UNIVERSITY OF MARYLAND
MEDICAL CENTER, LLC

MEDICAL STAFF BYLAWS

TABLE OF CONTENTS

DEFINITIONS ... 2
ARTICLE 1. NAME, DESCRIPTION & MISSION ... 4
ARTICLE 2. PURPOSE AND AUTHORITY ... 4
ARTICLE 3. MEMBERSHIP ... 6
ARTICLE 4. CATEGORIES OF MEMBERSHIP ... 11
ARTICLE 5. MEDICAL STAFF APPOINTMENT ... 14
ARTICLE 6. CLINICAL PRIVILEGES ... 26
ARTICLE 7. OFFICERS ... 33
ARTICLE 8. COMMITTEES ... 36
ARTICLE 9. CLINICAL SERVICES ... 45
ARTICLE 10. MEETINGS ... 48
ARTICLE 11. COLLEGIAL, EDUCATIONAL, AND/OR INFORMAL PROCEEDINGS ... 52
ARTICLE 12. INITIATION AND NOTICE OF HEARING ... 58
ARTICLE 13. HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER ... 64
ARTICLE 14. PRE-HEARING AND HEARING PROCEDURE ... 66
ARTICLE 15. APPEAL TO THE HOSPTIAL BOARD ... 69
ARTICLE 16. CONFIDENTIALITY, IMMUNITY AND RELEASES ... 71
ARTICLE 17. GENERAL PROVISIONS ON GOVERNANCE ... 74
ARTICLE 18. ADOPTION AND AMENDMENT OF BYLAWS ... 75

DEFINITIONS

1. The term "Applicant" means or refers to a practitioner who has formally applied to be a member of the Medical Staff.

2. The term "Chief of Service" means the member of the Active Medical Staff appointed to be the administrative head of a clinical service.

3. The term “CMO” means Chief Medical Officer of the Hospital.

4. The term “CQO” means Chief Medical Officer of the Hospital.

5. 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.

6. The term "Medical Center” and “Hospital” are used interchangeably to refer to the University of Maryland Medical Center, LLC.

7. 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.

8. 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.

9. The term "Governing Body" means the Board of Directors of the University of Maryland Medical Center, LLC.

10. The term “System” means the University of Maryland Medical System Corporation. The term “System Members” means affiliated hospitals within the System.

11. 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.

12. 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.

13. 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.

14. 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. Qualifications for membership are set forth in Article 3.2.

15. The term "Member" or "Members of the Medical Staff" refers to practitioners appointed to the Medical Staff.

16. The term "Physician" means a doctor of medicine or a doctor of osteopathic medicine who is licensed in Maryland.

17. 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.

18. 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.

19. The term "School of Dentistry" means the University of Maryland School of Dentistry.

20. 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, The Joint Commission, 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, and other privileged providers, 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, sexual identity, age or disability;

(c) To strive to maintain and enhance the professional performance of all Members of the Medical Staff, and those granted clinical privileges, 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, 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 Medical Center; 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 credentialed clinicians, 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 Medical Center 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, including centralizing the credentialing functions within the System, 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 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.

Administrative procedures described herein for 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 Recognition members, 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;

(vii) are willing to discharge properly the responsibilities established by the Hospital; and

(viii) shall be deemed to possess the basic qualifications for membership in the Medical Staff, except for the Honorary Recognition 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 Recognition 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 Recognition 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 Recognition 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 Recognition 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.

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 <u>BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP</u>. Except for those in the Honorary Recognition category, 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, 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;

(m) 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;

(n) working with other individuals and organizations in a cooperative, professional and civil manner and refraining from activity that is disruptive of Hospital operations;

(o) adhering to the ethical standards generally applicable to his or her licensure;

(p) 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;

(q) 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;

(r) 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;

(s) 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; or

(v) the patient exhibits severe symptoms of mental illness or psychosis.

(t) completion of history and physical examinations in the following manner:

(i) medical history and physical exam (H&P) must be completed on all patients within 24 hours after 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. This must be completed and documented by an appropriately credentialed physician, dentist, podiatrist, advanced practice nurse or physician assistant in accordance with Hospital policy. Residents and Fellows may complete and document with counter signatures from an Attending Physician.

(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; or

(iii) the content of a completed and focused H&P is delineated in hospital policy MOI-022.

(u) Medical Screening Exam: The following persons are authorized to perform medical screening examinations for the purpose of determining the presence of an emergency medical condition or active labor pursuant to the Emergency Medical Treatment and Labor Act: Physicians, physician assistants, nurse practitioners, and certified nurse midwives.

(u) completing such health requirements as may be set and approved by the Medical Executive Committee;

(v) 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;

(w) maintain and preserve the confidentiality of patient information in accordance with applicable law and UMMC's policies and procedures; and

(x) 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, Associate, and Courtesy Associate. At the time of appointment and reappointment, the Member's Medical Staff category shall be determined. Honorary Recognition, while not a category of Medical Staff membership, is a status that may be granted by special request.

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, 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 Articles 12-15.

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; and

(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; and,

(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; and

(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;

(a) 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;

(b) 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;

(c) 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

(d) have fair hearing rights as specified in Article 11 of these bylaws.

4.5 TELEMEDICINE MEDICAL STAFF

4.5.1 QUALIFICATIONS. The Telemedicine Medical Staff shall consist of practitioners who:

(b) meet the general qualifications for membership set forth in these Medical Staff Bylaws and specifically in Article 3;

(c) are granted privileges to provide medical services via a telemedicine link from a remote location for the specific purposes of providing consultation, preliminary or final interpretation in the diagnosis and treatment of patients.

4.5.2 PREROGATIVES.

(a) Appointees of this category shall exercise the privileges granted to them; however, they may not admit patients at the Hospital.

(b) Appointees of this category are not required to attend Medical Staff events/meetings, and are not entitled to vote, hold office or Chair any committee at the hospital.

(c) Appointees of this category are required to pay dues but are exempt from PPD, flu and immunization vaccination requirements.

(d) Appointees of this category shall have fair hearing rights as specified in Article 11 of these bylaws.

4.6 HONORARY RECOGNITION

4.5.1 QUALIFICATIONS. Honorary Recognition may be granted to select individuals with outstanding reputations, noteworthy contributions to health and medical sciences or who have rendered distinguished service or valuable assistance to the Hospital. Recipients of Honorary Recognition need not maintain qualifications for Medical Staff membership, nor need they participate in the appointment process.

4.5.2 PREROGATIVES. Honorary Recognition recipients 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. Subject to approval by the Governing Body, Honorary Recognition may be revoked by a two-thirds vote of the Medical Executive Committee, without any procedural rights under Articles 12-15.

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 Articles 12-15.

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 or disaster 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 and policies of the Medical Staff and the Medical Center 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 render the application incomplete and the application cannot be processed. 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 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; and

(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, 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, or the Bylaws of the Medical Center;

(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; and

(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 Articles 12-15. 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 Articles 12-15. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate service(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. A criminal background check shall be completed.

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 evaluation.

(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 Articles 12-15. The applicant shall then be entitled to procedural rights under Articles 12-15.

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 Articles 12-15.

5.5.8 EXPEDITED CREDENTIALING. Expedited review and approval for credentialing may be achieved for an initial appointment to membership/granting of privileges or for reappointment to membership/renewal of privileges when a completed application raises no concerns, and there is no intended limitation on the duration of the privileges sought:

(a) Section Chief, Department Chair approves application;

(b) Credentials Committee Chair (or designee) acting on behalf of the Credentials approves application;

(c) MEC subcommittee consisting of at least two members approves application; and

(d) Board committee consisting of at least two individuals approves the application.

If at any point in the evaluation process a concern is raised regarding the application, the expedited credentialing process is terminated and the application is returned to the standard approval process. Such re-classification of the application for consideration shall not be deemed to be an adverse action relative to the applicant.

Applications with the following conditions are ineligible for expedited credentialing:

(a) Application is incomplete;

(b) Medical Executive Committee has made a recommendation that is adverse or that limits or restricts an applicant's privileges; or

(c) There has been a historical adverse action against the applicant that involuntarily limited or restricted the applicant's privileges.

5.5.-9 TEMPORARY PRIVILEGES.

(a) The CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances:

(i) Fulfill an Important Patient Care, Treatment or Service Need:

Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure and current competence.

(ii) Initial Applicant With Complete Application Awaiting Review and Approval:

(b) Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. The applicant must meet all stipulations of the credentialing process up to and including recommendation by the Credentials Committee. Criteria for granting temporary privileges in these circumstances include no current challenges or previously successful challenges to licensures or registrations; no involuntary terminations of medical staff membership at another organization; no involuntary limitations, reduction, denial or loss of clinical privileges at another organization; no issues of significant concern to the Credentials Committee, the Section Chief or the Chief Medical Officer.

Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws and policies control all matters relating to the exercise of clinical privileges.

The CEO, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when reasonable, in choosing a substitute practitioner.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Articles 12-15 these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.5.10 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.

5.5.11 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.

5.5.12 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.

5.8 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

5.8.1 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. The request shall be submitted for approval to the Governing Body.

5.8.2 <u>EFFECT OF APPLICATION</u>. 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.

5.8.3 <u>STANDARDS AND PROCEDURE FOR REVIEW</u>. 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 inquiries 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 Service Chief at the time of the Member's reappointment.

5.8.4 <u>IN THE EVENT OF PROCESSING DELAY</u>. 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 shall be presented to the President of the Medical Staff for consideration and approval and submitted to the CEO for a final decision. 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.

5.8.5 <u>FAILURE TO FILE REAPPOINTMENT APPLICATION</u>. 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 the President of the Medical Staff and presented to the CEO for a final decision. 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 Articles 12-15 shall not apply.

5.9 LEAVE OF ABSENCE

5.9.1 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.

5.9.2 TERMINATION OF LEAVE. At least ten (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 Articles 12-15 hereof and shall be required to reapply.

5.9.3 FAILURE TO REQUEST REINSTATEMENT. If a Member fails to provide written notice of the termination of a leave of absence as described in 5.9.2 without good cause as determined in good faith by the Medical Executive Committee, the Member shall be deemed to have voluntarily resigned from the Medical Staff. This shall result in automatic termination of Medical Staff membership, clinical privileges, and prerogatives. A Member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Articles 12-15. Instead, such Member shall be permitted to submit a written request for

reinstatement to the CEO, solely addressing the question of whether the failure to request reinstatement was unintentional or excusable. There shall be no appeal from a decision of the CEO. 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.

5.9.4 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 BASIS 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 Orthopaedic 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.

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

6.6 TEMPORARY CLINICAL PRIVILEGES

6.6.1 The CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

(a) Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure and current competence.

(b) Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. The applicant must meet all credentialing requirements up to and including recommendation by the Credentials Committee. Criteria for granting temporary privileges in these circumstances include no current challenges or previously successful challenges to licensures or registrations; no involuntary termination of medical staff membership at another organization; no involuntary limitations, reduction, dental or loss of clinical privileges at another organization; no issues of significant concern to the Credentials Committee, the Department Chair or the CMO.

Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws and policies control all matters relating to the exercise of clinical privileges.

(c) Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

(d) Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Articles 12-15 of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

6.7 DISASTER PRIVILEGES.

A disaster is defined as any officially declared local, state or national disaster for which this institution's emergency management plan has been activated.

(a) If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

(i) A current picture hospital ID card that clearly identifies professional designation;

(ii) A current license to practice;

(iii) Primary source verification of the license;

(iv) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

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

(vi) Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

(b) The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

(c) The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster privileges should be continued.

(d) Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be

performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

(e) Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

(f) Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

6.8 EMERGENCY PRIVILEGES.

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 Articles 12-15 will not apply.

6.10 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, be made subject to monitoring. Action on such recommendation shall follow the procedures substantially as set forth in Section 5.5. In the event the recommended change is a limitation of privileges requested or already granted, then the practitioner may be entitled to a fair hearing and appeal rights set forth in Articles 12-15.

6.11 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 Articles 12-15.

6.12 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 or otherwise provide clinical treatment to a patient at the Hospital 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.

6.13 AFFILIATE STAFF

Privileged Affiliate Staff shall include designated health care professionals; including but not limited to nurse anesthetists, nurse midwives, nurse practitioners, physician assistants, physicists, surgical first assistants and other Health Care Professionals certified or licensed by an appropriate body and such other individual practitioners as shall be designated from time to time by the President of the Medical Staff with approval of the Medical Executive Committee.

Such individuals shall be appointed in one of the Services of the Medical Staff, shall not have the privilege to admit inpatients, and shall serve patients who are the primary responsibility of members of the Medical Staff. Clinical privileges or job descriptions of the Affiliate Staff shall be delineated by the appropriate Service Chief with the approval of the Medical Executive Committee. In each category, they shall be appointed by the Governing Body after submission of an application and recommendation by the appropriate Chief, the Credentials Committee, and Medical Executive Committee. The process for granting clinical privileges for Affiliate Staff shall follow the procedures in the Clinical Privileges section of these Bylaws.

Members of this Affiliate Staff are not deemed to be members of the Medical Staff; the various provisions of these Bylaws shall apply to the Affiliate Staff only where specifically provided or where the context requires application.

6.13.1 QUALIFICATIONS

The Affiliate Staff shall consist of members who:

(a) meet the general qualifications set for in Article 3, excluding the requirement for Faculty Appointment with the School of Medicine or Dentistry;

(b) regularly care for patients under the supervision of a member of the Attending Medical Staff, or be regularly involved in the activities of the Medical Center;

All allied health practitioners are authorized to practice within their scope of practice and as specified in their delineation of privileges or approved job description.

A member of the Affiliate Staff who is required to have a supervising physician may not exercise any clinical privileges if there no longer is a supervising physician. In the event that a member of this staff who is required to have a supervisory physician no longer is sponsored by that physician, the member immediately shall notify the President of the Medical Staff and provide the name of the new supervisory physician or be deemed to have resigned from the Affiliate Staff.

6.13.2 PREROGATIVES

The prerogatives that may be extended to an Affiliate Staff member may include:

(a) Provision of specified safe patient care, treatment and services under the supervision or direction of an Active Medical Staff member and consistent with the standardized procedures or protocols granted to the Affiliate Staff and within the scope of the Affiliate Staff's licensure or certification;

(b) Serve on Medical Staff, Department, Clinical Service and Hospital Committees, as otherwise designated in the Medical Staff Bylaws; and

(c) Attendance at meetings of the Department and Clinical Service to which the Affiliate Staff is assigned, as permitted by the Department, and attendance at education programs relevant to the Affiliate Staff member's field of practice.

6.13.3 RESPONSIBILITIES

Each Affiliate Staff member shall:

(a) Meet the responsibilities required by the Policies of the relevant Department and those responsibilities specified in Section 3.5 of these Bylaws as are deemed to be applicable to the limited scope of practice of the Affiliate Staff member;

(b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services;

(c) Participate, as appropriate, in patient care audits and other quality review,

evaluation and monitoring responsibilities required of Affiliate Staff members, and in discharging such other functions as may be required by the Medical Staff from time to time;

(d) Notify the Service Chief and Medical Staff Office in writing immediately upon any action taken or initiated that could result in a change of license, DEA registration, participation in any program or plan for the reimbursement of services, professional liability coverage, membership or employment status or clinical privileges at other health care institutions or affiliations and the initiation, status and resolution of malpractice claims.

(e) Abide by the Bylaws and Hospital Policies and Procedures as well as the policies of the Department in which he/she participates.

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 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; and

(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; 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;

(o) 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; and

(p) 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.

8.3.3 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.

In the event there is a conflict between the Board and the Medical Staff or MEC, involving issues of patient care or safety, the matter may be resolved in the following ways:

(a) At the request of the MEC, the matter may be submitted to a Joint Conference Committee. The Joint Conference Committee shall be made up of three members of the MEC chosen by the President of the Medical Staff, and three members of the Board, chosen by the Chair of the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

(b) To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff; the Chair of the Board, CEO, or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.3.5 <u>AUTHORITY OF MEDICAL EXECUTIVE COMMITTEE</u>. 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.

8.3.6 <u>REMOVAL FROM MEDICAL EXECUTIVE COMMITTEE.</u> Removal of an at large member (as referenced in section 8.3.1 (g)) of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Executive Committee, by a two-thirds vote of the voting staff, or by the Board, should the member suffer a loss or significant limitation of clinical privileges, or if any other good cause exists. At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to address the Medical Executive Committee, the voting staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

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; and

(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, Chief Clinical Officer, Chief Quality 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 coordinating all performance improvement activities;

(i) facilitating multidisciplinary departmental Quality Management activities;

(ii) prioritizing improvement efforts;

(iii) commission of quality improvement teams; and

(iv) 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 (The Joint Commission, Medicare, NCQA, Maryland State); and

(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 a triannual review of the Medical Staff Bylaws;

(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, and 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 a subcommittee of the Medical Executive Committee composed of not fewer than (6) Active Members of the Medical Staff, including representatives of the Divisions of Surgical Critical Care, Pulmonary Critical Care, Pediatric Critical Care, Program in Trauma, and Departments of Emergency Medicine and Anesthesiology. In light of the multidisciplinary and multi-professional collaborative nature of Resuscitation, members will also include an appointed member from the nursing code blue committee, nurse leader of the Rapid Response team, member from Maryland Express Care, the nurse managers of the ICUs, Respiratory Therapy, Pharmacy, Patient Quality, Information technology, equipment management, hospital communications, and other individuals on an ad hoc basis. Additional members will be appointed at the discretion of the Chair as appropriate.

8.9.2 DEFINITION. Resuscitative care encompasses identification of patients at risk of acute demise, provide appropriate level of bedside care to those patients to either forestall physiologic worsening or intervene when physiologic deterioration occurs, to provide safe and appropriate immediate triage for those patients.

8.9.3 DUTIES. The Resuscitation Committee shall:

(a) Serve as a multidisciplinary forum to develop, initiate, coordinate, sustain and be responsible for efforts to improve quality of resuscitative care, patient safety, and enhancement of resuscitation resource utilization across UMMC medical center;

(b) Review clinical, operational and financial data to identify quality and performance improvement opportunities for resuscitation;

(c) Develop, modify, and approve policies, procedures, guidelines, protocols and order sets related to resuscitation practice to reflect current evidenced-based best practice that will enhance clinical care, resource utilization, education, and financial performance of critical care units;

(d) Promote standardization, where appropriate, of clinical care processes, and resources across UMMC hospital Units, and ensure unique, specialized care capabilities where appropriate.

(e) Provide recommendations and action plans to the medical center regarding policies and procedures and capital expenditures that impact resuscitation effort;

(f) Identify and promote the development and implementation of educational opportunities related to resuscitation practices;

(g) Provide medical and nursing leadership to facilitate compliance of policies and practice with Joint Commission and other regulatory agencies that relate to resuscitation;

(h) Assure adherence to the Medical Staff bylaws and hospital policies as they relate to patient care.

8.9.4 MEETINGS. The Resuscitation Committee will meet at least 10 times per year. Attendance and minutes will be maintained for each meeting.

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

(h) Neurology/Rehabilitation Service

(i) 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 <u>FUNCTIONS OF SERVICES</u>. 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 semi-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; and

(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, 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;

(o) provide for an appropriate alternate to discharge his or her responsibilities in times of absence or disability; and

(p) 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; and

(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, or 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 Courtesy 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) calendar 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. Only non-confidential business shall be conducted when a telephone conference meeting is held unless each meeting member confirms orally, documented in the meeting minutes, that any confidential business cannot be heard by individuals not authorized to hear that information. 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.
COLLEGIAL, EDUCATIONAL, AND/OR INFORMAL PROCEEDINGS REGARDING CLINICAL PRACTICE AND/OR PROFESSIONAL CONDUCT

11.1 CRITERIA FOR INITIATION. Medical staff leaders and hospital management are encouraged to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct

when it is appropriate to do so. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. Collegial intervention efforts may include but are not limited to the following:

(a) Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

(c) Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

11.2 INVESTIGATIONS

11.2.1 INITIATION. A request for an investigation must be submitted in writing by a medical staff officer, committee chair, Department Chair, CEO, CMO, CQO or hospital board chair to the MEC. The request should be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall document its reasons.

11.2.2 INVESTIGATION. If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. Alternatively, the committee may appear before the MEC to present its findings, conclusions and recommendations

orally. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, including the practitioner in question, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. Any meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to a meeting and shall not have a right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

11.2.3 EXTERNAL PEER REVIEW. An external peer review consultant should be considered when:

(a) Litigation seems likely;

(b) The hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer; and

(c) There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

11.2.4 MEC ACTION. As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

(a) Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

(b) Deferring action for a reasonable time when circumstances warrant;

(c) Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or

Department Chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;

(d) Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

(e) Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

(f) Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

(g) Recommending suspension, revocation, or probation of Medical Staff membership; or

(h) Taking other actions deemed appropriate under the circumstances.

11.3. CORRECTIVE ACTION.

11.3.1 AUTOMATIC RELINQUISHMENT/VOLUNTARY RESIGNATION. In the following triggering circumstances, the Practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff, with the approval of the CMO, may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty days, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

(a) Licensure.

(i) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

(ii) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that 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.

(iii) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status 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.

(b) Medicare, Medicaid, Tricare. (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

(c) Controlled Substances.

(i) DEA certificate: Whenever a Practitioner's United States Drug Enforcement Agency (DEA) certificate or Maryland Controlled Dangerous Substance (CDS) registration is revoked, limited, or suspended, the practitioner will 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.

(iii) Probation: Whenever a practitioner's DEA certificate or Maryland Controlled Dangerous Substance (CDS) registration is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

(d) Loss of Faculty Appointment. A practitioner 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.

(e) Failure to Maintain Requirements of Membership. A practitioner who fails to maintain the requirements of Medical Staff membership delineated in these Bylaws shall be automatically suspended from exercising all clinical privileges at the Hospital until the requirements have been met to the satisfaction of the Medical Executive Committee or further action is taken under these Medical Staff Bylaws or by the Governing Body.

(f) Medical record completion requirements. A Practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the

MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies. In the event of repeated violations, the practitioner will be required to attend MEC for further action.

(g) Professional liability insurance. Failure of a Practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a Practitioner's clinical privileges. If within 60 calendar days of the relinquishment the Practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The Practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

(h) Medical Staff dues/special assessments. Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a Practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the Practitioner shall be considered to have voluntarily resigned membership on the medical staff.

(i) Health screening and immunization requirements. The Governing Body establishes these requirements for the entire campus, including employees, voluntary medical staff, and volunteers. Whenever such requirements may affect the Medical Staff, or Members of the Medical Staff, the Board will seek the input of the MEC prior to finalizing any requirement, including input regarding limitations and/or sanctions for failure to comply with requirements, except where the immunization/health screening is required by state or federal law/regulation or accreditation/licensing agency standard. Failure to promptly comply with health screening and immunization requirements shall be considered an automatic limitation of a Practitioner's membership and privileges, as described in any requirement established by the Board. If within sixty (60) calendar days after written warning of the delinquency the practitioner does not comply with the policy or the described limitations, the practitioner shall be considered to have voluntarily accepted the sanctions described in the requirement, without the right to a hearing.

(j) Felony conviction. A Practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, or physical/sexual abuse in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

(k) Failure to satisfy the special appearance requirement. A Practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws, including any meeting requested by a committee in pursuit of an investigation of the Practitioner, shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the Practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

(l) Failure to participate in an evaluation. A Practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

(n) Failure to Execute Release and/or Provide Documents. A Practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the Practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

11.3.2. MEC DELIBERATION. As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

11.3.3 PRECAUTIONARY (SUMMARY) RESTRICTION OR SUSPENSION

(a) Criteria for Initiation. A precautionary (summary) restriction or suspension may be imposed when a good faith belief exists that:

(i) immediate action must be taken to protect the life or well-being of patient(s); or

(ii) to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person;

(iii) when medical staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution; or

(iv) the reputation of the hospital is at risk.

Based on any of the criteria listed above, the MEC or any two of the following: CEO or designee, President of the Medical Staff or designee, or CMO may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. In addition, a suspension of all or any portion of a practitioner's clinical privileges at another hospital or indictment for a capital crime may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the Chair of the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the President of the Medical Staff or designee, considering the patient in the choice of a substitute practitioner, and where feasible, the wishes of the affected practitioner.

11.3.4 <u>MEC action</u>. As soon as feasible and within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

11.3.5 Procedural rights: If the restrictions or suspension last more than fourteen (14) calendar days, the practitioner shall be entitled to the procedural rights afforded by this hearing and appeal plan.

ARTICLE 12.
INITIATION AND NOTICE OF HEARING

12.1 INITIATION OF HEARING.

Any practitioner eligible for medical staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by

the following “adverse actions” when the basis for such action is related to clinical competence or professional conduct:

(a) Denial of medical staff appointment or reappointment;

(b) Revocation of medical staff appointment;

(c) Denial or restriction of requested clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;

(d) Involuntary reduction or revocation of clinical privileges;

(e) Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

12.2 HEARINGS WILL NOT BE TRIGGERED BY THE FOLLOWING ACTIONS

(a) Issuance of a letter of guidance, warning, censure or reprimand;

(b) Imposition of a requirement for voluntary proctoring (i.e., observation of the practitioner’s performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;

(c) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

(d) Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

(e) Requirement to appear for a special meeting under the provisions of these bylaws;

(f) Automatic relinquishment or voluntary resignation of appointment or privileges;

(g) Imposition of a precautionary suspension out that does not exceed fourteen (14) calendar days;

(h) Denial of a request for leave of absence, or for an extension of a leave;

(i) Determination that an application is incomplete or untimely;

(j) Determination that an application will not be processed due to misstatement or omission;

(k) Decision not to expedite an application;

(l) Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

(m) Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

(n) Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

(o) Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

(p) Termination of any contract with or employment by hospital;

(q) Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

(r) Any recommendation voluntarily accepted by the practitioner;

(s) Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(t) Change in assigned staff category;

(u) Refusal of the Credentials and Bylaws Committee or MEC to consider a request for appointment, reappointment, or privileges within ten (10) years of a final adverse decision regarding such request;

(v) Removal or limitations of emergency department call obligations;

(w) Any requirement to complete an educational assessment;

(x) Retrospective chart review;

(y) Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

(z) Grant of conditional appointment or appointment for a limited duration; or

(aa) Appointment or reappointment for duration of less than 24 months.

12.3 NOTICE OF RECOMMENDATION OF ADVERSE ACTION.

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall, within a reasonable timeframe, be given written notice by the CEO delivered either in person or by certified mail, return receipt requested or via email with read receipt. This notice shall contain:

(a) A statement of the recommendation made and the general reasons for it (Statement of Reasons);

(b) Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

(c) Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

(d) The individual shall receive a copy of this section of these bylaws outlining procedural rights with regard to the hearing.

12.4 REQUESTS FOR HEARING.

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CEO or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final board action.

12.5 NOTICE OF HEARING AND STATEMENT OF REASONS.

Upon receipt of the practitioner's timely request for a hearing, the CEO shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

(a) The time, place, and date of the hearing;

(b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;

(c) The names of the hearing panel members and presiding officer or hearing officer, if known; and

(d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

12.6 WITNESS LIST.

At least seven (7) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses and the length of the testimony.

ARTICLE 13.
HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER

13.1 HEARING PANEL.

(a) When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel, and any alternates, will be appointed by a joint decision of the CEO and the President of the Medical Staff. No individual appointed to the hearing panel, or as an alternate, shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel, or as an alternate. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel or as an alternate. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members, and alternates, shall be clinical practitioners. Panel members, including alternates, need not be clinicians in the same specialty as the member requesting the hearing.

(b) The hearing panel, including alternates, shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

(c) The CEO or designee shall notify the practitioner requesting the hearing of the names of the panel members, including alternates, and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel, including alternates, or to the hearing officer or presiding officer shall be made in writing to the CEO, citing all arguments regarding those objections, who, in conjunction with the President of the Medical Staff, shall determine whether a replacement panel member should be utilized. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member’s participation. Final authority to appoint panel members will rest with the CEO and the President of the Medical Staff.

13.2 HEARING PANEL CHAIRPERSON OR PRESIDING OFFICER.

In lieu of a hearing panel chair, the CEO, acting for the Board and after considering the recommendations of the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous history with either the hospital or the practitioner, except that an attorney who has acted as a hearing officer at this hospital or another hospital within the University of Maryland Medical System shall not be excluded solely on the basis of their previous history as a hearing officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

13.2.1 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.

13.2.2 The presiding officer (or hearing panel chair) shall do the following:

(a) Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

(b) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. Maintain decorum throughout the hearing;

(c) Determine the order of procedure throughout the hearing;

(d) Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

(e) Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

(f) Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

(g) Seek legal counsel when s/he feels it is appropriate. An attorney may serve as legal counsel to the presiding officer or panel chair and may be present at the hearing. However, legal counsel may not vote or advocate for or against any party. Their role is limited to providing legal services, including counsel regarding procedure and the Medical Staff Bylaws.

13.3 <u>HEARING OFFICER</u>

13.3.1 As an alternative to the hearing panel described above, the CEO, acting for the Board and in conjunction with the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

13.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

ARTICLE 14.
PRE-HEARING AND HEARING PROCEDURE

14.1 PROVISION OF RELEVANT INFORMATION

14.1.1 PRE-HEARING AND HEARING PROCEDURE

There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

(a) Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

(b) Reports of experts relied upon by the MEC;

(c) Copies of redacted relevant committee minutes;

(d) Copies of any other documents relied upon by the MEC or the Board;

No information regarding other practitioners shall be requested, provided, or considered and evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

14.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

14.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

14.2 PRE-HEARING CONFERENCE.

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

14.3 FAILURE TO APPEAR.

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

14.4 RECORD OF HEARING.

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but preparation and copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Maryland.

14.5 RIGHTS OF THE PRACTITIONER AND THE HOSPITAL

At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

To call and examine witnesses to the extent available;

(a) To introduce exhibits;

(b) To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

(c) To have representation by counsel or other person as desired who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Both sides shall notify the other of the name of their counsel or representative at least ten (10) calendar days prior to the date of the hearing;

(d) To submit a written statement at the close of the hearing.

Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

14.6 ADMISSIBILITY OF EVIDENCE.

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

14.7 BURDEN OF PROOF.

It is the burden of the practitioner to prove by clear and convincing evidence that the recommendation(s) for corrective action is not substantiated.

14.8 POST-HEARING MEMORANDA.

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

14.9 OFFICIAL NOTICE.

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

14.10 POSTPONEMENTS AND EXTENSIONS.

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer or the CEO on a showing of good cause.

14.11 PERSONS TO BE PRESENT.

The hearing shall be restricted to those individuals involved in the proceeding. As requested by the President of the Medical Staff or CEO, administrative personnel and critical others who may include but not be limited to legal counsel, President of the Medical Staff, Department Chairs and the Chief Medical Officer may be present. All members of the hearing panel shall be present for all stages of the hearing and deliberations.

14.12 ORDER OF PRESENTATION.

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

14.13 ADJOURNMENT AND CONCLUSION.

The presiding officer may adjourn the hearing and reconvene the same as needed and as reasonable to complete the presentation of the evidence. The presiding officer or CEO shall have the ultimate authority regarding the length of the hearing. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

14.14 BASIS OF RECOMMENDATION.

The hearing panel shall recommend against the person who is requesting the hearing unless it finds that the requesting party has proven by clear and convincing evidence that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence or was otherwise unfounded.

14.15 DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL.

Within thirty (30) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed and a scribe as needed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

14.16 DISPOSITION OF HEARING PANEL REPORT.

The hearing panel shall deliver its report and recommendation to the CEO who shall forward it, along with all supporting documentation, to the Board for further action. The CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested; via tracked mail service; or hand-delivery to the individual who requested the hearing, and to the MEC for information and comment.

ARTICLE 15.
APPEAL TO THE HOSPITAL BOARD

15.1 TIME FOR APPEAL.

Any appeal of the hearing panel's recommendation, either by the practitioner subject to the hearing or the MEC must be received within ten (10) days of receipt of that recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such

appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the board.

15.2 GROUNDS FOR APPEAL.

The grounds for appeal shall be limited to the following:

(a) There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

(b) The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

(c) The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

15.3 TIME, PLACE, AND NOTICE.

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

15.4 NATURE OF APPELLATE REVIEW

(a) The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

(b) The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but preparation and copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Maryland.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

(d) The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

15.5 FINAL DECISION OF THE HOSPITAL BOARD

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the Credentials and Bylaws Committee and MEC, in person or by certified mail, return receipt requested.

15.6 RIGHT TO ONE APPEAL ONLY

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

15.7 FAIR HEARING AND APPEAL FOR THOSE WITH PRIVILEGES WITHOUT MEDICAL STAFF MEMBERSHIP AND WHO ARE NOT PHYSICIANS OR DENTISTS.

Allied Health Professionals are not entitled to the hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The allied health practitioner and the supervising physician must request such a meeting in writing to the CEO within 10 working days from the date of receipt of such notice. At the meeting, the allied health practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the medical staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board.

The allied health practitioner and the supervising physician may request an appeal in writing to the CEO within 10 days of receipt of the findings of the review body.

The grounds for appeal shall be limited to the following:

(a) The recommendation by the MEC was made arbitrarily, capriciously or with prejudice; or

(b) The recommendation of the MEC was not supported by substantial evidence.

Two (2) members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within 10 days of the final decision of the Board.

ARTICLE 16.
CONFIDENTIALITY, IMMUNITY AND RELEASES

16.1 CONFIDENTIALITY OF INFORMATION

16.1.1 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.

16.1.2 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.

16.2 IMMUNITY FROM LIABILITY

16.2.1 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.

16.2.2 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.

16.3 ACTIVITIES AND INFORMATION COVERED

16.3.1 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.

16.4 **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 17.
GENERAL PROVISIONS ON GOVERNANCE

17.1 **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.

17.2 **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.

17.3 **AUTHORITY TO ACT**.

Any Member or Members who act in the name of this Medical Staff, the Hospital or the Medical Center 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.

17.4 **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 Center, LLC
110 S. Paca Street
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 18.
ADOPTION AND AMENDMENT OF BYLAWS AND MEDICAL STAFF POLICIES

18.1 PROCEDURE.

The Medical Staff shall have the responsibility to formulate, review at least every three years, 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.

18.1.1 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 M**edical 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.

18.1.2 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.

18.2 APPROVAL.

Bylaw amendments approved by the MEC and the Medical Staff 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.

18.3 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. 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
Last Approved by the Medical Executive Committee:	1/5/15
Approved by the Board of Directors:	1/27/15
Last Approved by the Medical Executive Committee:	9/27/2017
Approved by the Board of Directors:	9/29/2017
Last Approved by the Medical Executive Committee:	11/20/2019
Approved by the Board of Directors:	2/20/2020
Last Approved by the Medical Executive Committee:	4/9/2021
Approved by the Board of Directors:	4/19/2021