient is not currently suffering from a medical condition requiring the attention of a physician.

6.3-2 CLINICAL PRIVILEGES

The clinical privileges for surgical procedures of each dentist shall be recommended by the Chief of the Dental Service except when the Medical Executive Committee determines that certain surgical privileges also require the recommendation of another appropriate Chief of Service.

6.3-3 MEDICAL APPRAISAL

Where a dispute exists regarding proposed treatment between a physician Member and a dentist (or qualified oral-maxillofacial surgeon) 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 services.

6.4 CONDITIONS FOR PRIVILEGES OF PODIATRISTS

6.4-1 ADMISSIONS

Podiatrists who are Members of the Medical Staff may only admit patients if a physician Member of the Medical Staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to podiatry), and will assume responsibility for problems, present at the time of the admission or which may arise during hospitalization, which are outside of the podiatrist's lawful scope of practice.

6.4-2 SURGERY

Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Surgery Service, or the Chief's designee.

6.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician Member, upon arrangement by the podiatrist, shall 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 a physician Member and podiatrist based upon medical or surgical factors outside of the scope of licensure of the podiatrist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate service.

6.5 CONDITIONS FOR PRIVILEGES OF CLINICAL PSYCHOLOGISTS

6.5-1 ADMISSIONS

Psychologists who are Members of the Medical Staff may not admit patients to the Hospital.

6.6 TEMPORARY & VISITING TEMPORARY CLINICAL PRIVILEGES

6.6-1 CIRCUMSTANCES

(a) Necessary Conditions: Following the procedure in Section 6.6-2, temporary privileges may be granted to a practitioner when:

- i. There is a specifically documented urgent patient care need that mandates an immediate authorization to practice as determined by the Service Chief, President of the Medical Staff and Hospital Chief Executive Officer, or his/her designee. Such privileges may be granted for a specified period, no more than 120 days, while full credentials information is verified and approved. Such person may provide coverage, for a period not to exceed the period specified.
- ii. An applicant for Medical Staff membership or privileges has completed the application, primary source verification/processing has been completed by Medical Staff Services, and the applicant is waiting for review, recommendation and approval by the organized Medical Staff and governing body. Applicants may not be considered for temporary approval in this situation if there is a current or previously successful challenge to licensure or registration, involuntary termination of medical staff membership or limitation, reduction, denial or loss of clinical privileges at another institution, or any unusual pattern of or excessive number of professional liability actions resulting in a final judgment against the applicant.

- (b) Visiting Temporary Privileges: Upon written request by the Service Chief, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients after having satisfied the conditions listed in this section. Such privileges shall be restricted to not more than thirty (30) days during a calendar year provided that the procedure described in Section 6.6-2 has been followed.

6.6-2 APPLICATION AND REVIEW

- (a) Upon receipt of a completed application from a practitioner authorized to practice in Maryland, the Governing Body, acting through the Hospital CEO or his or her designee, may grant specific temporary privileges for a specific period of time to a practitioner who has qualifications, ability and judgment, consistent with these bylaws, and consistent with State law, but only when the President of the Medical Staff, after reviewing the applicant's file and consulting with the appropriate Chief of Service, makes a favorable recommendation to grant specific privileges for a specific period of time.
- (b) If the practitioner requests temporary privileges in more than one service, written concurrence shall first be obtained from the appropriate service chief and forwarded to the President of the Medical Staff and the Hospital CEO.

6.6-3 GENERAL CONDITIONS

- (a) All practitioners requesting or receiving temporary privileges shall be bound by the bylaws, rules and regulations and policies of the Medical Staff.
- (b) If granted temporary privileges, the practitioner shall act under the supervision of the service chief to which the practitioner has been assigned, and shall ensure that the chief, or the chief's designee, is kept closely informed as to his or her activities within the Hospital.
- (c) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Medical Executive Committee upon recommendation of the service chief or the Credentials Committee.
- (d) Requirements for monitoring may be imposed on such terms as may be appropriate under the circumstances upon any practitioner granted temporary privileges by the Governing Body, acting through the Hospital CEO or his or her designee, after consultation with the service chief or his designee.
- (e) Temporary privileges may be immediately terminated at any time by the Hospital CEO or the President of the Medical Staff. In such cases, the appropriate service chief shall assign him or herself or a Member of the

Medical Staff to assume the responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff Member.

- (f) A practitioner shall not be entitled to the procedural rights afforded by Article 12 because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended.

6.7 DISASTER PRIVILEGES

6.7.1 DISASTER PRIVILEGES

Practitioners who are not members of the medical staff of the University of Maryland Medical Center a disaster (defined as any officially declared disaster, whether it is local, state or national), for which the institution's emergency management plan has been activated.

- (a) In the case of a disaster, the President/CEO, or his/her designee (including the Incident Commander), after conference with the President of the Medical Staff (or his/her designee) shall have the authority to grant disaster privileges applicable to the situation to a practitioner, regardless of whether or not he/she is a member of the Medical Staff or has delineated Clinical Privileges. Following compliance with the Credentialing of Physicians in the Event of a Disaster Policy, the granting of disaster privileges shall be based on the opinion of the President of the Medical Staff (or his/her designee) as to the qualifications, competence and ethical standing of the practitioner to appropriately exercise the temporary disaster privileges. These disaster privileges will be for the period needed for the duration of the disaster only.

6.8 EMERGENCY PRIVILEGES

- 6.8.1 In the event of an emergency, any practitioner shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to Members of the appropriate service of the Medical Staff when such persons become reasonably available.

6.9 NEW OR EXPERIMENTAL PROCEDURES

A practitioner may not perform or use a new, untried or unproven procedure, treatment, instrument or item of equipment ("New Procedures") until granted appropriate clinical privileges for the same. New Procedures are those that cannot easily be derived or extended from existing accepted procedures or skills. An untried, experimental activity (experimental drug, diagnostic procedure, test, operative procedure, therapy or so on) may be undertaken in the Hospital, provided a specific and comprehensive experimental protocol for the experimental activity has been approved by the appropriate institutional Review Board, or equivalent body of the University of Maryland at Baltimore. All experimental activities are the responsibility of the Chief of Service.

6.9.1 NO DUE PROCESS

In the event a New Procedure or experimental protocol is not approved or any clinical privileges required by either are not granted, the procedural rights under Article 12 will not apply.

6.10 SPECIAL TRAINING PRIVILEGES

6.10.1 GENERALLY

Special Training Privileges are clinical privileges extended for a short time to a practitioner who is neither a member of the Medical Staff nor intends to apply for Medical Staff membership, but is interested in training under a UMMC faculty member for a specific procedure.

6.10.2 ELIGIBILITY AND OBLIGATIONS

To be eligible for Special Training Privileges, the practitioner must hold a current license to practice his/her discipline in the State of Maryland, or in the case of a practitioner who resides in another jurisdiction, he/she shall otherwise satisfy the legal requirements of practicing medicine, dentistry, podiatry or psychology in this State as follows:

- (a) Hold a current license to practice medicine in another jurisdiction, in which case Special Training Privileges granted pursuant to this section shall be limited by the requirement that the physician's practice in the Medical Center be performed under supervision of a member of the Active Medical Staff; or
- (b) Produce a certificate of professional liability insurance in accordance with limits agreed upon annually by the Board;
- (c) Provide the names of medical institutions where he/she holds current privileges;
- (d) Agree to abide by the Bylaws, Rules and Regulations of the Medical Staff Organization; and
- (e) Be in compliance with the Maryland Board of Physician Quality Assurance to practice as requested.

6.10.3 PROCEDURE AND LIMITATIONS

Upon the recommendation of the Chief of Service concerned and the President of the Medical Staff that specifically delineated clinical privileges be granted, the CEO, or his/her designee may in special circumstances grant the recommended Special Training Privileges on a case specific basis or on a time limited basis, such time period not to exceed thirty (30) days. The clinical privileges so granted shall not exceed those granted by the medical institution at which the Practitioner holds primary affiliation.

6.10.4 PROCEDURAL RIGHTS

The denial of requested Special Training Privileges does not entitle the individual requesting such privileges to any of the procedural rights provided in these Bylaws.

6.11 MODIFICATION OF CLINICAL PRIVILEGES OR SERVICE ASSIGNMENT

On its own or upon recommendation of the Credentials Committee, the Chief of Service, the Medical Executive Committee may recommend a change in the clinical privileges of a Member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff Member, such as is provided for in Section 5.6.1(b), be made subject to monitoring. Action on such recommendation shall follow the procedures substantially as set forth in Section 5.5.

6.12 LAPSE OF APPLICATION

If a Medical Staff Member requesting a modification of clinical privileges or service fails to furnish, in a timely fashion, the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not have procedural rights under Article 12.

6.13 TELEMEDICINE

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Practitioners who render a diagnosis (excluding those who provide official readings of images, tracings, or specimens through contracted services) or otherwise provide clinical treatment to a patient at the University of Maryland Medical Center are credentialed and privileged through the medical staff mechanisms set forth in Article 6 of these Bylaws. This institution may use credentialing information from distant site (where the practitioner is located) if said site is another Joint Commission accredited facility, which meets the same standards as set forth in Article 6. The decision to delineate privileges will be made by this institution. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner is encompassed in clinical privileging decisions.

ARTICLE 7. OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1-1 IDENTIFICATION

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

7.1-2 QUALIFICATIONS

Officers must be Members of the Active Medical Staff for a minimum of three (3) continuous years at the time of their nomination and election, and must remain such Members in good standing during their terms of office. Candidates for office shall have demonstrated executive and administrative ability through experience and prior constructive participation in Medical Staff activities and be recognized by their peers for their clinical competence and leadership skills. A Member may hold only one office at one time.

7.1-3 NOMINATIONS

Nominations shall be made by the Administrative Affairs Committee or from the floor at the time of the Annual Meeting, provided the nominee consents. The nominations of the Administrative Affairs Committee shall be delivered or mailed to the Members eligible to vote at least fourteen (14) days prior to the election.

7.1-4 ELECTIONS

- (a) Officers shall be elected at the Annual (Spring) Meeting of the Medical Staff (except that the President-Elect shall automatically succeed to the office of President at the end of his or her term as President-Elect or as otherwise provided for herein). Only Members of the Active Medical Staff are eligible to vote.
- (b) In the event of three or more candidates, with no candidate receiving a majority vote, the candidate with the fewest votes will be dropped from the list. Successive balloting, omitting the name with the fewest votes from each slate, will continue until a majority vote is achieved for one candidate.

7.1-5 TERM OF ELECTED OFFICE

Except as provided in Subsection 7.1-4 above, each officer shall serve a two (2) year term, commencing on the first day of July following his or her election. Each officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he or she resigns or is removed from office.

7.1-6 REMOVAL OF OFFICERS

Removal of a Medical Staff officer for failure to perform his/her duties in an appropriate manner may be initiated by a two-thirds vote of the Medical Executive Committee, by a petition signed by at least one-third of the total number of Members of the Medical Staff eligible to vote for officers or by the Governing Body. Removal shall be considered at a special meeting of the Medical Staff called for that purpose. Removal shall require a two-thirds vote of the Medical Staff Members eligible to vote for Medical Staff officers who actually cast votes at the special meeting either in person or by mail ballot.

7.1-7 AUTOMATIC REMOVAL OF OFFICERS

An Officer's conviction of a felony (even if under appeal), or suspension, limitation, or termination of Active Staff status, automatically results in the Officer's removal from office.

7.1-8 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death, disability, resignation of the Officer or removal under 7.1-6 or 7.1-7. Vacancies, other than that of President of the Medical Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of the President of the Medical Staff, then the President-Elect shall serve out that remaining term and such succession shall not preclude the President-Elect from assuming the office of President in normal course.

7.2 DUTIES OF OFFICERS

7.2-1 PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff shall serve as the chief officer of the Medical Staff. The duties of the President of the Medical Staff shall include, but not be limited to:

- (a) 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;
- (b) calling, presiding at, and being responsible for the agenda of all Medical Staff meetings;
- (c) serving as a member and the chairman of the Medical Executive Committee;
- (d) serving as an ex officio member of all other Medical Staff committees. As an ex officio member of such committees, the President of the Medical Staff will have no vote, unless his or her vote in a particular committee is otherwise required by these bylaws;

- (e) interacting with the Hospital CEO and Governing Body in all matters of mutual concern within the Hospital;
- (f) appointing from the Medical Staff, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, Hospital-wide or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairmen of these committees;
- (g) representing the views and policies of the Medical Staff to the Governing Body and to the Hospital CEO;
- (h) being a spokesperson for the Medical Staff in professional and public relations situations;
- (i) performing such other functions as may be assigned by these bylaws, the Medical Staff or the Medical Executive Committee;
- (j) serving on liaison committees with the Governing Body and Management, as well as outside licensing or accreditation agencies;
- (k) reporting, through its chairman, to the Medical Staff at each regular Medical Staff meeting.

7.2-2 PRESIDENT-ELECT

The President-Elect shall assume all duties and authority of the President of the Medical Staff during the absence or incapacity of the President of the Medical Staff and as otherwise provided for herein. The President-Elect shall be a member of the Medical Executive Committee and shall perform such other duties as the President of the Medical Staff may assign or as may be delegated by these Medical Staff Bylaws or by the Medical Executive Committee.

7.2-3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer shall include, but not be limited to:

- (a) maintaining a roster of Members;
- (b) keeping, or causing to be kept, accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;
- (c) calling, or causing to be called, meetings on the order of the President of the Medical Staff or Medical Executive Committee;
- (d) attending to all appropriate correspondence and notices on behalf of the Medical Staff;

- (e) receiving and safeguarding all funds of the Medical Staff;
- (f) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the President of the Medical Staff or Medical Executive Committee.

7.2-4 IMMEDIATE PAST PRESIDENT

The Immediate Past President shall be a member of the Medical Executive Committee and the Administrative Affairs Committee. He shall assume such other duties and responsibilities as are assigned him by the President of the Medical Staff.

ARTICLE 8. COMMITTEES

8.1 MEDICAL STAFF COMMITTEES

Medical Staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of services and divisions, meetings of committees established under this Article 8, and meetings of special or ad hoc committees created by the Medical Executive Committee or by services. 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 to perform specified tasks. Unless otherwise specified, the chairman and voting members of all Medical Staff committees must be Members of the Medical Staff and shall only be appointed by, and may only be removed by, the President of the Medical Staff, after consultation with Management. Medical Staff committees shall be responsible to the Medical Executive Committee. Unless otherwise specified, Management, after consultation with the President of the Medical Staff, shall appoint all committee members who are not Members of the Medical Staff.

8.2 GENERAL PROVISIONS

8.2-1 TERM OF COMMITTEE MEMBERS

Unless otherwise specified, all committee chairpersons and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. Committees shall name a vice-chair, and to the extent possible, the terms for the Chair and Vice-Chair should be staggered to allow for continuity.

Unless otherwise provided for herein or by the Medical Executive Committee when creating special or ad hoc committees, committee members who are not Members of the Medical Staff, shall be ex officio committee members with no vote.

8.2-2 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 clinical privileges, or if any other good cause exists, that member may be removed from committee membership by the President of the Medical Staff.

8.2-3 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; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the President of the Medical Staff.

8.3 MEDICAL EXECUTIVE COMMITTEE

8.3-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

- (a) the then serving officers of the Medical Staff and the Immediate Past President;
- (b) the then serving service chiefs;
- (c) the Hospital CEO as an ex officio non-voting member;
- (d) the Chief Medical Officer and Senior Vice President;
- (e) the Chief Nursing Officer and Senior Vice President as an ex officio, non-voting member;
- (f) the Dean of the School of Medicine as an ex officio, non-voting member;
- (g) additional voting members elected from the membership of the Active Medical Staff who shall be nominated and elected for one (1) year terms in the same manner and at the same time as provided in Articles 7 and 8 for the nomination and election of officers and who are neither officers of the Medical Staff nor Chiefs of Service as designated in Section 8.3-1(b) so that the number of elected voting members plus the number of officers who are not Chiefs of Services totals five (5);

8.3-2 DUTIES

Duties of the Medical Executive Committee shall include, but not be limited to:

- (a) 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;
- (b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- (c) receiving and acting upon reports and recommendations from Medical Staff services, divisions, committees, and assigned activity groups;
- (d) recommending action to the Hospital CEO and to the Governing Body on Medical Staff matters;
- (e) recommending to the Governing Body the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of performance improvement 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;
- (f) evaluating the medical care rendered to patients in the Hospital;
 - (g) participating in the development of all Medical Staff policies and all Hospital policies, practices and plans directly affecting the Medical Staff;
 - (h) reviewing the qualifications, credentials, performance and professional competence and character of applicants and Medical Staff Members and making recommendations to the Governing Body regarding Medical Staff appointments and reappointments, assignments to services, divisions, clinical privileges, and corrective action;
 - (i) taking reasonable steps to promote and improve the professional conduct and competent clinical performance on the part of all Members including the initiation of and participation in Medical Staff corrective or review measures when warranted;
 - (j) taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
 - (k) assisting in the obtaining and maintaining of the accreditation of the Hospital;
 - (l) providing for the development and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
 - (m) establishing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;
 - (n) reviewing the quality and appropriateness of services provided by contract practitioners;
 - (o) accounting to the Governing Body, by written report, on the quality and appropriateness of medical care provided to patients of the Hospital, including summaries of specific findings, actions and follow-up;
 - (p) presenting to the Governing Body for approval, the Medical Staff's recommendations pertaining to the participation of the Medical Staff in organizational performance improvement activities.
 - (q) Reviews and evaluates on a regular basis reports from the Graduate Medical Education Committee regarding the safety and quality of patient care provided by the participants in professional graduate education programs as well as compliance with supervision policies.

8.3 MEDICAL EXECUTIVE COMMITTEE (continued)

8.3-3 MEETINGS

The Medical Executive Committee shall meet at least ten (10) times a year and on the call of its chairman and shall maintain a record of its proceedings and actions. Minutes from each meeting shall be available to members of the Medical Staff exclusive of peer review type/credentialing/quality management material.

8.3-4 CONFLICT RESOLUTION

Any conflict between the Medical Staff and the Medical Executive Committee (MEC) will be resolved using the mechanisms noted below:

Each staff member in the Active category may challenge any policy established by the MEC through the following process:

- (a) Submission of written notification to the President of the Medical Staff of the challenge and basis for the challenge, including any recommended changes to the 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 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 policy to the President of the Medical Staff. If there is no further challenge, the adopted change(s) will remain. The changes are then final.
- (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 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 policy. Upon presentation of such a petition, the adoption procedure outlined in Article 15 will be followed.

If the Medical Staff votes to recommend directly to the Governing Body 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 Governing Body alternative language. If the Governing Body receives differing recommendations for bylaws or a policy from the MEC and the Medical Staff, the Governing Body shall also have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate Governing Body action. Whether or not the Governing Body appoints such a task force, the Governing Body shall have final authority to resolve the differences between the Medical Staff and the MEC.

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 Governing Body.

Each staff member in the Active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Article 7.1-6 of these bylaws regarding removal and resignation from office.

8.3-5 AUTHORITY OF MEDICAL EXECUTIVE COMMITTEE

The MEC shall recommend bylaws amendments to the Medical Staff for approval.

The MEC will approve policies and forward them, as information only, to the Board. If the Medical Staff disagrees with a policy approved by the MEC, it can utilize the conflict resolution mechanism.

8.4 CREDENTIALS COMMITTEE

8.4-1 COMPOSITION

The Credentials Committee shall consist of not less than seven (7) Active Members of the Medical Staff selected on a basis that will insure, insofar as feasible, representation of major clinical specialties and two non-voting representatives from Management.

8.4-2 DUTIES

The Credentials Committee shall:

- (a) 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 services;
- (b) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges

including recommendations with respect to appointment, membership category, service affiliation, clinical privileges and special conditions;

- (c) investigate, review and report on matters referred by the President of the Medical Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff Member;
- (d) submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

8.4-3 MEETINGS

The Credentials Committee shall meet at least ten (10) times per year and on the call of its chairman. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

8.5 PERFORMANCE IMPROVEMENT STEERING COMMITTEE

8.5-1 COMPOSITION

The Performance Improvement Steering Committee shall be composed of not less than seven (7) Active Members of the Medical Staff including the following; the President-Elect of the Medical Staff serving as Chair; Senior Vice President for Patient Care Services, Senior Vice President and Chief Medical Officer, and Senior Leadership representing Quality and Safety, Risk Management, Operations, Human Resources and Information Technology.

8.5-2 DUTIES

The duties of the Performance Improvement Steering Committee shall include:

- (a) developing and overseeing implementation of the plan for improving organizational performance to include:
 - (i) coordinating all performance improvement activities;
 - (ii) facilitating multidisciplinary departmental Quality Management activities;
 - (iii) prioritizing improvement efforts;
 - (iv) commission of quality improvement teams;
 - (v) monitoring of organizational performance.
- (b) establishing annual organizational improvement priorities;

- (c) reviewing performance data;
- (d) developing and assuring implementation of the organization's quality training strategy;
- (e) assuring compliance with regulatory standards (JCAHO, Medicare, NCQA, Maryland State);
- (f) reviewing annually the effectiveness of performance improvement activities and recommending improvements to the Plan for Improving Organizational Performance.

8.5-3 MEETINGS

The Performance Improvement Steering Committee shall meet at least ten (10) times each year and upon the call of its Chair and shall report to the Medical Executive Committee.

8.6 PROFESSIONAL ASSISTANCE COMMITTEE

8.6-1 COMPOSITION

The Professional Assistance Committee shall be comprised of not less than three (3) Active Members of the Medical Staff, a majority of whom, including the chairman, shall be physicians. These members should not include a Chief of Service or a member of the Credentials Committee or of the Performance Improvement Steering Committee or any of its subcommittees.

8.6-2 DUTIES

The Professional Assistance Committee may receive reports related to the health, well-being or impairment of Members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff Members, the committee may, on a voluntary basis, provide such advice, counseling or referrals to an approved treatment provider, or such other referrals as may seem appropriate. Such activities shall be confidential. In the event information received by the committee, which in their judgment, demonstrates that the health or known impairment of a Medical Staff Member poses a risk of harm to patients, and that member refuses to comply with the recommendations of the Professional Assistance Committee, then said Committee will report the member to their Chief of Service for appropriate action. The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

8.6-3 MEETINGS

The committee shall meet at least every six (6) months and on the call of its chairman. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. The committee will record or report the name of a practitioner to those parties or agencies stipulated by law.

8.7 ADMINISTRATIVE AFFAIRS COMMITTEE

8.7-1 COMPOSITION

The Administrative Affairs Committee shall consist of not less than five (5) Active Members of the Medical Staff, a majority of whom shall be physicians, who shall be appointed by the President of the Medical Staff and shall include the Immediate Past President and the two prior past Presidents, provided they are still members of the Active Staff.

8.7-2 DUTIES

The Administrative Affairs Committee shall:

- (a) offer nominees for election as officers and as at-large members of the Medical Executive Committee, as provided for in these bylaws;
- (b) conduct an annual review of the Medical Staff Bylaws and Medical Staff Rules and Regulations;
- (c) submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices;
- (d) receive and evaluate, for recommendation to the Medical Executive Committee, suggestions for modification of the Medical Staff Bylaws.

8.7-3 MEETINGS

The Administrative Affairs Committee shall meet annually and at the call of its chairman and as otherwise required by these bylaws.

8.8 ETHICAL ADVISORY COMMITTEE

8.8-1 COMPOSITION

The Ethical Advisory Committee shall consists of no less than eight (8) Active Members of the Medical Staff which include the Chairman and Vice Chairman (each of the following clinical services shall be represented by a physician: Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, Neurology, Neurosurgery, Psychiatry, Cancer Center, Shock Trauma Center and Family Medicine). The membership shall include patient care providers who are active in the direct provision of patient care to include: at least one (1) nurse; at least one (1) social

worker; at least one (1) representative of the Hospital Management; at least one (1) representative from Pastoral Care. A representative of the community will be considered an ad hoc member of the committee.

8.8-2 DUTIES

The Ethical Advisory Committee shall:

- (a) assist in the education and communication of ethical issues in medical decision making to the Medical Staff, Hospital personnel, patients, and patients' families;
- (b) review and recommend Hospital policies and guidelines concerning the withholding of medical treatment and other ethical issues in the provision of medical care;
- (c) upon request, review, investigate and advise on ethical issues in the provision of medical care for individual patients;
- (d) adopt procedures concerning the operations of the Committee;
- (e) maintain written records with respect to the activities of the Committee, including advice on options for medical care and treatment for an individual patient.

8.8-3 MEETINGS

The Ethical Advisory Committee shall meet at least ten (10) times a year and on the call of its chairman and shall report to the Medical Executive Committee.

8.9 RESUSCITATION COMMITTEE

8.9-1 COMPOSITION

The Resuscitation Committee shall be composed of not less than four (4) Active Members of the Medical Staff, a majority of whom, including the chairman, shall be physicians. The members shall include the UMMC ACLS Medical Director, the UMMC ACLS Clinical Coordinator, representatives from Anesthesiology, Cardiology and/or Electrophysiology, Critical Care Medicine, Emergency Medicine, Equipment Management, Nursing, Pediatrics, Pharmacy Services, School of Pharmacy, Surgery and other individuals on an ad-hoc basis.

8.9-2 DUTIES

The Resuscitation Committee shall:

- (a) provide quality management of the resuscitation process through review of resuscitation records, insuring that current resuscitation guidelines are followed;

- (b) work with the UMMC American Heart Association training center to ensure that staff are taught the latest standards in basic (BLS), advanced cardiac life support (ACLS); and Pediatric Advanced Life Support (PALS);
- (c) modify the drugs and equipment on crash carts as required by changing standards;
- (d) provide recommendations to the medical center regarding resuscitation policies and procedures;
- (e) communicate policy, equipment and crash cart changes to Medical Staff and Patient Care Services.

8.9-2 MEETINGS

The Resuscitation Committee will meet at least every two months and on the call of the Chairperson.

ARTICLE 9. CLINICAL SERVICES

9.1 ORGANIZATION OF CLINICAL SERVICES

The Medical Staff shall be divided into clinical services. Each service shall be organized as a separate component of the Medical Staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in Section 9.4-4. A service may be further divided, as appropriate, into divisions which shall be directly responsible to the service within which it functions, and which shall have a division chief appointed, and subject to removal, by the service chief and entrusted with such authority, duties and responsibilities as the service chief may assign. A Member of the Medical Staff may be a voting member in only one service.

9.2 CURRENT SERVICES

The current services are:

- (a) Anesthesiology Service
- (b) Dentistry Service
- (c) Dermatology Service
- (d) Emergency Medicine Service
- (e) Epidemiology/Preventive Medicine Service
- (f) Family Medicine Service
- (g) Medicine Service
- (g) Neurology/Rehabilitation Service
- (h) Neurosurgery Service
- (j) Obstetrics/Gynecology Service
- (k) Ophthalmology Service
- (l) Orthopaedic Surgery Service
- (m) Pathology Service
- (n) Pediatric Service
- (o) Psychiatry Service
- (p) Radiation Oncology Service
- (q) Radiology Service

- (r) Surgery Service
- (s) Shock Trauma Center
- (t) Cancer Center

9.3 FUNCTIONS OF SERVICES

The general functions of each service shall include:

- (a) provision of safe, quality care for all persons to whom services are provided;
- (b) coordinating patient care provided by the service's Members with nursing and ancillary patient care services;
- (c) reviewing and evaluating service adherence to Medical Staff policies and procedures and sound principles of clinical practice;
- (d) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the service. The service shall routinely collect information about important aspects of patient care provided in the service, 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 service, regardless of whether the Member whose work is subject to such review is a Member of that service;
- (e) recommending to the Medical Executive Committee, for approval by the Governing Body, the criteria for the granting of clinical privileges and the performance of specified services within the service;
- (f) evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that service;
- (g) conducting, participating in and making recommendations regarding continuing education programs pertinent to clinical practice of the service;
- (h) review all mortalities and morbidities of patients on that service;
- (i) submitting written reports to the Performance Improvement Steering Committee concerning the service's review and evaluation activities, actions taken thereon, and the results of such action and recommendations for maintaining and improving the quality of care, according to performance improvement standards, provided in the service and the Hospital;
- (j) meeting at a minimum of bi-annually to evaluate patient care and review the effectiveness of the service's review and evaluation procedures;

- (k) establishing and appointing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including monitoring of professional performance;
- (l) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- (m) overseeing the performance of service personnel who provide patient care and recommending corrective action when standards are not met;
- (n) reviewing and recommending policies and procedures to ensure that all practitioners with clinical privileges only provide services within the scope of the privileges granted;
- (o) accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;
- (p) formulating recommendations for service rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Governing Body and not inconsistent with these Medical Staff Bylaws.

9.4 SERVICE CHIEFS

9.4-1 QUALIFICATIONS

Each service shall have a chief who shall be a Member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the service. Service Chiefs shall be board certified or have comparable competence.

9.4-2 SELECTION

The chairmen of the appropriate clinical departments of the School of Medicine shall serve as the Chiefs of the Services of the Medical Staff. The Chief of the Dentistry Service shall be selected by the School of Dentistry. The Clinical Directors of the Shock Trauma Center and the Cancer Center shall be their respective Chiefs. The Chief of Emergency Medicine shall be the Chief of clinical service.

9.4-3 TERM OF OFFICE

Each Chief of Service shall serve in such position as long as he or she satisfies the criteria set forth in Sections 9.4-1 and 9.4-2.

9.4-4 DUTIES

Each chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned to him or her:

- (a) act as presiding officer at meetings of the service;
- (b) report to the Medical Executive Committee and to the President of the Medical Staff regarding all professional and administrative activities within the service;
- (c) generally monitor the quality of patient care and professional performance rendered by Members with clinical privileges in the service through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the service by the Medical Executive Committee;
- (d) develop and implement service programs for retrospective patient care review, on-going monitoring practice, credentials review and privileges delineation, orientation, continuing education, utilization review, performance improvement and coordinates the integration of interdepartmental and intradepartmental services;
- (e) serve as a member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding his or her service including the need for off-site sources for needed patient care services not provided by the department or institution;
- (f) transmit to the Credentials Committee the service's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in his or her service;
- (g) endeavor to enforce the Medical Staff bylaws, rules, regulations and policies within his or her service;
- (h) implement within his or her service appropriate actions taken by the Medical Executive Committee and communicates the findings, conclusions, recommendations and actions taken to improve organizational performance;
- (i) participate in every phase of administration of his or her service, as appropriate including assessing and recommending sufficient space and other resource needs to the appropriate hospital authority;
- (j) assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her service as may be required by the Medical Executive Committee or Management;
- (k) recommend delineated clinical privileges for each Member of the service;

- (l) perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Medical Staff, the Medical Executive Committee or Management;
- (m) provide for an appropriate alternate to discharge his or her responsibilities in times of absence or disability.
- (n) determines qualifications and competencies of department personnel who are not licensed independent practitioners and who provide patient care services.

ARTICLE 10. MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 ANNUAL MEETING

There shall be an Annual Meeting of the Medical Staff which shall occur in the Spring. The President of the Medical Staff, or such other officers, service chiefs, or committee chairmen that the President of the Medical Staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the Members. Notice of this meeting shall be given to the Members at least twenty (20) days prior to the meeting.

10.1-2 REGULAR MEETINGS

Regular meetings of the Medical Staff shall be held at least three (3) times a year, including the Annual Meeting. The date, place and time of the regular meetings shall be determined by the President of the Medical Staff, and adequate notice shall be given to the Members.

10.1-3 AGENDA

The order of business at a regular meeting of the Medical Staff shall be determined by the President of the Medical Staff. The agenda shall include, insofar as is feasible:

- (a) acceptance of the minutes of the last regular meeting and all special meetings held since the last regular meeting;
- (b) administrative reports from the President of the Medical Staff, services and committees, and the Hospital CEO;
- (c) election of officers when required by these bylaws;
- (d) reports by responsible officers, committees and services on the overall results of performance improvement activities, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;
- (e) old business;
- (f) new business.

10.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, the Medical Executive Committee, the Governing Body. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive

Committee within twenty (20) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members of the Medical Staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.1-5 QUORUM FOR MEDICAL STAFF MEETINGS

The presence of thirty-five (35) Members of the Active Medical Staff shall constitute a quorum for the transaction of all Medical Staff business.

10.1-6 ATTENDANCE REQUIREMENTS

Except as stated below, each Member of the Active Staff, and all provisional members of the Active Staff during the term of appointment who are entitled to attend meetings under Article 4 shall be encouraged during each Medical Staff year to attend at least one of the duly convened regular meetings of the Medical Staff (the Annual Meeting is a regular meeting).

Each Member of the Consulting or Courtesy Staff, all provisional Members of the Courtesy or Consulting Staff and each member of the Clinical Fellows Medical Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

10.2 MEDICAL STAFF COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairmen of committees may establish the times for the holding of regular meetings. Committee chairmen shall make every reasonable effort to ensure the meeting dates are disseminated to the Members with adequate notice.

10.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee may be called by the chairman thereof, the Medical Executive Committee, the Governing Body or the President of the Medical Staff, and shall be called by written request of one-third of the current Members thereof eligible to vote, but not less than two Members.

10.2-3 QUORUM FOR MEDICAL EXECUTIVE COMMITTEE MEETINGS

The presence of fifty percent (50%) of the voting members of the Medical Executive Committee shall constitute a quorum for the transaction of its business.

10.2-4 QUORUM FOR OTHER COMMITTEE MEETINGS

Except as provided in Section 10.2-3, the presence of three (3) voting Members of the Medical Staff on a committee shall constitute a quorum for the transaction of all committee business.

10.2-5 SPECIAL ATTENDANCE REQUIREMENTS

At the discretion of the committee chairman, when a Member's practice or conduct is scheduled for discussion at a committee meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, a notice shall be given at least ten (10) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a Member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for disciplinary action.

10.2-6 ELECTRONIC MEETINGS AND VOTING

The voting members of the Medical Staff, a service, or a committee may be presented with a question by mail, facsimile, email, hand delivery, or telephone, and their votes returned to the Chairperson by the method designated in the notice. A quorum for purposes of these votes shall be the number of responses returned to the Chairperson by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

10.3 CLINICAL SERVICE MEETINGS

10.3-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chiefs of services may establish the times for the holding of regular meetings. The chiefs shall make every reasonable effort to ensure the meeting dates are disseminated to the Members with adequate notice.

10.3-2 SPECIAL MEETINGS

A special meeting of any service may be called by the chief thereof, the Medical Executive Committee, the Governing Body or the President of the Medical Staff, and shall be called by written request of one-third of the current Members thereof eligible to vote, but not less than two Members.

10.3-3 QUORUM FOR SERVICE MEETINGS

The presence of three (3) of the voting members of a service shall constitute a quorum for the transaction of all service business.

10.3-4 SPECIAL ATTENDANCE

At the discretion of the service chief, when a Member's practice or conduct is scheduled for discussion at a regular or special service meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, a notice shall be given at least ten (10) days prior to the meeting and

shall include the time and place of the meeting and a general indication of the issue involved. Failure of a Member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for disciplinary action.

10.4 GENERAL PROVISIONS

10.4-1 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee, if it is acknowledged by a writing setting forth the action so taken which is signed by all of the Members entitled to vote.

10.4-2 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of Members and the votes taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

10.4-3 ABSENCE FROM MEETINGS

Any Member who is compelled to be absent from any Medical Staff, service, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the service or committee, or the Secretary-Treasurer for Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action.

10.4-4 CONDUCT OF MEETINGS

Unless otherwise specified herein, meetings shall be conducted according to Robert's Rules of Order. However, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE 11. DISCIPLINARY PROCEDURES

11.1 CORRECTIVE ACTION

11.1-1 CRITERIA FOR INITIATION

Any person may provide information to the President of the Medical Staff, a Service Chief or the Medical Executive Committee about the conduct, performance, or competence of a Member. When reliable information indicates that a Member may have exhibited acts, demeanor or conduct reasonably likely to be (1) detrimental to a patient's or anyone's safety or to the delivery of patient care within the Hospital; (2) contrary to the Medical Staff Bylaws or Rules and Regulations; or (3) below applicable professional standards, a request for an investigation or action against such Member may be initiated by the President of the Medical Staff, the Chief of Service, the Hospital CEO, the Governing Body or the Medical Executive Committee.

11.1-2 INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of its reasons.

11.1-3 INVESTIGATION

If the Medical Executive Committee concludes that an investigation is warranted, it shall direct that an investigation be undertaken, with notice to the Hospital CEO. The Medical Executive Committee will assign the task to an ad hoc committee of the Medical Staff composed of members who are not in direct economic competition with the individual under investigation. The committee shall proceed with its investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The Member shall promptly be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the ad hoc committee deems appropriate. The ad hoc committee may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article 12, nor shall the procedural rules with respect to hearings apply. Despite the status of any investigation, the Medical Executive Committee and the Governing Body shall at all times 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.

11.1-4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall, with notice to the Hospital CEO, take action which may include, without limitation:

- (a) determining no corrective action be taken;
- (b) deferring action for a reasonable time where circumstances warrant;
- (c) issuing letters of admonition, warning, reprimand or censure, although nothing herein shall be deemed to preclude service or division chiefs 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 Member may make a written response which shall be placed in the Member's file;
- (d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or the exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation or monitoring;
- (e) recommending reduction, modification, suspension or revocation of clinical privileges;
- (f) recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;
- (g) recommending suspension, modification, probation or revocation of Medical Staff membership.

11.1-5 SUBSEQUENT ACTION

- (a) If corrective action as set forth in subsections (d) through (g) of Section 11.1-4 is recommended by the Medical Executive Committee, that recommendation shall be transmitted in writing to the Member and, in these cases only, the Member shall then be entitled to his or her rights as set forth in Article 12.
- (b) If the Member does not exercise his or her rights under Article 12, the Medical Executive Committee shall forward its recommendation to the Governing Body within 30 days.
- (c) The decision of the Governing Body shall be deemed final action.

11.1-6 REMEDICATION

Notwithstanding the foregoing, the Medical Executive Committee may, in the alternative and with notice to the Hospital CEO, enter into a remedial agreement with the affected Member to resolve the problem. If the affected Member fails to

abide by the terms of the remedial agreement, the Member will be subject to the standard corrective action procedures of this Article 11.

11.2 SUMMARY RESTRICTION OR SUSPENSION

11.2-1 CRITERIA FOR INITIATION

Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient or wherever the Member'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 of Service (or his or her designee) in which the Member holds privileges), the President of the Medical Staff, the Medical Executive Committee, Hospital CEO or the Governing Body, may summarily restrict or suspend the Medical Staff membership or clinical privileges of such Member. 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 the Member, the Governing Body, the President of the Medical Staff, the Medical Executive Committee and the Hospital CEO. The summary restriction or suspension 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 Member's patients shall be promptly assigned to another Member by the Chief of Service or by the President of the Medical Staff considering, where feasible, the wishes of the patient in the choice of a substitute Member.

11.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Medical Executive Committee shall complete its review and makes its decision within ten (10) days after the restriction or suspension. The suspended Member 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 Member, constitute a "hearing" within the meaning of Article 12. The Medical Executive Committee may recommend modification, continuation, or termination of the summary restriction or suspension, but in any event it shall promptly furnish the Member, the Hospital CEO and the Governing Body with notice of its decision.

11.2-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension within fourteen (14) days of its effective date, the Member shall be entitled to his or her rights as set forth in Article 12, but not otherwise.

11.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing under Article 12 or further review.

11.3-1 LICENSURE

- (a) Revocation and Suspension: Whenever a Member's license or other legal credential authorizing practice in this State is limited, suspended, revoked, or has lapsed, the Member shall immediately notify the Hospital CEO and his or her Medical Staff membership and clinical privileges shall be automatically limited, suspended or revoked as of the date such action becomes effective.
- (b) Restriction: Whenever a Member's license or other legal credential authorizing practice in this State is limited, suspended or revoked by the applicable licensing or certifying authority, the Member shall immediately notify the Hospital CEO and any membership or clinical privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation: Whenever a Member is placed on probation by the applicable licensing or certifying authority, the Member shall immediately notify the Hospital CEO and his or her membership and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

11.3-2 CONTROLLED SUBSTANCES

- (a) Restriction. Whenever a Member's DEA certificate, Maryland CDS or prescribing authority is revoked, limited, suspended, or has lapsed the Member shall immediately notify the Hospital CEO and the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a Member's DEA certificate or prescribing authority is subject to probation, the Member shall immediately notify the Hospital

CEO and the Member'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.

11.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A Member, who, without good cause, fails to appear and satisfy the requirements of Section 10.2-5 or 10.3-4, shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that Section, until the situation is remedied to the satisfaction of the Medical Executive Committee or further action is taken under these Medical Staff Bylaws or by the Governing Body.

11.3-4 PROFESSIONAL LIABILITY INSURANCE

A member who fails to maintain the level and type of professional liability insurance coverage as required by the Hospital shall automatically be suspended from exercising all clinical privileges at the Hospital, until the situation is remedied to the satisfaction of the Medical Executive Committee or further action is taken under these Medical Staff Bylaws or by the Governing Body.

11.3-5 LOSS OF FACULTY APPOINTMENT

A member who fails to maintain faculty appointment in either the School of Medicine or the School of Dentistry shall automatically be suspended from exercising all clinical privileges at the Hospital, until the situation is remedied to the satisfaction of the Medical Executive Committee or further action is taken under these Medical Staff Bylaws or by the Governing Body.

11.3-6 LOSS OF MEDICARE OR MEDICAID PROVIDER STATUS

A member who fails to maintain his or her status as a Medicare or Medicaid provider shall automatically be suspended from exercising all clinical privileges at the Hospital, until the situation is remedied to the satisfaction of the Medical Executive Committee or further action is taken under these medical Staff Bylaws or by the Governing Body.

11.3-7 EXPIRATION OF MEDICAL STAFF APPOINTMENT

A member who fails to maintain his or her medical staff membership/privileges due to the expiration of same shall automatically be suspended from exercising all clinical privileges at the Hospital, until the situation is remedied to the satisfaction of the Medical Executive Committee and Governing Body.

11.3-8 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Sections 11.3-1(b) or (c), Section 11.3-2, 11.3-3, 11.3-4, 11.3-5, or 11.3-6, the Medical Executive Committee shall convene to review and consider the facts, and may

recommend such further disciplinary action as it may deem appropriate following the procedures generally set forth in Articles 11 and 12 hereof.

ARTICLE 12. PROFESSIONAL REVIEW PROCEDURE

12.1 RIGHT TO HEARING

- (a) Except as otherwise provided for herein, any practitioner whose appointment or re-appointment to the Medical Staff or advancement in Medical Staff membership has been denied or any practitioner whose clinical privileges have been curtailed, suspended, revoked or denied, or any practitioner who has received any adverse recommendation from the Medical Executive Committee, Medical Staff or Governing Body, relative to a matter of Medical Staff appointment or clinical privileges ("adverse action") shall have the right to a formal hearing by a panel of individuals appointed by the Governing Body, or its designee. No Member of the panel shall be in direct competition with the affected practitioner. The Members of this panel shall not have been involved in the formal evaluation of the affected practitioner's credentials or in the formulation of the adverse decision or recommendations. Such panel shall consist of an odd number of Members, a majority of whom shall be physicians.
- (b) A practitioner shall not be permitted to re-apply for any denied or terminated Medical Staff appointment, category or privilege for at least one (1) year following an adverse final decision by the Governing Body.

12.2 HEARING REQUIREMENTS

- (a) A practitioner, who is the subject of an adverse action, shall receive written notice from the Hospital CEO containing the following information: (i) a statement that an adverse action has been proposed or taken against the practitioner; (ii) the reason for such adverse action; (iii) the practitioner' right to request a hearing on the adverse action; (iv) the time limits within which to request such a hearing; (v) appeal rights; and (vi) a summary of rights as contained in this Article.
- (b) The practitioner requesting a hearing must do so in writing, delivered in person or by certified mail to the Hospital CEO within thirty (30) days following receipt of any adverse action notice. If a hearing is not requested within thirty (30) days, the practitioner shall be deemed to have accepted the adverse action and it shall become effective immediately and the practitioner shall have waived all rights due under the provisions of this Article.
- (c) The chairman of the panel shall arrange for the hearing and shall give written notice to the requesting practitioner of the time, place and date of the hearing which shall take place within thirty (30) days after the date of the hearing request. The Hospital shall provide the practitioner and the chairman of the panel with a list of the witnesses expected to testify at the hearing on behalf of the Hospital. This list of witnesses shall be provided at least seven (7) days prior to the commencement of the hearing.

- (d) The practitioner requesting the hearing shall be entitled to be represented at the hearing by an attorney or any other person of the practitioner's choice. The attorney or other person representing the practitioner may participate fully in the hearing. Such representation shall include, but shall not be limited to, presentation of the practitioner's case and examination and cross-examination of witnesses. The practitioner shall provide a list of his or her witnesses to the chairperson of the panel at least seven (7) days prior to the commencement of the hearing.
- (e) After the panel is appointed, it shall select a chairman to preside over the hearing, if one has not been designated by the Governing Body, or its designee. Such chairperson shall act to provide that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence and that decorum is maintained. Such chairman shall be entitled to determine the order or procedure during the hearing. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The chairman and members of the hearing panel may directly question any of the participants in the hearing, including witnesses.
- (f) The practitioner and the Hospital shall have the following rights:
 - (i) A record shall be made of the proceedings, copies of which shall be available to the practitioner upon payment to the Hospital of any reasonable costs or charges associated with their preparation;
 - (ii) To call, examine and cross-examine witnesses;
 - (iii) To introduce evidence determined to be relevant by the panel regardless of its admissibility in a court of law;
 - (iv) To impeach any witness;
 - (v) To rebut any evidence;
 - (vi) To submit a written statement at the close of the hearing; and
 - (vii) To be represented by an attorney.
- (g) The chairman may recess the hearing, and reconvene the same within fifteen (15) days, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, all without special notice. Upon conclusion of the presentation of evidence, the hearing shall be closed. The panel may, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

- (h) Within fifteen (15) days of the final adjournment of the hearing, the panel shall make a written report and recommendation to the Governing Body. Such report and recommendation shall include a statement of the basis for the recommendation. The report may recommend confirmation, modification, or rejection of the adverse action. A copy of that report and recommendation shall be sent to the practitioner on the same day it is forwarded to the Governing Body.
- (i) Absent a timely appeal under (j) below, within thirty (30) days after receipt of the hearing panel's report and recommendation, the Governing Body shall render a written decision in the matter, including a statement of the basis for the Board's decision, and shall forward a copy of its decision to the Hospital CEO for transmittal to the practitioner for whom the hearing was held. The decision of the Governing Body is final.
- (j) Within ten (10) days from receipt of the hearing panel's report and recommendation, the practitioner may submit to the Hospital CEO, in writing, by personal delivery or certified mail, return receipt requested, a request for appellate review of the hearing panel's report and recommendation.
- (k) If an appeal is timely filed, the Governing Body shall provide appellate review in accordance with its appellate review procedures. The procedures shall include a review of the record of the hearing of the hearing panel's written report and recommendation, and of any written memoranda submitted by the practitioner or the hospital addressing disagreement with or support for the hearing panel's report and recommendation. In its discretion, the Governing Body may permit the parties to present oral argument supporting their positions.
- (l) If an appeal is timely filed, the Governing Body shall use its best efforts to reach a final decision on any appeal within ninety (90) days from receipt of the request for appellate review, and shall render decision, including a statement of the basis for the Board's decision, and shall forward the decision to the Hospital Chief Executive Officer for transmittal to the practitioner. The Governing Body's decision is final.

ARTICLE 13. CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 CONFIDENTIALITY OF INFORMATION

13.1-1 GENERAL

Except as otherwise provided for herein, Medical Staff, service, or committee minutes, files and records, including information regarding any Member or applicant to this Medical Staff shall be confidential as mandated by Maryland law.

13.1-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff services, divisions, or committees, except in conjunction with other appropriate Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and may violate provisions of Maryland law, imposing civil liability. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such disciplinary action as it deems appropriate with a report to the Governing Body.

13.2 IMMUNITY FROM LIABILITY

13.2-1 FOR ACTION TAKEN

Each representative of the Medical Staff, Hospital and Governing Body shall be exempt, to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital.

13.2-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or Member 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 staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

13.3 ACTIVITIES AND INFORMATION COVERED

13.3-1 ACTIVITIES

When there is compliance with the terms of all applicable laws and regulations, 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:

- (a) applications for appointment, reappointment, or clinical privileges;
- (b) disciplinary action;
- (c) investigations and hearings;
- (d) utilization reviews;
- (e) other service, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
- (f) peer review organizations, Maryland licensure boards and similar reports.

13.4 RELEASES

Each applicant or Member 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 and these bylaws. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article or these bylaws.

ARTICLE 14. GENERAL PROVISIONS ON GOVERNANCE

14.1 RULES AND REGULATIONS

The Medical Executive Committee shall initiate and adopt such Rules and Regulations or Medical Staff policies as it may deem necessary for the proper conduct of the work of the Medical Staff and shall periodically review and revise its Rules and Regulations to reflect the Hospital's current practices with regard to Medical Staff organization and function. Following adoption, such Rules and Regulations shall become effective with the approval of the Governing Body. Applicants and Members of the Medical Staff shall be governed by such Rules and Regulations or Policies as are properly initiated and adopted. If there is a conflict between the Medical Staff Bylaws and the Rules and Regulations, the Medical Staff Bylaws shall prevail; and if there is a conflict between or among the Medical Staff Rules and Regulations or Policies, the Medical Staff Bylaws and the Bylaws of the Corporation, the Bylaws of the Corporation shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations or Policies.

14.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Governing Body, and to determine, in all cases, the manner of expenditure or distribution of such funds received.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both sexes wherever a gender term is used.

14.4 AUTHORITY TO ACT

Any Member or Members who act in the name of this Medical Staff, the Hospital or the Corporation without proper authority shall be subject to such disciplinary action as the Governing Body deems appropriate or as determined by the Medical Executive Committee with the approval of the Governing Body.

14.5 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery

mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or services, divisions or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of service, division or committee
c/o Medical Staff Office
University of Maryland Medical System
22 South Greene Street
University Center
Baltimore, MD 21201-1544

Mailed notices to a Member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

ARTICLE 15. ADOPTION AND AMENDMENT OF BYLAWS
AND MEDICAL STAFF POLICIES

15.1 PROCEDURE

The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Governing Body any Medical Staff Bylaws amendments as needed. Amendments to the Bylaws shall be effective when approved by the Governing Body. The Medical Staff must exercise this responsibility regarding Bylaws through direct vote of its membership. The Medical Staff can exercise this responsibility regarding policies through its elected and appointed leaders via the Medical Executive Committee (MEC) or through direct vote of its membership. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner.

Any Member of the Active Staff, the Governing Body or the Medical Executive Committee may propose an amendment to the Bylaws and policies. Such a proposal shall be made in writing to the Medical Executive Committee; Nothing contained within the Bylaws shall supersede the general authority of the University of Maryland Medical System Corporation as set forth in its corporate bylaws or applicable common law or statutes.

15.1-1 PROPOSED AMENDMENTS

- (a) Proposed amendments to the Bylaws may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the voting members of the Medical Staff.
- (b) When proposed by the MEC, there will be communication of the proposed amendment to the Medical Staff before a vote is taken by the MEC. When proposed by the Medical Staff, there will be communication of the proposed amendment to the MEC before a vote is taken by the Medical Staff.
- (c) Proposed amendments to the Medical Staff policies may be originated by the MEC or by a petition signed by twenty-five (25%) of the voting members of the Medical Staff.

15.1-2 COMMUNICATION OF PROPOSED AMENDMENTS

- (a) When proposed by the MEC, there will be communication of the proposed amendment to the Medical Staff before a vote is taken by the MEC. When proposed by the Medical Staff, there will be communication of the proposed amendment to the MEC. If the MEC does not approve the proposed amendment to the policy, the Medical Staff can ask for a Medical Staff vote using the mechanisms noted in the conflict resolution process.
- (b) When the MEC adopts a policy or amendment thereto, there will be communication of the policy or amendment to the Medical Staff.

15.1-3 URGENT AMENDMENTS

In cases of a documented need for an urgent amendment to the Bylaws, the MEC and Governing Body may adopt such provisional amendments to the Bylaws that are in the MEC's and Governing Body's judgments necessary for legal or regulatory compliance. After adoption, these provisional amendments will be communicated to the Medical Staff for review.

- (a) If the Medical Staff approves the provisional amendment, the amendment will no longer be provisional, and will become effective as of the date approved by the Governing Body.
- (b) If the Medical Staff does not approve the provisional amendment, the disagreement will be resolved using the conflict resolution mechanism noted in Article 8.3-4. If a substitute amendment is then proposed, it will follow the usual approval process.

15.2 APPROVAL

Bylaw amendments approved by the MEC shall be presented to the Governing Body. Bylaw amendments recommended by the Medical Staff shall become effective upon the approval by the Governing Body and shall be communicated to all Members of the Medical Staff. With its approval of these Medical Staff Bylaws, and any amendments to them, the Governing Body expressly delegates certain of its legal responsibilities to the Medical Staff. However, this delegation is conditional and is not an abdication of the Governing Body's responsibilities or if its authority, so that it retains the power to act directly on any subject treated herein or as a result hereof.

15.4 OTHER MEDICAL STAFF DOCUMENTS

- (a) In addition to the Medical Staff Bylaws, there shall be policies, that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, shall be considered an integral part of the Medical Staff Bylaws.
- (b) Medical Staff documents including the Credentialing Procedures Manual may be amended by a majority vote of the members of the Medical Executive Committee present and voted on at any meeting of that committee where a quorum exists.
- (c) No amendment will be effective unless and until it has been approved by the Governing Body.

Approved by Medical Executive Committee	2/23/99
Approved by Board of Directors	4/28/99
Approved by Medical Executive Committee	12/19/00
Approved by Board of Directors	1/2001
Approved by Medical Executive Committee	12/18/01
Approved by Board of Directors	1/10/02
Approved by Medical Executive Committee	6/25/02
Approved by Board of Directors	7/2002
Approved by Medical Executive Committee	7/25/02
Approved by Board of Directors	8/2002
Approved by Medical Executive Committee	11/26/02
Approved by Board of Directors	12/2002
Approved by Medical Executive Committee	12/17/03
Approved by Board of Directors	1/29/04
Approved by Medical Executive Committee	9/28/04
Approved by Board of Directors	9/28/04
Approved by Medical Executive Committee	2/22/05
Approved by Board of Directors	7/7/05
Last Approved by the Medical Executive Committee:	11/28/06
Approved by the Board of Directors:	11/30/06
Last Approved by the Medical Executive Committee:	12/17/08
Approved by the Board of Directors:	12/18/08
Last Approved by the Medical Executive Committee:	12/16/09
Approved by the Board of Directors:	2/11/10
Last Approved by the Medical Executive Committee:	5/26/10
Approved by the Board of Directors:	6/10/10
Last Approved by the Medical Executive Committee:	2/23/11
Approved by the Board of Directors:	4/7/11
Reviewed by MEC Administrative Affairs Committee	1/5/15