Medical Staff Bylaws

2020

100 Hospital Road, Prince Frederick, Maryland 20678

Bylaws of the Medical Staff of CalvertHealth Medical Center

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PREAMBLE

WHEREAS, Calvert Health Medical Center is a not-for-profit corporation organized under the laws of the State of Maryland; and
WHEREAS, its purpose is to serve as a general medical center providing patient care, education and research; and
WHEREAS, it is medical center policy not to deny patient care on the basis of sex, age, race, creed, color or national origin; and
WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the medical center and must accept and discharge this responsibility, subject to the ultimate authority of the medical center Board of Directors, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board of Directors are necessary to fulfill the medical center's obligations to its patients; THEREFORE, the physicians, podiatrists and allied health professionals practicing in this medical center hereby organize themselves into a Medical Staff in conformity with these bylaws.

DEFINITIONS

1. ACTIVE STAFF MEMBER WITH CLINICAL PRIVILEGES—a duly licensed and qualified practitioner, who regularly admits patients to the medical center or regularly practices a medical center-based specialty at the medical center and is permitted to vote and hold office. Active staff members support the medical center community by maintaining a professional office within 25 miles of the medical center.

2. ACTIVE STAFF MEMBER WITHOUT CLINICAL PRIVILEGES—a duly licensed and qualified practitioner who does not admit patients but maintains competency by working in an office setting and refers patients for admission to medical center services and is permitted to vote and hold office with some restrictions. Active staff members support the medical center community by maintaining a professional office within 25 miles of the medical center.

3. ADJUNCT MEMBER—an individual who serves as a non-voting member of a body by virtue of an office or position held.

4. ALLIED HEALTH PROFESSIONAL (AHP)—a licensed heath care provider, other than a licensed physician or podiatrist, approved by the Board of Directors to exercise clinical privileges at the medical center consistent with these Medical Staff bylaws and the rule, regulations, and policies of the medical center, including but not limited to physician assistants, certified registered nurse anesthetists, certified registered nurse practitioners and certified nurse midwives.

5. BOARD OF DIRECTORS—the governing body of the corporation; referred to herein as "the Board."

6. CHIEF EXECUTIVE OFFICER—the individual appointed by the Board to act on its behalf as the overall administrative agent of the medical center.

7. CLINICAL PRIVILEGES OR PRIVILEGES—the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

8. DENTIST—an individual with a D.D.S. or D.M.D. degree who is fully licensed to practice dentistry in all its phases.

9. EX-OFFICIO—serving as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, possessing voting rights.

10. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)—an evaluative process used to assess competence and clinical practice of a practitioner who (1) is new to the organization, (2) is a known practitioner requesting new privileges, or (3) when questions arise about whether a practitioner can continue to provide safe, high-quality care. Monitoring methods include but are not limited to prospective proctoring, concurrent proctoring and retrospective evaluation.

11. GOOD STANDING—a status achieved when during the current term of appointment the physician has maintained all qualifications for his/her category of Medical Staff membership; has not received a limitation, suspension or restriction of Medical Staff membership or privileges, is in compliance with all Medical Staff obligations, and is not in arrears of Medical Staff dues.

12. JOINT QUALITY IMPROVEMENT COMMITTEE (JQIC)—a committee of the Board composed of an equal number of Board members and Medical Staff members.

13. MEDICAL CENTER REPRESENTATIVES—persons including the members of the Board, its directors and committees; the Chief Executive Officer or his/her designee; the Medical Staff organization and all Medical Staff members, departments and committees that have responsibility for collecting or evaluating an applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

14. MEDICAL STAFF OR STAFF—the formal organization of all licensed physicians, allied health professionals and podiatrists who have been recommended by the Medical Staff and granted membership by the Board.

15. MEDICAL STAFF YEAR—a 12-month period beginning with the annual meeting of the Medical Staff.

16. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)—a process conducted to evaluate a practitioner's on-going competence and clinical practice that utilizes outcome and performance data including, but not limited to, direct observation, practice patterns, patient outcomes, peer review data, and core measures.

17. PEER—an individual practicing in the same profession and who has expertise in the appropriate subject matter. For peer review matters, the level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well trained and competent in that surgical specialty.

18. PHYSICIAN—an individual with an M.D. or D.O. degree who is fully licensed to practice medicine in all its phases.

19. PODIATRIST—an individual with a D.P.M. degree who is fully licensed to practice podiatry.

20. PRACTITIONER—unless otherwise expressly limited, any physician, dentist, podiatrist or allied health professional applying for or exercising clinical privileges in this medical center.

21. PREROGATIVE—a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional and exercisable subject to the conditions imposed in these bylaws and in other medical center and Medical Staff rules, regulations, and policies.

22. PROFESSIONAL PERFORMANCE REVIEW—concurrent or retrospective review of a health professional's performance of clinical professional activities through formal written procedures, including OPPE, FPPE, and peer review.

23. QUORUM—the requirement for a quorum provides protection against totally unrepresentative action in the name of the whole body by an unduly small number of persons.

a. Medical Staff meetings: those present, but no less than 35% of the voting Medical Staff

b. MEC, Credentials Committee: 50% + 1 of members

c. Department/clinical service meetings or Medical Staff committees other than those listed previously: those present

24. SPECIAL NOTICE—written notification delivered in person or by certified mail.

25. VICE PRESIDENT MEDICAL AFFAIRS (VPMA)—a practitioner, employed by or otherwise serving the medical center on a full- or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. The clinical responsibilities are defined as those involving professional capability as a practitioner that require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners under his/her direction.

MISSION STATEMENT

Calvert Health's trusted team provides Southern Maryland residents with safe, high quality health care and promotes wellness for a healthy community.

ARTICLE 1: NAME

The name of this organization will be the Medical Staff of Calvert Health Medical Center, Prince Frederick, Maryland.

ARTICLE 2: PURPOSES AND RESPONSIBILITIES

2.1. Purposes. The Medical Staff will be a single organized body whose purposes are:

2.1.1. to assure the Board of Directors that every patient treated at Calvert Health Medical Center receives equal care;

2.1.2. to account to the Board for the professional performance and ethical conduct of its members and to continually improve the process of patient care and resulting patient outcome, consistent with the state of the healing arts and the resources locally available;

2.1.3. to provide an organizational structure through which individual practitioners may obtain membership and fulfill their obligations as staff practitioners;

2.1.4. to provide a means through which practitioners may collaborate with the Board and medical center administration in the development of medical center policies and strategic planning and in the selection of leadership.

2.2. Responsibilities of the Medical Staff. In order to fulfill the responsibilities inherent in the above purposes, the Medical Staff will:

2.2.1. monitor and evaluate the quality of patient care through effective peer review procedures, both retrospectively and concurrently;

2.2.2. establish, maintain, improve and enforce professional practice standards, which allow continuous quality improvement;

2.2.3. initiate mechanisms for appointment, reappointment and the matching of clinical privileges or specified services with the verified credentials and current demonstrated performance of applicants;

2.2.4. encourage continuing education, fashioned at least in part on the needs demonstrated through the quality improvement and evaluation program;

2.2.5. participate in ongoing utilization review to provide for the appropriate allocation of inpatient medical and health services to patients;

2.2.6. initiate and pursue corrective action with respect to practitioners, when warranted;

2.2.7. make regular reports and recommendations to the Board concerning the implementation, operation and outcomes of the quality improvement and evaluation activities;

2.2.8. recommend to the Board action with respect to elections, appointments, reappointments, staff category and department assignments, clinical privileges and discipline;

2.2.9. assist in identifying community health needs and in setting appropriate goals and implementing programs to meet those needs;

2.2.10. make its members available to serve on various Board committees;

2.2.11. adopt, amend and enforce the Medical Staff bylaws, Medical Staff rules and regulations, and medical center policies. The organized Medical Staff will make recommendations to the Board when appropriate and take action to enforce the bylaws when necessary;

2.2.12. provide through clinical service lines an on-call schedule to the Emergency Department for unassigned patients who require admission to the medical center and/or outpatient follow-up; and

2.2.13. exercise the authority granted by these bylaws as necessary to fulfill adequately the foregoing responsibilities.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

3.1. Scope of Medical Staff membership. Membership on the Medical Staff will be open to qualified physicians, dentists, podiatrists, and AHPs, licensed to practice in the State of Maryland, who meet the requirements of this article and of Article 7, and for whom there is a demonstrated community need. Licensure is not necessary for Honorary staff membership. It is the responsibility of the Board, after considering the recommendations of the Medical Executive Committee (MEC), to determine what types of health care providers should be granted Medical Staff membership and/or clinical privileges based on the needs of the community served by the medical center and the capabilities of the medical center.

3.2. Organized Health Care Arrangement. All practitioners having clinical privileges at Calvert Health Medical Center or any related facility will be deemed to be part of an Organized Health Care Arrangement as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations (the Privacy Rule).

3.3. Professional criteria for membership with clinical privileges.

Membership on the Medical Staff and/or clinical privileges will be granted and continued by the Board in its sole discretion for those practitioners who demonstrate to the satisfaction of the Board that they meet the following continuing criteria, qualifications, and obligations: Medical Staff members must

3.3.1. Maintain a current, valid, unrestricted license that is not subject to any conditions, or have other authority to act pursuant to the laws of the State of Maryland, as well as any other licensure, registration, certification, or other authorization required by any regulatory authority to permit the practitioner to provide the appropriate health care service at the medical center.

3.3.2. Document their experience, background, specific training, demonstrated ability to perform the privileges requested, clinical results, current clinical competence, and physical and mental health status sufficiently to demonstrate that any patients treated by them have in the past and will in the future receive care of an appropriate level of professional quality, efficiency, and cost effectiveness.

3.3.3. Demonstrate a willingness and capability to:

3.3.3.1. work with other members of the Medical Staff, health care providers, medical center administration, management, and employees, visitors, and the community in general in the cooperative and professional manner that is essential for maintaining a medical center environment appropriate to quality health care;

3.3.3.2. participate in the performance of Medical Staff obligations and discharge such staff, committee, department, and other medical center functions for which he/she is responsible by staff category, assignment, appointment, election, or otherwise;

3.3.3.3. adhere to generally recognized standards of professional and personal ethics and conduct;

3.3.3.4. prepare and complete in a timely fashion the medical and other required records for all patients for whom the member provides care in the medical center; and

3.3.3.5. in all circumstances act appropriately to provide information and education to and communicate with patients and their families so that they are adequately informed about the patient's condition, prognosis, plan of care, and risks and benefits of proposed treatment, and can give informed consent for treatment when warranted.

3.3.4. Abide by the Medical Staff and medical center bylaws, rules, regulations, policies, and procedures.

3.3.5. Satisfy any continuing education requirements established by the Medical Staff, the medical center, and any appropriate professional organizations or regulatory and licensing authorities.

3.3.6. Participate actively in the medical center and Medical Staff's performance improvement, peer review, patient safety, quality improvement, and risk management programs.

3.3.7. Agree that they will provide continuous care for their patients and be available and respond in person or by telephone to see patients in the medical center within a reasonable period of time to provide care to patients in the medical center, considering the needs of the patient.

3.3.8. Have not been excluded from or sanctioned by the Medicare or Medicaid programs or any other government program.

3.3.9. Upon request provide evidence of both physical and mental health status that does not impair the fulfillment of their responsibilities of Medical Staff membership and the exercise of the specific clinical privileges requested by and granted to applicants.

3.3.10. Have appropriate written and verbal communication skills.

3.3.11. Possess a current valid and unrestricted Drug Enforcement Administration (DEA) number if applicable.

3.3.12. Not have been involuntarily terminated from the Medical Staff of this medical center or any other health care facility, or resigned from this medical center or any other health care facility, while under

investigation in order to avoid investigation or disciplinary action, or following adverse recommendations by department chairs, credentialing committees, or MECs.

3.3.13. Not have their practitioner clinical privileges currently suspended at or not have been involuntarily terminated by any other health care facility.

3.3.14. Provide patient care in a dignified and courteous manner that does not exclude from participation in, deny the benefits of, or otherwise subject to discrimination in the provision of patient services on the basis of race, sex, religion, color, national or ethnic origin, disability, age, gender, gender identification, sexual orientation, or military service. Further, practitioners will not discriminate in the quality of patient services provided based on patient financial or insurance status or source of insurance.

3.4. Board certification

3.4.1. All initial applicants must eventually be board certified, demonstrating board eligibility or board certification in their area of expertise at the time of application. They must be board certified within five years after the applicant's governing board allows them to sit. If there is evidence that an applicant is not following due diligence in obtaining board certification, a special review may be initiated.

3.4.2. All applicants for reappointment must maintain their current level of board eligibility or certification in their primary areas of expertise. Members who have not maintained board certification due to extenuating circumstances may be granted renewal of privileges after review by the MEC and the Board if they can show evidence of clinical competence comparable to board certification as affirmatively established by the OPPE/FPPE process and meet all other criteria. The burden of proof in all cases is on the applicant.

3.5. Basic responsibilities of individual staff membership. By applying for Medical Staff membership and/or clinical privileges, each practitioner will agree to:

3.5.1. provide patients with continuous care in accordance with professional standards;

3.5.2. provide timely and effective communication of essential patient information, to facilitate a safe continuum of care, and in keeping with communication and documentation criteria as outlined in the rules and regulations;

3.5.3. abide by the Medical Staff bylaws, rules and regulations and all other lawful standards, policies and rules of the medical center, and adhere to the Code of Ethics as adopted by the American Medical Association, as well as any code of conduct or corporate responsibility program adopted by the medical center. These medical ethics encompass: competent care, compassion, respect of persons; upholding standards of professionalism; honesty; respect for the law; confidentiality; scientific knowledge; commitment to medical education; consultation; contributing to improvement of the community and betterment of public health; responsibility to the patient; and supporting access to medical care for all people;

3.5.4. discharge such staff, department, committee and medical center functions for which he/she is responsible by appointment, election, or otherwise;

3.5.5. maintain (in force) professional liability insurance for not less than the minimum limits of liability as established by the Board. At the beginning of each practitioner's policy year, he/she will supply to the medical center a signed authorized certificate of insurance that verifies compliance with this requirement. Each practitioner will provide the medical center with not less than 10 days' notice of a change of insurance carrier, notice of cancellation or reduction in policy limits or coverage. Medical Staff privileges will, at all times, be expressly conditioned upon active malpractice insurance. In order to comply with this requirement, the insurer must be licensed or authorized to do business in Maryland and/or must be otherwise acceptable to the medical center. Finally, the certificate evidencing the insurance must specify whether the policy is written or the insurance is afforded on an occurrence or claims made form. If claims made policies are used, the effective coverage dates must evidence continuing coverage (with appropriate retrospective endorsements or "nose" coverage) and, in the case of a physician withdrawing from the Medical Staff for any reason, evidence reasonable continuous coverage "tail" protection;

3.5.6. notify the Chief of Staff (COS) and/or CEO immediately in writing upon learning that he/she

3.5.6.1. is the subject of a complaint, investigation or disciplinary action taken by any federal, state or local disciplinary agency, commission or medical society or other healthcare organizations;

3.5.6.2. is or has been the subject of any actual or proposed disciplinary action, including any modification, suspension (other than medical records suspension), loss (voluntary or involuntary) or denial (voluntary or involuntary) of clinical privileges, restriction of clinical privileges, or placing of conditions on clinical privileges (including any form of monitoring or review), by any other hospital or health care facility or organization;

3.5.6.3. has developed any physical, mental or emotional limitation which could adversely affect his/her ability to deliver safe and effective medical care;

3.5.6.4. has had any restrictions, suspensions or revocation of Drug Enforcement Administration registration certification or Maryland Controlled Dangerous Substances Registration certification;

3.5.6.5. has been notified that he/she is or may be excluded from the Medicare or Medicaid program, is under investigation by Medicare or Medicaid, or has been subjected to any fine, penalty, or sanction by Medicare or Medicaid;

3.5.6.6. has been notified of his/her professional liability insurance carrier's intent to cancel, not renew, restrict or impose any conditions or deductibles on his/her professional liability insurance; or

3.5.6.7. has been charged with a misdemeanor carrying a potential jail sentence of more than 30 days or felony.

3.5.7. be familiar with the principles and standards of The Joint Commission (TJC) on and cooperate with the medical center in acquiring and maintaining TJC or other accreditation;

3.5.8. disclose to the MEC those direct or indirect personal, professional or financial affiliations or relationships of which he/she is reasonably aware could foreseeably result in a conflict of interest with activities or responsibilities on behalf of the Medical Staff;

3.5.9. immediately notify the Medical Staff office in writing of any change in his/her home or office address or telephone numbers so that the Medical Staff office has current addresses and telephone numbers at all times. The practitioner further agrees that any notice delivered to his/her home or office address, which is on file in the Medical Staff office, will be deemed conclusively to have been received by him/her. Any notice sent by regular mail will be expected to have been received not later than the fifth business day after the date the notice was mailed;

3.5.10. work with other members of the Medical Staff, health care providers, hospital management and employees, visitors and the community in general in the cooperative and professional manner that is essential for maintaining a medical center environment conducive to quality patient care and consistent with the values and operating principles of the medical center;

3.5.11. provide any information or documentation, including appropriate medical records, which may be required to answer any questions or resolve any issues concerning the practitioner's clinical competence or conduct, or to provide information concerning any matters or actions set forth in Section 3.5.6 or concerning whether the practitioner continually meets all the requirements and qualifications for Medical Staff membership and clinical privileges set forth in these bylaws;

3.5.12. submit any reasonable evidence of current health status that may be requested by the chair of the appropriate department, the COS, the Credentials Committee, or the MEC, and to submit to such mental or physical examination, including providing blood, urine, or other samples, as might be required by the department chair, the COS, the Credentials Committee, and/or the MEC, for any reason, including random, unannounced drug screens ordered without cause. If a practitioner fails or refuses to provide any requested evidence of current health status, including providing blood, urine, or other samples for testing for drug or alcohol use, he/she will be deemed to be no longer qualified for Medical Staff membership and clinical privileges, in which event the Medical Staff membership and clinical privileges may be terminated for administrative reasons and the practitioner will not be entitled to a hearing;

3.5.13. provide upon request access to an copies of the practitioner's office charts and records relating to the treatment of patients receiving care in the medical center if deemed necessary for the review of the practitioner's professional activities and current clinical competence;

3.5.14. maintain as confidential all information relating to the condition or treatment of patients, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care or actions or the qualifications, competence, or conduct of health care providers at the medical center;

3.5.15. acknowledge that having Medical Staff membership or clinical privileges confers on the practitioner only the right to treat his/her own patients in the medical center and does not automatically entitle any practitioner to receive referrals or participate in any service or program provided by the medical center or any affiliated organization or to treat patients coming to the medical center who do not specifically request treatment by the practitioner;

3.5.16. acknowledge that any material misstatement or omission, or failure to provide complete and accurate information in connection with any application for appointment, reappointment, or clinical

privileges, or any investigation concerning the practitioner's Medical Staff membership or clinical privileges, will be grounds for not processing an application for appointment or reappointment, immediate denial of the application for appointment or reappointment, or termination of Medical Staff membership and clinical privileges; and

3.5.17. disclose to the Medical Staff and medical center any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or medical center, pursuant to such policies as may be adopted by the Medical Staff and/or medical center.

3.6. Terms of appointment

3.6.1. Upon recommendation by the appropriate department chair, the Credentials Committee, and the MEC, and approval by the Board, appointments to the medical or allied health staff will be for a period not to exceed 24 months. Appointments and reappointments may be for less than two years if the Board determines it is necessary to establish an orderly system for renewal of appointments. In addition, the Board may, after considering the recommendations of the MEC, establish a shorter term of appointment or reappointment to permit further review or more frequent reappraisals of individual practitioners if determined to be necessary to assure that the practitioner's care, qualifications, competence, and/or conduct are appropriate. Appointment or reappointment for a period of less than two years will not entitle a practitioner to a hearing or other rights as set forth in the Fair Hearing and Appellate Review Plan.

3.6.2. Initial appointments

3.6.2.1. Any new practitioner will undergo a focused professional practice evaluation ("FPPE" or "focused evaluation") per Article 3.7. This review will occur for new practitioners and all newly requested and granted privileges. Upon satisfactory completion of the focused review, the FPPE period will be replaced by ongoing professional practice evaluation ("OPPE" or "ongoing evaluation").

3.6.2.2. Any concerns during OPPEs regarding the provision of safe, high quality care by a current Medical Staff member may be addressed by a focused review, as recognized through the professional performance review process.

3.6.2.3. A new member will not be allowed to vote on department matters including department elections for the first year during his/her appointment and in accordance with his/her staff category, and will not be allowed to vote or hold office at the General Staff meetings until he/she has been proctored and approved for appointment as outlined in Article 7 of the Medical Staff bylaws.

3.6.2.4. Except as otherwise determined by the Board, all initial appointments for any privileges held will be subject to a period of focused review. Each initial appointee will be assigned to a department where his/her performance will be reviewed by the chairman or designee of the department. The purpose of the focused review will be to determine eligibility for continued staff privileges in the staff category appointed and for exercising the clinical privileges granted in that department. Exercise of clinical privileges in any other department will also be subject to focused review by that department's members. An appointee will remain subject to focused review until he/she has furnished to the MEC and to the CEO a statement signed by the chair of the department to which he/she is assigned that the appointee meets all of the qualifications, has discharged all of the responsibilities and has not exceeded or abused the prerogatives of the staff category to

which he/she was appointed; and has satisfactorily demonstrated the ability to exercise the clinical privileges granted

3.6.3. Reappointments

3.6.3.1. After the initial appointment, practitioners must apply for reappointment.

3.6.3.2. Reappointments to any category of the Medical Staff will be for a period up to two years.

3.6.4. Appointments and reappointments of contract practitioners.

3.6.4.1. A contract practitioner must be a Medical Staff member achieving staff status in the same manner as all other practitioners. The contracted staff appointment or clinical privileges of any contracted practitioner or any employee, partner or principal of, or in, an entity that has a contractual relationship with the medical center to provide direct patient care services, will terminate automatically, immediately and without notice upon:

3.6.4.1.1. the expiration or other termination of the exclusive contractual relationship with the medical center; or

3.6.4.1.2. the expiration of such termination or the staff member with the entity that has the exclusive contractual relationship with the medical center.

3.6.4.2. In the event of such termination, no rights to a hearing or appellate review provided in the bylaws under Article 11 or the Fair Hearing and Appellate Review Plan will apply. Medical Staff appointment and clinical privileges of any contractual Medical Staff member will be contingent on the continued occupation of that position unless otherwise provided in the employment contract.

3.7. Term of Focused Professional Practice Evaluation (FPPE). A focused review period for initial appointment or modification of privileges will extend for no more than 24 months. Any and all pertinent data may be considered in keeping with the requirements of the health system policy on FPPE. If no data can be collected or reviewed and if there is no proof of involvement to justify membership with privileges at the facility, and if an initial appointee fails within that period to finalize the initial review required in Article 3.5.2, his/her staff membership or particular clinical privileges, as applicable, will come under immediate review. If a staff member requesting modification fails to complete the initial review within that period, the change in staff category or department assignment or the additional privileges, as applicable, will come under immediate review. The initial appointee or staff member so affected will be given special notice of such review. The ultimate responsibility to provide documentation will rest with the practitioner.

3.8. Modification of membership status or privileges. A practitioner may, either in connection with reappointment or at any other time, request modification of his/her staff category, department assignment, or clinical privileges by submitting a written application to the appropriate department chair containing such information as the medical center may require. A practitioner will be eligible for change in staff category if he/she has met all requirements for the category requested during the preceding year, unless this condition is

waived by the Board upon recommendation of the MEC. Such requests will be processed, to the extent appropriate, in substantially the same manner as provided in Section 3.6.3 of this Article relating to reappointment and will be effective upon approval by the Board.

3.9. **Leave of absence**

3.9.1. Leave status. A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the COS and the CEO stating the approximate period of leave, which may not exceed one year. Absences longer than one year may be granted by the Board upon recommendation of the MEC if there are extenuating circumstances. However, a practitioner may not take a voluntary leave of absence if the COS or the medical center CEO determines that the purpose of the leave is to avoid taking call or fulfilling other Medical Staff obligations, in which event the matter will be presented to the MEC for review and a recommendation to the Board, which will take final action on the request. The practitioner retains the right to provide evidence and/or documentation in support of the leave of absence request. If a practitioner's reappointment expires during the leave of absence, the reappointment must be processed within the required time frame. The two-year reappointment time frame is waived for practitioners fulfilling obligatory military duties; such practitioners must request their reappointment applications within 14 days after return from active duty and complete them in the required time frame. While a practitioner is on leave of absence, he/she will not have clinical privileges and all his/her rights and obligations, including meeting attendance, voting, and payment of dues, will be suspended. However, a leave of absence will not affect any investigation or pending action concerning the practitioner's professional conduct or exercise of clinical privileges, and any corrective action may go forward while the practitioner is on a leave of absence.

3.9.2. Termination of leave. At least 30 days prior to the termination of the leave, the staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to the CEO for transmittal to the MEC. The MEC or the Board may request a written summary of relevant activities during the leave. The MEC will make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives. In the event the practitioner takes a leave of absence for medical reasons, the COS or the health system CEO may require that he/she be examined by an independent physician or physicians designated by the COS or the health system CEO or provide any other requested information or records to enable them to determine whether the practitioner may return from leave or whether any conditions should be placed on the practitioner's exercise of clinical privileges upon returning from leave. If the MEC recommends that the practitioner should not be reinstated or should be reinstated subject to any conditions not agreed to by the practitioner, the health system CEO will notify the practitioner of the reasons for the action and the practitioner will be entitled to a hearing in accordance with the medical center's Fair Hearing and Appellate Review Plan.

3.9.3. Automatic termination of staff membership and privileges. Failure, without good cause, to request reinstatement or to provide the requested information as above provided will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of staff membership, privileges, and prerogatives. No additional action or notification has to follow after the initial notification that privileges will be considered automatically terminated, effective starting at the end of the leave of absence A request for staff membership subsequently received from a staff member so terminated will be deemed an application for initial appointment.

3.10. Resignation

3.10.1. Any member of the Medical Staff in good standing may voluntarily resign his/her appointment to the Medical Staff.

3.10.2. At least 30 days prior to the effective date of the resignation, the Medical Staff member wishing to resign will submit written notice of his/her intention to resign to the CEO, with a copy provided to the appropriate department chair and to the COS. This notice will specify the reason for the resignation and the effective date. A practitioner may not resign some of his/her privileges but retain others unless such resignation is approved by the Board after considering the recommendations of the appropriate department chair and the MEC. A practitioner may not resign a portion of his/her privileges in order to avoid taking call or fulfilling any other Medical Staff obligation. Resignations will be accepted and deemed resignations in good standing where the Medical Staff member:

3.10.2.1. completes all medical records to the satisfaction of the Medical Record Review Team. Failure to do so will result in an entry in the practitioner's credentials file that he/she was not in good standing at the time of his/her resignation; and

3.10.2.2. has taken appropriate steps to assure patient care or hospital duties for which he/she is responsible have been delegated or reassigned.

3.11. Staff dues. Each member of the Medical Staff, including Active staff, Active without clinical privileges, Consulting staff and AHPs, will pay staff dues yearly. The amount of dues for the year will be set at the annual meeting or at a regular meeting of the Medical Staff and will be paid to the staff treasurer by March 1. Dues will be used for continuing medical education, library resources, or any other use which may be deemed necessary by the Medical Staff.

ARTICLE 4: CATEGORIES OF THE MEDICAL STAFF

4.1. Categories. The Medical Staff categories will include Active with clinical privileges, Active without clinical privileges, Consulting, Telemedicine, Consulting (contract), and Honorary categories.

4.2. Active staff with clinical privileges. The Active staff with clinical privileges will consist of duly licensed and qualified practitioners who regularly admit patients to the medical center or practice a medical center-based specialty.

4.2.1. Qualifications. Active staff members will meet the basic qualifications set forth in Article 3.3 and will satisfy at least one of the following criteria:

4.2.1.1. They establish and maintain regular office hours in offices located within 25 miles of the medical center within six months of initial appointment to the Medical Staff. Physicians hired solely as hospitalists will not be subject to the office requirement.

4.2.1.2. Emergency Department (ED) physicians and hospitalists will automatically be appointed to the Active staff with all voting privileges and meeting and committee responsibilities if they satisfy the following criteria:

4.2.1.2.1. They act as director of the group of physicians providing ED or hospitalist services, or provide emergency medicine or hospitalist services on average 24 hours or more monthly.

4.2.1.2.2. They work fewer than 24 hours per month but attend at least two departmental meetings and 50% of Medical Staff meeting AND participate in one committee meeting at least 25% of the time OR demonstrate commitment to CHMC by regular participation in CHMC activities including, but not limited to, communicating with CHMC's physician liaison, administration or MEC to improve CHMC's service to the community.

4.2.2. Prerogatives. Each member of the Active staff with clinical privileges will be entitled to:

4.2.2.1. admit patients to inpatient services in accordance with state law and criteria for standards of medical care established by the Medical Staff and provide consultations without limitation. ED physicians cannot admit patients to their own services, but may facilitate admission of patients only to the service of an attending physician, with the prior approval of said physician;

4.2.2.2. exercise such clinical privileges as are granted pursuant to Article 8;

4.2.2.3. vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he/she is a member after holding privileges for one year and remaining in good standing, unless otherwise provided by resolution of the Medical Staff, department, or committee, and approved by the MEC; and

4.2.2.4. hold office in the Medical Staff organization and in the department and committees of which he/she is a member after holding privileges for one year, remaining in good standing, and meeting the qualifications specified in Article 13, unless otherwise provided by resolution of the Medical Staff, department or committee and approved by the MEC.

4.2.3. Responsibilities. Each member of the Medical Staff will:

4.2.3.1. meet the basic responsibilities set forth in Article 3.5;

4.2.3.2. retain responsibility within his/her area of professional competence for the continuous care and supervision of each patient in the medical center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

4.2.3.3. actively participate in utilization review and other required quality evaluation and monitoring activities; in supervising initial appointees of his/her same profession; and in discharging such other Medical Staff functions as required from time to time;

4.2.3.4. support the patient care mission of the medical center by providing treatment for patients presenting to the facility seeking emergency medical care, regardless of the patient's ability to pay for such

services. Active staff members of the Medical Staff will be required to participate in the on-call system, and to respond promptly (in accordance with the applicable Medical Staff policies) when called to render clinical services within their area of specialization, pursuant to the Medical Staff rules and regulations; and

4.2.3.5. agree to serve in an on-call rotation for unassigned ED or urgent care patients who are not admitted to the medical center but require outpatient follow-up, pursuant to applicable Medical Staff rules and regulations as they may be adopted from time to time. This obligation may only be for one visit if the patient does not have insurance or if the patient has insurance not accepted by the practitioner. [Noncompliance with on-call responsibilities may result in initiation of corrective action as outlined in Article 10 of the bylaws.]

4.3. Active staff without clinical privileges. The Active staff without clinical privileges will consist of duly licensed and qualified primary care practitioners whose patients are regularly admitted to the medical center through the use of a hospitalist program and who are actively involved in the affairs of the medical center and practice medicine in an outpatient setting.

4.3.1. Prerogatives

4.3.1.1. Each member of the active staff without admitting privileges will be entitled to:

4.3.1.1.1. refer patients for purposes of medical center admission to a member of the Active staff with clinical privileges in accordance with state law and criteria for standard of medical care established by the Medical Staff;

4.3.1.1.2. initiate direct admission from the outpatient setting after communicating with an admitting physician in accordance with policy on direct admission. The outpatient physician may write the history and physical examination and admitting orders. The accepting medical center physician will see the patient and cosign the orders within eight hours;

4.3.1.1.3. review medical records through electronic access or in person, but not write any notes into the medical records;

4.3.1.1.4. visit inpatients without directing care or placing orders;

4.3.1.1.5. write orders for outpatient procedures and the Infusion Center;

4.3.1.1.6. attend meetings of the Medical Staff and of the department and committees of which he/she is a member;

4.3.1.1.7. vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he/she is a member after holding privileges for one year and remaining in good standing, unless otherwise provided by resolution of the Medical Staff, department or committee and approved by the MEC; and

4.3.1.1.8. hold office in the Medical Staff organization and in the department and committees of which he/she is a member after holding privileges for one year, remaining in good standing, and meeting the

qualification specified in Article 13.1.2, unless otherwise provided by resolution of the Medical Staff, department or committee and approved by the MEC.

4.3.1.2. For Active staff members without clinical privileges to maintain prerogatives 4.3.1.1.7 and 4.3.1.1.8, they must show an on-going commitment to CHMC by at time of reappointment by:

4.3.1.2.1. attending at least 50% of departmental and Medical Staff meetings; and

4.3.1.2.2. participating in one committee meeting at least 25% of the time or demonstrating commitment to CHMC by regular participation in CHMC activities including, but not limited to, participation in outpatient call to the ED, or communicating with CHMC's physician liaison, administration or MEC to improve CHMC's service to the community.

4.3.2. Responsibilities. Each member of the Active staff without clinical privileges will:

4.3.2.1. establish and maintain regular office hours in an office within 25 miles of the medical center within six months of initial appointment to the Medical Staff;

4.3.2.2. agree to serve in an on-call rotation for unassigned ED or urgent care patients who are not admitted to the medical center but require outpatient follow-up, pursuant to applicable Medical Staff rules and regulations as they may be adopted from time to time. This obligation will only be for one visit if the patient does not have insurance or if the patient has insurance not accepted by the practitioner; and

4.3.2.3. meet the responsibilities set forth in Article 3.4 (3, 6, 8, 9, and 10).

4.4. Consulting staff. The Consulting Medical Staff will consist of practitioners of recognized professional ability who provide consultation on patients upon written request by an attending physician. Consulting staff may not admit patients, vote, or hold office. Consulting staff must fulfill the responsibilities as outlined in Article 4.2 of these bylaws, excluding the prerogatives to admit patients, vote, and hold office.

4.4.1. Prerogatives: A Consulting staff member may

4.4.1.1. request Active status if he/she meets the basic qualifications in Articles 3.1-3.2 and Article 4.2 of these bylaws; and

4.4.1.2. provide medical and/or surgical services as defined by the Medical Staff rules and regulations.

4.4.1.3. review medical records through electronic access or in person;

4.4.1.4. in coordination with the consulting inpatient care provider, write orders pertinent to the matter under consultation; and

4.4.1.5. attend meetings of the Medical Staff, departments, and committees of which he/she is a member.

4.4.2. Responsibilities: A Consulting staff member will

4.4.2.1. provide an original written record of his/her findings and opinions, followed by an in-depth transcription of his/her consultation if the care warrants such a record in compliance with Medical Staff rules and regulations;

4.4.2.2. demonstrate current clinical competence as determined by OPPE;

4.4.2.3. adhere to bylaws; and

4.4.2.4. establish regular office hours in an office within 25 miles of the medical center within six months of initial appointment to the Medical Staff**; and**

4.4.2.5. meet the responsibilities set forth in Article 3.5.

4.5. Telemedicine practitioners

In this category are licensed independent practitioners who are responsible for a patient's care, treatment, and services via telemedicine and are credentialed and privileged to do so at CHMC through one of the following mechanisms:

4.5.1. Telemedicine is defined as the medical diagnosis, management, evaluation, treatment, or monitoring of injuries or diseases through the use of communication technology when the practitioner is not in the same geographical area as the medical center and does not come to the medical center. The Board will determine what clinical services may be provided through telemedicine after considering the recommendation of the appropriate department chair, the Credentials Committee, and the MEC.

4.5.2. Practitioners who diagnose and treat medical center patients via telemedicine link will not be members of the Medical Staff but will be privileged and credentialed in accordance with these Medical Staff bylaws. However, if permitted by law, regulations, and any applicable accreditation standards, CHMC may obtain and rely on information and documentation related to the practitioner's qualifications and competence provided by the site or organization where the practitioner is located if that site is accredited by an organization approved by the Centers for Medicare and Medicaid Services (CMS) to grant the deemed status. The medical center may verify directly through original sources such information as it deems appropriate.

4.5.3. All practitioners providing telemedicine services must be properly licensed, certified, and/or permitted to practice in the State of Maryland.

4.5.4. The granting of telemedicine privileges will be at the discretion of the Board. Such privileges may be terminated or withdrawn at any time by the Board or medical center CEO, with or without cause, after consultation with the chair of the appropriate department and the COS. Practitioners with telemedicine privileges will not be entitled to a hearing or other review procedures pursuant to these bylaws or the Fair Hearing and Appellate Review Plan unless action is taken with regard to a practitioner that is required to be reported to the National Practitioner Data Bank or a state licensing or disciplinary agency.

4.6. Consulting (contract) practitioners. These are practitioners that have a contracted relationship with the medical center, whether directly or as an employee, partner, or principal of or in an entity that has such a contractual relationship with the medical center, and will not be subject to the requirement to be an Active staff member at another health care organization or facility.

4.7. Honorary staff. The Honorary staff will consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the medical center. Honorary staff members will not be eligible to vote or to hold office in this Medical Staff organization. Honorary staff members are not eligible to admit patients to the medical center or to exercise clinical privileges in the medical center. Honorary staff members may attend staff and department meetings and any Medical Staff or medical center educational meetings.

4.8. Limitation of prerogatives. The prerogatives set forth under each Medical Staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff membership, by other sections of these bylaws and by other policies of the medical center.

4.8.1. Practitioners who have reached the age of 65 or have 20 years or more of service to the medical center may be excused from the ED on-call rotation roster at the discretion of the department and the MEC. The department must provide evidence that community needs for on-call coverage are fulfilled.

4.8.2. Practitioners requesting privileges in more than one department will be subject to approval based on the education, training, and competency requirements stipulated by the departments. Practitioners requesting additional privileges in emergency medicine, including urgent care, will refrain from the practice of self-referral of patients treated in the ED or urgent care centers. Evidence of referral to the practitioner's medical practice will be grounds for termination of the emergency medicine and/or urgent care privileges. Any reduction or termination of privileges based on allegations of self-referral will entitle the practitioner to a hearing subject to the provisions of the Fair Hearing and Appellate Review Plan.

ARTICLE 5: ALLIED HEALTH PROFESSIONALS

5.1. Definition. Allied health professionals (AHPs) are members of the professional staff of the medical center assigned to clinical departments. AHPs may include dentists, physician assistants, certified registered nurse anesthetists, certified registered nurse practitioners, and certified nurse midwives.

5.2. Qualifications. In order to be eligible to provide specified services in the medical center, AHPs must

5.2.1. hold a license, certificate, or other legal credential as required by state law;

5.2.2. meet the qualifications for Medical Staff membership as set forth in Article 3.3; and

5.2.3. be determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others.

Where appropriate, the MEC may establish particular qualifications required of members of a specific category of AHPs, provided that such qualifications are not founded on an arbitrary or discriminatory basis and conform to applicable law.

5.3. Procedure for specification of services

5.3.1. An application for specified services for an AHP will be submitted and processed in the same manner as provided in Article 8 for clinical privileges. The Board may delegate to the CEO or his/her designee the authority to take action on any applications from specific categories of AHPs.

5.3.2. An AHP will be individually assigned to the clinical department appropriate to his/her professional training and will be subject in general to the same terms and conditions as specified in Article 3 for Medical Staff appointments.

5.4. Prerogatives. The prerogatives of an AHP will be to:

5.4.1. provide specified patient care services, either independently or under the supervision or direction of a designated practitioner of the Medical Staff as stipulated by the State of Maryland, except as otherwise expressly provided by resolution of the department and approved by the MEC) and consistent with the limitations stated in Article 8.4;

5.4.2. write orders regarding the care of CHMC patients only to the extent established by the Medical Staff, but not beyond the scope of the AHP's license, certificate, or other credentials;

5.4.3. serve on Medical Staff, department, and medical center committees;

5.4.4. attend meetings of the department to which he/she is assigned and medical center education programs; and

5.4.5. exercise such other prerogatives as may, by resolution or written policy duly adopted by the Medical Staff or by any of its departments or committees and approved by the MEC, be accorded AHPs as a group or to any specific category of AHPs. These prerogatives may include the right to vote on specified matters, to hold defined offices or any other prerogative for which medical education training and experience, beyond that which an AHP can demonstrate, is not a prerequisite.

5.4.6. access Meditech or other medical center clinical information databases on site or remotely from office and home.

5.4.7. In the event of the termination, restriction, or suspension of the Medical Staff membership or clinical privileges of the sponsoring, supervising, or collaborating physician of any dependent AHP, the clinical privileges of the AHP may be immediately and automatically suspended. The AHP will have 60 days within which to arrange an affiliation with another member of the Medical Staff and provide a copy of the written affiliation agreement. If the AHP does not provide a new affiliation agreement within 60 days, the clinical privileges of the AHP will immediately and automatically terminate, and the practitioner will not be entitled to a hearing in accordance with the hospital's Fair Hearing and Appellate Review Plan.

5.5. Responsibilities. Each AHP will:

5.5.1. meet the same basic responsibilities as required by Article 3.5 for Medical Staff members;

5.5.2. retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the medical center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision following consultation with the supervising practitioner; and

5.5.3. participate as appropriate in the quality improvement activities required of the Medical Staff in supervising initial appointees of his/her same profession during the observation period and in discharging such other Medical Staff functions as may be required from time to time.

5.5.4. agree to pay annual Medical Staff membership dues by the first day of March each year at the rate set by the MEC; and

5.5.5. where appropriate, establish and maintain regular office hours in offices located within 25 miles of the medical center within six months of initial CHMC credentialing. AHPs hired solely as medical center-based practitioners will not be subject to the office requirement

ARTICLE 6: AFFILIATE STAFF

6.1. Definition. The Affiliate staff will consist of physicians with appropriate professional degrees who are serving as residents or fellows, with an appropriate affiliation agreement with CHMC through their graduate medical education program.

6.2. Scope of Practice. Affiliate Staff are licensed in Maryland and may render supervised services to CHMC patients in accordance with the medical center's policies and procedures, as well as with Maryland and federal laws and regulations. Affiliate Staff are not members of the Medical Staff and therefore are not afforded rights and responsibilities of Medical Staff membership.

6.3. Qualifications

6.3.1. Members of the Affiliate staff are considered to be in training and will provide services at CHMC only under the appropriate supervision of active members of the Medical Staff.

6.3.2. Sponsoring members of the Active medical staff assume responsibility for Affiliate staff supervision for the safe, effective, and compassionate care of patients in inpatient services, in the outpatient facilities, and in medical care facilities administered by the medical center, consistent with their training and expertise.

6.3.3. Members of the Affiliate staff will be graduates of approved or recognized schools of medicine or osteopathy. Graduates of approved or recognized schools elsewhere than in the United States, Puerto Rico, or Canada must present a valid ECFMG certificate prior to beginning the credentialing process.

6.3.4. Members of the Affiliate staff will be licensed in the State of Maryland unless they have received exemption for licensure (through registration as an unlicensed practitioner) by the State of Maryland.

6.4. Responsibilities and restrictions

6.4.1. Members of the Affiliate staff will comply with ongoing risk management education requirements and will agree to be governed by these bylaws.

6.4.2. Affiliate staff are not considered members of the Medical Staff. They may not serve on committees or vote or hold office. Denial, suspension, or revocation of appointment to the Affiliate staff does not impart entitlement to a hearing in accordance with the hospital's Fair Hearing and Appellate Review Plan as specified in Article 11. Disciplinary or adverse actions involving Affiliate staff will be governed by the Graduate Trainee Adverse Action Process of the referable training program. It is the responsibility of the Affiliate staff member to report immediately to the Medical Staff office any investigation or actions taken with regard to any hospital appointment, licensure, certification, health care affiliation, or criminal charges.

6.4.3. Appointment is for the duration of the Affiliation Agreement. Provisions for termination of the appointment are included in said Agreement.

ARTICLE 7. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

7.1. General procedure.

7.1.1. The Medical Staff, through its designated departments, committees and officers, will investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of Medical Staff membership status or privileges and will adopt and transmit recommendations to the Board. Credentialing of each new applicant will start at the department level. The specific mechanism for appointment and reappointment is contained in P&P MS-006, Credentialing: Initial Appointment to the Medical Staff, and P&P MS-013, Credentialing for Reappointment to the Medical Staff. Upon receipt of all items, the complete file is presented to the Credentials Committee for review and recommendation to the MEC.

7.1.2. There will be no appointment or reappointment of Medical Staff members who are ineligible for appointment or reappointment by virtue of inconsistency of their proposed or continued Medical Staff membership and privileges with (a) the provision of Article 3.5 of these bylaws regarding Medical Staff members in a contractual relationship with the health system; (b) any Board resolution or policy concerning exclusivity of health system contracts for physician services; or (c) any health system exclusive contract for physician services. The medical center will not receive and process applications or information for appointment or reappointment in these cases, and such actions will not give rise to rights to a Fair Hearing or Appellate Review as provided in these bylaws under Article 10 or the Fair Hearing and Appellate Review Plan.

7.2. Application for initial appointment

7.2.1. Application form

7.2.1.1. Each applicant for clinical privileges will complete and sign the prescribed application form and provide supporting documentation as requested. Upon request for an application form, the applicant will be given a copy of, or access to a copy of, these bylaws, the Medical Staff rules and regulations, and summaries of other medical center and Medical Staff policies relating to clinical practice in the medical center.

7.2.1.2. Any false statement made on this application or other official communications to the staff or medical center will be grounds for instant denial of privileges or dismissal from the Medical Staff, in accordance with the Fair Hearing and Appellate Review Plan.

7.2.1.3. Applications that are not complete, will not be reviewed and will be considered withdrawn after a period of 60 days if the applicant is not actively pursuing completion of the missing items.

7.2.2. Effect of application. By applying for appointment or reappointment to the Medical Staff or for clinical privileges, the applicant automatically:

7.2.2.1. agrees to complete a drug and alcohol-screening test (Breath Alcohol and 511 Panel Urine Screen) at a NIDA approved laboratory. CHMC has adopted a policy on substance abuse, which requires all applicants to the Medical Staff to complete a drug and alcohol-screening test;

7.2.2.2. agrees to submit to an alcohol or drug screening test at the request of the Chief of Staff or CEO or his/her designee, including the administrator on call, based on reasonable suspicion that the practitioner may be under the influence of drugs or alcohol;

7.2.2.3. agrees to baseline health assessments;

7.2.2.4. agrees to undertake the responsibility for producing all information and materials required by the Medical Staff and medical center to establish the applicant's qualifications for the Medical Staff membership and clinical privileges requested, including appearing for interviews with regard to the application and submit to medical and/or psychiatric evaluation, if requested;

7.2.2.5. consents to medical center representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, or his/her physical and mental health status and of his/her professional ethical qualifications;

7.2.2.6. releases from any and all liability all medical center representatives for their actions performed in good faith and without malice, in connection with providing, obtaining or reviewing information and evaluating or making recommendations concerning the applicant and the applicant's credentials. These actions may include collecting otherwise privileged or confidential information, relating to the applicant's ability, background, professional ethics, character, physical and mental health, emotional stability, and other matters relating to the applicant's qualifications for Medical Staff appointment and clinical privileges. The term "medical center representatives" as used in these bylaws includes the members of the Board, all officers, employees, and agents of the medical center, all members of the Medical Staff, and all officers of the Medical Staff, its departments and committees;

7.2.2.7. authorizes and consents to medical center representatives providing other health care organizations and facilities, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the medical center may have concerning him/her and absolutely and releases medical center representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice;

7.2.2.8. agrees to abide by the terms of the bylaws, rules, regulations, policies and procedures of the medical center and Medical Staff in all matters relating to the consideration of the application and the exercise of Medical Staff membership and clinical privileges;

7.2.2.9. agrees that if at any time an adverse ruling is made with respect to the applicant's membership, staff status, and/or clinical privileges, the applicant will exhaust all remedies afforded by these bylaws and the Fair Hearing and Appellate Review Plan before resorting to formal legal action; and

7.2.2.10. acknowledges that the granting of Medical Staff membership and clinical privileges will not make the practitioner an employee of the medical center for any purposes and the practitioner will at all times be an independent practitioner unless the practitioner has a separate employment relationship with the medical center above and beyond having Medical Staff membership and clinical privileges.

7.3. Application for reappointment.

7.3.1. At least 180 days prior to the expiration date of the present staff appointment, the Medical Staff office will provide each Medical Staff member with a reappointment application. Each Medical Staff member will submit his/her reappointment application by the deadline established. Failure, without good cause, to return the application will be deemed a voluntary resignation from the Medical Staff and will result in an automatic termination at the expiration of the member's current term. A practitioner whose membership is so terminated will be entitled to the procedural rights provided in Article 10 and in the Fair Hearing and Appellate Review Plan for the sole purpose of determining the issue of good cause.

7.3.2. Any false statement made on this application or other official communications to the Medical Staff or medical center will be grounds for instant denial of privileges or dismissal from the medical staff, in accordance with the Fair Hearing and Appellate Review Plan.

7.4. Processing of applications.

7.4.1. Applicant's burden. The applicant will have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability and physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in Article 3.3.

7.4.2. Verification of information

7.4.2.1. Initial application. The applicant will provide a completed application as specified in the application packet cover letter to the Medical Staff office, which will collect and verify all qualification evidence submitted.

7.4.2.2. Reappointment application. The department chair, Credentials Committee, MEC, JQIC, COS, and the CEO will, in a timely fashion, collect and verify the additional information made available on each reappointment form application and collect any other materials or information deemed pertinent, including information regarding professional activities, performance, and conduct in this medical center.

7.4.2.3. The Medical Staff office will promptly notify the applicant of any problems in obtaining the information required; it will then be the applicant's obligation to obtain the required information.

7.4.2.4. When collection and verification is accomplished, the Medical Staff office will transmit the application and all supporting materials to the chairs of every department in which the applicant seeks privileges for credentials review.

7.4.3. Department action

7.4.3.1. Upon receipt, each department chair, or his/her designee in the event of a conflict of interest, will review the application and supporting documentation and conduct a personal interview with the initial applicant. Within 60 days of receiving the verified application, the chair of the department will then submit a written recommendation and send it to the Credentials Committee for review. For initial applications, this report will include, if appointment is recommended, the Medical Staff category, department affiliation, clinical privileges to be granted and any special conditions to be attached to the appointment. For reappointments, this report will specify if the appointment will be granted; renewed; renewed with modified Medical Staff category, department affiliation and/or clinical privileges; or terminated; and will be reported to the members of his/her department at their next meeting.

7.4.3.2. A department chair may also recommend that the Credentials Committee defer action on the application as long as a written explanation of just cause for the delay is included. The chair of the department will transmit the above information to the MEC via Credentials Committee within 60 days of receiving a completed application, including verification of the information. Reasons for each recommendation will be stated and supported by reference to the completed application and all other documentation considered by a chair, all of which shall be transmitted with the report. Any minority views will also be stated, supported by reasons and references, and transmitted with the chair's report.

7.4.4. Credentials Committee action

7.4.4.1. The Credentials Committee will assess all credentials and privilege requests or recommendations received from department chairs. The Credentials Committee will forward recommendations to the Chief of Staff and MEC for review at the next scheduled MEC meeting. Applicants who qualify will be placed on the next MEC agenda for consideration.

7.4.4.2. For details on the composition and mission of the Credentials Committee, see Policy MS-040 Credentials Committee.

7.4.5. MEC action

7.4.5.1. At its next regular meeting after receipt of the Credential Committee report and recommendations, the MEC will consider the report and such other relevant information available to it. After due consideration, recommendations of the MEC as to Medical Staff appointment, department affiliation, clinical privileges, and any special conditions will be forwarded to the JQIC and the Board.

7.4.5.2. Reasons for each recommendation will be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which will be transmitted with the report. Minority views will be put in writing, supported by reasons and references and transmitted with the majority report.

7.4.5.2.1. Deferral: Action by the MEC to defer the application for further consideration must be followed up within 90 days with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for Medical Staff membership.

7.4.5.2.2. Favorable recommendation: When the recommendation of the MEC is favorable, the CEO will forward it promptly, together with all supporting documentation, to the JQIC and the Board. For the purposes of this Article, "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department chair and minority views.

7.4.5.2.3 Adverse recommendation: When the MEC recommendation is adverse, the Chief of Staff will immediately so inform the applicant by special notice and he/she will be entitled to the procedural rights as provided in Article 11 and in the Fair Hearing and Appellate Review Plan. For the purposes of this Article, an "adverse recommendation" by the Medical Staff is as defined in the Fair Hearing and Appellate Review Plan.

7.4.6. Board action

7.4.6.1. Upon favorable MEC and JQIC recommendation: At its next regularly scheduled meeting, the Board will adopt or reject in whole or in part a favorable recommendation of the MEC and JQIC or refer the recommendation to the Medical Staff for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation will be made. If the Board's action is adverse to the applicant as defined in the Fair Hearing and Appellate Review Plan, the CEO or Chief of Staff will promptly so inform the applicant by special notice delivered in person or by certified mail and he/she will be entitled to the procedural rights as provided in Article 10 and in the Fair Hearing and Appellate Review Plan.

7.4.6.2. Without benefit of MEC recommendation: If the Board does not receive an MEC recommendation within the time period specified in this Article, it may, after notifying the MEC, take action on its own initiative in the manner set forth in the health system's corporate bylaws. If such action is favorable, it will become effective as the final decision of the Board. If not, the CEO will promptly so inform the applicant by special notice delivered in person or by certified mail, and he/she will be entitled to the procedural rights as provided in Article 10 and in the Fair Hearing and Appellate Review Plan..

7.4.6.3. After procedural rights: In the case of an adverse recommendation pursuant to this Article, the Board will take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 10 and in the Fair Hearing and Appellate Review Plan. Action thus taken will be the conclusive decision of the Board.

7.4.7. Conflict resolution. If the Board's final proposed decision is contrary to the MEC's recommendation, the Board will submit the matter to a joint conference of equal members of the Medical Staff and Board members for review and recommendation before making its final decision and giving notice of final decision required by this Article.

7.4.8. Notice of final decision

7.4.8.1. Notice of the Board's final decision will be given through the CEO and Chief of Staff to the chair of each department concerned and to the applicant by means of special notice delivered in person or by certified mail.

7.4.8.2. A decision and notice to appoint will include: (1) the Medical Staff category to which the applicant is appointed; (2) the department to which he/she is assigned; (3) the clinical privileges he/she may exercise; and (4) any special conditions attached to the appointment.

7.4.9. Reapplication after adverse appointment action. An applicant who has received a final adverse decision regarding appointment will not be eligible to reapply for a period of one year. Any such reapplication will be processed as an initial application, and the applicant will submit such additional information as the Medical Staff or the Board may require demonstration that the basis for the earlier adverse action no longer exists.

7.4.10. Time period for processing. A decision on an application for Medical Staff membership will be rendered within 180 days from the time a complete application, with all related documentation, is received by the Medical Staff office. The medical center will not be responsible for any delay in appointment due to a physician's failure to submit all of the required information in a timely fashion.

7.4.11. Basis for recommendation.

7.4.11.1. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted will be based upon such member's professional ability and clinical judgment in the treatment of patients; his/her professional ethics; his/her discharge of Medical Staff obligations; his/her compliance with the Medical Staff bylaws, rules, and regulations; his/her cooperation with other practitioners and with patients; and with other matters bearing on his/her ability and willingness to contribute to quality patient care.

7.4.11.2. Should the practitioner's activity at the medical center not be sufficient for the chair to make a recommendation for reappointment, either a letter will be sent to the practitioner's primary health care facility for information regarding performance and competency at that institution or the chair may request additional information from the practitioner to support his/her request for reappointment.

7.5. Requests for modification of membership status or privileges. A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category, department, assignment or clinical privileges by submitting written application to the department chair on the prescribed form. A request for a change in clinical privileges will be provisional for up to 12 months. Such application will be processed in substantially the same manner a provided in this Article for reappointment.

ARTICLE 8. DETERMINATION OF CLINICAL PRIVILEGES

8.1 Exercise of privileges. Every practitioner or other professional providing direct clinical services at this hospital will, in connection with such practice and except as otherwise provided in Article 7.6, be entitled to exercise only those clinical privileges or specified services approved by the Medical Staff and specifically granted to him/her by the Board. In the event that a patient is suffering from a condition requiring immediate treatment and no member of the Medical Staff having privileges to provide such treatment is reasonably available, any member of the Medical Staff may provide such emergency treatment as is necessary without regard to whether the Medical Staff member has privileges to provide such treatment.

8.2 Delineation of privileges in general

8.2.1. Requesting privileges. Each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a Medical Staff member pursuant to Article 7.6 for a modification of privileges must be supported by documentation of additional training and/or experience supportive of his/her request. An application for reappointment may contain the phrase "privileges as previously granted."

8.2.2. Basis for determining privileges. Requests for clinical privileges will be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise will include observed clinical performance (OPPE) and the documented results of monitoring and evaluation activities required by these and the health system's corporate bylaws. Privilege determinations will also be based on pertinent information concerning clinical performance obtained from other sources, specifically other institutions and healthcare settings where a practitioner exercises clinical privileges. This information will be maintained in the practitioner's credentials file.

8.2.3. Procedure. All requests for clinical privileges will be processed pursuant to the procedures outlined in Article 7. All new procedures and privileges will be subject to FPPE as outlined in MS 039.
ARTICLE 8. DETERMINATION OF CLINICAL PRIVILEGES

8.1 Exercise of privileges. Every practitioner or other professional providing direct clinical services at this hospital will, in connection with such practice and except as otherwise provided in Article 7, be entitled to exercise only those clinical privileges or specified services approved by the Medical Staff and specifically granted to him/her by the BOD. In the event that a patient is suffering from a condition requiring immediate treatment and no member of the Medical Staff having privileges to provide such treatment is reasonably available, any member of the Medical Staff may provide such emergency treatment as is necessary without regard to whether the Medical Staff member has privileges to provide such treatment.

8.2 Delineation of privileges in general

8.2.1. Requesting privileges. Each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a Medical Staff member pursuant to Article 7.8 for a modification of privileges must be supported by documentation of additional training and/or experience supportive of his/her request. An application for reappointment may contain the phrase "privileges as previously granted."

8.2.2. Basis for determining privileges. Requests for clinical privileges will be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgment. The basis for privilege determinations to be made in connection with periodic reappointment or otherwise will include observed clinical performance (OPPE) and the documented results of monitoring and evaluation activities required by these and the health system's corporate bylaws. Privilege determinations will also be based on pertinent information concerning clinical performance obtained from other sources, specifically other institutions and healthcare settings where a practitioner exercises clinical privileges. This information will be maintained in the practitioner's credentials file.

8.2.3. Procedure. All requests for clinical privileges will be processed pursuant to the procedures outlined in Article 7. All new procedures and privileges will be subject to FPPE as outlined in MS 039. The BOD may at any time after considering the recommendations of the MEC direct that specific procedures or clinical practices not be performed at the medical center if the BOD determines that such practices or procedures are not medically acceptable, cannot be properly performed at the medical center, or are inconsistent with the mission and principles of the medical center. No practitioner may engage in any clinical practices or procedures for which the medical center does not have appropriate facilities or services, or which the BOD has determined should not be performed at the medical center. There will be no appeal or hearing with regard to any decision by the BOD that any practices or procedures are not medically acceptable or are not to be performed in the medical center.

8.2.4. Termination or suspension of privileges of membership. Medical Staff membership will be terminated or suspended as outlined in these bylaws under sections of suspension and under the following circumstances:

8.2.4.1. Loss of license will be grounds for immediate loss of membership without recourse to fair hearing.

8.2.4.2. Members who are still on initial FPPE may be subject to removal from the Medical Staff or reduction in privileges without a fair hearing if the practitioner is found to not meet the standards of care, not

compliant with citizenship issues (behavior, medical records, or other citizenship criteria), or for not following the bylaws and rules and regulations.

8.2.4.3. Members who have met the initial FPPE are entitled to a fair hearing as outlined in these bylaws.

8.3. Special conditions for dental and podiatric membership

8.3.1. Requests for clinical privileges from dentists and podiatrists will be processed in the manner specified in Article 8.2. Surgical procedures to be performed by dentists will be under the overall supervision of the chair of the Department of Surgery or his/her designee. Surgical procedures to be performed by podiatrists will be under the overall supervision of the chair of the Department of Orthopedic Surgery or his/her designee. All dental and podiatric patients will receive the same basic medical appraisal as patients admitted to other surgical services. The history and physical examination will be performed by a physician member of the Medical Staff who has requested this privilege on his/her Delineated Privilege Form.

8.3.2. Podiatrists may choose to perform the history and physical examination for that portion of the patient's history and physical examination that relates to their specialty and for which they have clinical privileges or may delegate it to another physician member on staff.

8.4. Special conditions for allied health professional services. Requests to perform specified patient care services from AHPs will be processed in the manner specified in Article 5.3. An AHP may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his/her professional competence and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care; under current State of Maryland law, nurse practitioners are not subject to this requirement. Continuing education requirements must be fulfilled in accordance with the practitioners licensing board.

8.5. Temporary privileges. Temporary privileges may be granted to initial Medical Staff applicants or for important patient care needs as defined below. For an initial Medical Staff applicant seeking temporary privileges while his/her application is pending, an interview will be conducted by the CEO and /or the COS and/or the chair of the department where the privileges will be exercised. The CEO or designee may grant temporary privileges upon recommendation by the COS or authorized designee after a completed application and verification in writing of all credentials have been received in the Medical Staff office. This information must be received in the Medical Staff office before temporary privileges may be granted. Temporary privileges will be granted for a period of up to 120 days.

8.5.1. Conditions. Temporary privileges will be granted only when the verified information supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement, if any, of Article 3.5.5 regarding professional liability insurance. Special requirements of consultation and reporting may be imposed by the chair of the department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received and read, or been given access to and the opportunity to read, the Medical Staff bylaws, rules and

regulations and that he/she agrees to be bound by their terms. Temporary privileges will not be granted to a practitioner who previously has been denied Medical Staff privileges.

8.5.2. Termination. On the discovery of any information or the occurrence of any event which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the CEO or the COS may, after consultation with the department chair responsible for supervision, terminate any or all of the practitioner's temporary privileges. When the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article 10. In the event of any such termination, the practitioner's patients then in the medical center will be assigned to another practitioner by the department chair or designee responsible for supervision. The wishes of the patient will be considered where feasible in choosing a substitute practitioner. A practitioner will not be entitled to the procedural rights afforded by Article 11 and the Fair Hearing and Appellate Review Plan because all or any portion of his/her temporary privileges are terminated or suspended.

8.5.3. Special temporary privileges. When necessary, the CEO or designee upon recommendation by the COS or authorized designee may grant temporary emergency privileges to fulfill an important patient care, treatment, or service need.

8.5.3.1. Care of Specific Patients. Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner who is not an applicant for membership may be granted specific privileges for the care of one or more specific patients. Such privilege will be restricted to the treatment of not more than four patients in any one year by any practitioner, after which such practitioner will be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Before temporary privileges may be granted pursuant to this section, the practitioner will submit to the Medical Staff office such information and documentation as the medical center may require in order to establish current competence, including but not limited to the following:

8.5.3.1.1. a copy of the practitioner's current State of Maryland license or other authorization to practice pursuant to Maryland law;

8.5.3.1.2. a certificate from the practitioner's malpractice insurance carrier showing that the practitioner currently has in force malpractice insurance in the amount approved by the medical center;

8.5.3.1.3. a copy of the practitioner's curriculum vitae;

8.5.3.1.4. a letter from another health care organization or facility certifying that the practitioner is a member in good standing of that organization's active Medical Staff with the same clinical privileges as those sought on a temporary basis at this medical center;

8.5.3.1.5. a letter from the COS, Credentials Committee chair, or the appropriate Medical Staff department chair, recommending the practitioner for temporary privileges; and

8.5.3.1.6. a written statement specifying the scope of the requested privileges including the patient and any surgical or invasive procedures involved.

8.5.3.2. Locum Tenens. Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is serving as a locum tenens for a member of the Medical Staff may, without applying for membership on the Medical Staff, be granted specific privileges for an initial period of 120 days, but not to exceed his/her services as locum tenens, and will be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens. He/she will be entitled to admit only patients for whom he/she is serving as a locum tenens practitioner. Applicants for locum tenens privileges will submit an application in such form as the hospital directs and will provide such information and documentation as the medical center requires, including, but not limited to, all of the information required for temporary privileges. In addition, references will be obtained from the last three health care organizations or facilities where the applicant had locum tenens privileges, unless the medical center CEO determines such information is not reasonably available or is not required. No locum tenens privileges will be granted by the medical center CEO until such time as all required information has been received and verified, the practitioner's licensure and current clinical competence to exercise the privileges requested have been verified, and the application has been reviewed by the chair of the appropriate department and the chair of the Credentials Committee.

8.5.3.3. Emergency Privileges. In the event that a patient in the hospital is suffering from a condition requiring immediate treatment and no qualified member of the Medical Staff is reasonably available to provide such treatment, the medical center CEO or designee, upon recommendation by the chair of any department or section or the COS, may grant emergency privileges to any health care practitioner who is otherwise licensed and qualified to provide the required health care service. Such emergency privileges will be restricted to the particular patient or condition involved in the emergency and will terminate as soon as a qualified member of the Medical Staff is available to assume the care of the patient or the emergency no longer exists.

8.5.3.4. Disaster Privileges: During a disaster, privileges may be granted for practitioners who are not members of the Medical Staff nor possess clinical privileges at CHMC. A disaster is defined as any officially declared emergency, whether it is local, state, or national, as outlined in Medical Staff Policy MS-028, Disaster Credentialing.

8.5.3.4.1. The medical center CEO and/or COS or designees will consider granting emergency/disaster privileges on a case-by-case basis and are not required to grant such privileges to any particular practitioner. Emergency/disaster privileges may be granted upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license, passport) and at least one of the following:

8.5.3.4.1.1. a current photo identification card from another healthcare organization or health system that clearly identifies professional designation;

8.5.3.4.1.2. a current unrestricted license to practice in the State of Maryland;

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

8.5.3.4.1.4. identification indicating that the individual has been granted authority to render patient care, treatment, and services in emergency/disaster circumstances as granted by a federal, state, or municipal authority; or

8.5.3.4.1.5. identification by a current Medical Staff member who has personal knowledge regarding the volunteer practitioner's ability to act as a licensed independent provider during a disaster.

8.5.3.4.2. The Medical Staff will begin the verification process of the credentials and privileges of individuals who receive emergency/disaster privileges as soon as the emergency/disaster is under control. The verification process is identical to the process established in these bylaws for granting temporary privileges to meet an important patient care need as stipulated in this Article.

8.5.3.4.3. Initial disaster privileges cannot exceed 72 hours unless the MEC decides, based on information obtained during the professional practice of the volunteer practitioner to continue the disaster privileges.

8.5.3.4.4. Each practitioner exercising emergency/disaster privileges during a disaster will be assigned to a current member of the Medical Staff who will be responsible for overseeing the professional performance of the practitioner and providing the practitioner with such information and assistance as the practitioner may require.

8.5.3.4.5. Each volunteer practitioner granted disaster privileges will be given a badge that identifies him/her as a volunteer practitioner who has been grantee disaster privileges.

8.5.3.4.6. The person granting emergency or disaster privileges will keep a written record of the information received and the action taken.

8.5.3.4.7. Disaster privileges granted during any disaster will immediately and automatically terminate at such time as the medical center's emergency management plan is no longer in effect.

ARTICLE 9. PROFESSIONAL PRACTICE REVIEW PROCESS

The Medical Staff will be involved in activities to measure, assess, and improve performance on an organization-wide basis. The Medical Staff will conduct a properly designed peer review process that includes the following:

9.1. Circumstances requiring professional practice review:

9.1.1. Assessment of ongoing professional competence.

9.1.2. Determination of causes or trends in unexpected patient outcome or variations in the standard of care.

9.1.3. Determination of compliance with adopted Medical Staff rules, regulations, and bylaws.

9.1.4. Conduct of a “root cause” analysis of a sentinel event.

9.2. Participants in the professional practice review. Participants in the peer review process will include practitioners who have equal standing with the reviewed physician as to education or training. Participants may include professionals of the same specialty or professional practice or a related specialty as the professionals whose services are being reviewed.

9.3. Professional practice review panels. Peer review panels are selected and required for a focused review of professional competence or a sentinel event. The panel will be selected by the department chair, the MEC, and/or Chief of Staff and CEO of the medical center.

9.4. Time frames to conduct and report professional practice review activities. Peer review actions will be completed within 90 days and reported at the next scheduled department or committee meeting.

9.5. Circumstances under which external professional practice review may be required:

9.5.1. External peer review sources will be utilized in the event a Medical Staff department is unable to reach an objective opinion of professional competence, standard of care, or cause of negative patient outcome.

9.5.2. External peer review may also be used for the assessment of the services provided by an exclusive contracted service provider.

9.5.3. External peer review may be utilized when there are no “peers” within the Medical Staff that can render a peer review decision.

9.6. Participation in the professional practice review process by the individual whose performance is being reviewed:

9.6.1. An individual practitioner whose performance is being reviewed will be notified of the peer review findings and afforded the opportunity to discuss the peer review findings at the department or committee level, and if deemed necessary, at the MEC level.

9.6.2. The results of peer review activities are considered in practitioner-specific credentialing and privileging decisions and, as appropriate, in the organization’s performance improvement activities. Peer review conclusions are tracked over time, and actions based on peer review conclusions are monitored for effectiveness.

ARTICLE 10. CORRECTIVE ACTION

10.1. Routine corrective action

10.1.1. Criteria for initiation. Corrective action may be taken whenever the activities or professional conduct of any practitioner with clinical privileges are, or are reasonably likely to be:

10.1.1.1. detrimental to patient safety or to the delivery of quality patient care;

10.1.1.2. disruptive to medical center operations;

10.1.1.3. in violation of:

10.1.1.3.1. Medical Staff policies adopted by the MEC and the Medical Staff;

10.1.1.3.2. Medical Staff bylaws, rules and regulations or departmental rules and regulations;

10.1.1.3.3. medical center policies and procedures concerning patient care and staff;

10.1.1.3.4. external review or regulatory agency policies and procedures; or

10.1.1.4. abusive behavior that is otherwise disruptive, illegal or nonprofessional, unbecoming to a Medical Staff member.

10.1.2. Preliminary inquiry

10.1.2.1. Whenever any of the following events occur, action may be initiated to reduce, suspend, restrict, modify, revoke, impose conditions on, or refuse to renew the privileges of the practitioner involved:

10.1.2.1.1. the activities or conduct of any practitioner are detrimental to, or are reasonably expected to be detrimental to the medical center, the safety of patients or others at the medical center, or disruptive of medical center operations;

10.1.2.1.2. a practitioner fails to continue to meet any of the requirements of these bylaws;

10.1.2.1.3. a staff member has engaged in immoral, unethical, unlawful, or unprofessional conduct;

10.1.2.1.4. a staff member fails to provide appropriate medical care and information consistent with recognized standards of care;

10.1.2.1.5. any of the events identified in Article 10.2 occurs; or

10.1.2.1.6. a practitioner fails to comply with all medical center and Medical Staff rules, regulations, policies, and procedures.

10.1.2.2. The medical center CEO, the COS, and the chair of the department concerned will be notified of any information concerning the activities or professional or personal conduct of any practitioner which might be grounds for corrective action. Upon receipt of such information, the medical center CEO, the COS, or the department chair will conduct or cause to be conducted by other appropriate individuals or committees a preliminary inquiry regarding the allegations. The practitioner may be required to submit to a physical and/or mental evaluation.

10.1.2.3. A preliminary inquiry, including FPPE, will not be considered to be an investigation for purposes of reporting to the National Practitioner Data Bank should the practitioner resign from the Medical Staff or not seek reappointment while a preliminary inquiry is being conducted.

10.1.2.4. The results of any preliminary investigation will be provided to the MEC or to the appropriate department chair or designee, if the preliminary inquiry is conducted by a committee or individual other than the department chair. If, after consulting with the COS and the VPMA or CEO, the department chair or designee recommends that a formal investigation be initiated or that any action should be taken, including action to reduce, suspend, restrict, modify, revoke, impose conditions upon, or refuse to renew the privileges of the practitioner, such proposed action may be discussed with the practitioner.

10.1.3. Formal investigation

10.1.3.1. If the chair of the department or designee recommends that a formal investigation be initiated or that any action be taken with regard to a practitioner's Medical Staff status or privileges, including any monitoring or further review, the department chair will advise the medical center CEO, the COS, and the chair of the Credentials Committee in writing of the results of the preliminary inquiry and any recommended action.

10.1.3.2. If the medical center CEO, the COS, the department chair, the chair of the Credentials Committee, and the practitioner all agree with any proposed action, no further action will be necessary to implement the recommendations. If the medical center CEO, the COS, the department chair, the chair of the Credentials Committee, or the practitioner concerned disagrees with the recommendation of the department chair or designee, the matter will be referred to the Credentials Committee for review and formal investigation in accordance with Article 10.1.5 below. The practitioner concerned will be notified in writing that a formal investigation has been requested or that action has been recommended.

10.1.4. Investigation by a department. The department chair will conduct the initial investigation and submit findings to the MEC. Based upon the findings, the MEC will:

10.1.4.1. accept the findings and act accordingly;

10.1.4.2. conduct its own investigation and report its findings within 30 days of receipt of the request; or

10.1.4.3. appoint immediately an ad hoc committee, internal or external, to investigate the request.

The investigative procedures may include consultation with the practitioner involved and need not be conducted according to the formal procedures outlined in the Fair Hearing and Appellate Review Plan. If the practitioner in question is a department chair, the COS or designee will conduct the investigation and submit a report to the MEC. The practitioner will be notified in writing by the department chair of the recommendation and will be provided an opportunity to submit any information the practitioner wishes the MEC to consider regarding the recommendations.

10.1.5. MEC action. After the report of the investigation or the receipt of the report of the department chair or ad hoc committee, the MEC reviews the matter and may invite or require the practitioner to appear and answer questions and present any information. Any decision concerning whether the practitioner is to appear

before the MEC will be made by the COS. Any such appearance before the MEC will not be considered to be a hearing; however, the practitioner is entitled to be represented by counsel before the committee, provided that the practitioner is required to respond personally to any questions directed to him/her. The MEC may return the matter to any department or section chair or the Credentials Committee for further information or consideration. Upon completion of the review by the MEC, it will vote on its recommendations to the BOD and the COS will prepare a report to the BOD setting forth the MEC's recommendations and the reasons for them. The report of the COS and the report and recommendations of the Credentials Committee will be sent to the affected practitioner by regular and certified mail. The MEC's action may include, without limitation:

10.1.5.1. rejecting the request or recommendation for corrective action;

10.1.5.2. issuing a verbal or written warning, a letter of admonition or a letter of reprimand;

10.1.5.3. revoking eligibility for election to board membership, Medical Staff elective office or continued committee chairmanship for a stipulated length of time;

10.1.5.4. recommending terms of probation or individual requirements of consultation;

10.1.5.5. recommending reduction, suspension or revocation of clinical privileges;

10.1.5.6. recommending reduction of Medical Staff category or limitation of any Medical Staff prerogatives directly related to patient care; and/or

10.1.5.7. recommending suspension or revocation of Medical Staff membership.

When appropriate, progressive discipline will be initiated, with verbal and written warnings preceding final adverse action by the MEC. A record of MEC actions taken and reasons therefore will be kept as part of the file of all practitioners and considered at the time of reappointment pursuant to Article 7.7.2.

10.1.6. Procedural rights. If the recommendation of the MEC has a materially adverse effect on the practitioner's Medical Staff membership or clinical privileges, the practitioner will be advised by the medical center's CEO of any right to request a hearing and to be provided with a summary of the rights the practitioner has in the hearing. The affected practitioner may, within 30 calendar days after receipt of the report, request a hearing and review pursuant to the Fair Hearing and Appellate Review Plan. Such request will be submitted in writing to the medical center CEO and upon receipt of such request all further proceedings will be in accordance with the Fair Hearing and Appellate Review Plan if the practitioner is entitled to a hearing. If the practitioner requests a hearing, the BOD will take no action until the hearing and all related procedures have been completed. If the practitioner does not request a hearing within 30 calendar days, the practitioner will be deemed to have waived any right to a hearing and the report and recommendations of the MEC, as well as the report and recommendations of the department chair and all supporting materials, will be sent to the BOD for final action in accordance with Article 10.1.7.

10.1.7. Board of Directors action

10.1.7.1. Within 90 days after the date of the report of the COS concerning the recommendations of the MEC, the BOD will act to accept, reject, or accept with modification the recommendations of the MEC, or refer the matter back to the MEC for further consideration or investigation. If the BOD refers the matter back to the MEC for further consideration, the BOD will state the reasons for such referral.

10.1.7.2. The BOD may, at its sole discretion, permit the parties or their representatives to appear before the BOD or any committee designated by the BOD and present oral arguments in support of their positions.

10.1.7.3. In the event the decision of the BOD differs substantially from the recommendations of the MEC, further action will be held in abeyance for a period not to exceed 60 calendar days. The MEC will be advised of the intended action by the BOD and the reasons for such action. The MEC will review the proposed action of the BOD, conduct any further investigation, and make such additional comments or recommendations as the MEC deems appropriate. In addition, either the BOD or the MEC may request that the issue be referred to a Conflict Management Joint Conference Committee pursuant to Article 7.7.7 for consideration before the BOD takes final action. The COS will prepare a report for the BOD setting forth the recommendations of the MEC and the reasons for the recommendations. The practitioner will be notified of any further recommendations of the MEC and given a copy of any report.

10.1.7.4. After receiving any further comments or recommendations from the MEC, the BOD will take final action. In the event that no comments or recommendations are received from the MEC within 60 calendar days of the original decision of the BOD, that decision of the BOD will become final unless the BOD extends the time for the MEC to submit a report or comments.

10.1.7.5. The medical center CEO will, in writing, notify the practitioner, the MEC, and the chairs of the appropriate departments or sections of the final action taken by the BOD.

10.1.7.6. If the final decision of the BOD is materially adverse to the practitioner, he/she will be given a copy of any reports or recommendations of the department chairs and the MEC, and a written statement from the BOD setting forth the reasons for the action taken. The practitioner will be notified in writing if he/she is entitled to a hearing and given a summary of the rights a practitioner has in any such hearing.

10.1.7.7. The practitioner may, within 30 calendar days after receipt of notice of the final action of the BOD, request a hearing and further review pursuant to the Fair Hearing and Appellate Review Plan by delivering a written request to the medical center CEO. Such a request and hearing are permitted only if the decision of the BOD is more severe than the recommendations of the MEC and the practitioner has not previously had a hearing.

10.1.7.8. The final action of the BOD will be effective at such time as the BOD designates and such action will not be stayed by any judicial review proceedings without the consent of the BOD.

10.2. Summary suspension

10.2.1. Criteria for imposition

10.2.1.1. If any of the following events should occur, summary suspension of the Medical Staff member's status or all or any portion of the clinical privileges of such practitioner may be initiated. Summary suspension may be initiated by the COS, or the medical center CEO or his/her designee after consultation with the COS or his/her designee. Grounds for summary action include:

10.2.1.1.1. the conduct or clinical practice of a practitioner creates a reasonable possibility of injury or damage to any patient, employee, or person present in the medical center, or to the medical center itself;

10.2.1.1.2. a practitioner is charged with the commission of a felony;

10.2.1.1.3. a practitioner is charged with commission of a misdemeanor that may relate to his/her suitability for Medical Staff membership and clinical privileges;

10.2.1.1.4. there is reason to believe that a practitioner has engaged in or is charged with unlawful, immoral, unprofessional, or unethical activity related to the practice of medicine;

10.2.1.1.5. a practitioner engages in unprofessional, abusive, or inappropriate conduct that is or may be disruptive of medical center operations and procedures;

10.2.1.1.6. a practitioner is excluded from participation in, or is sanctioned by, Medicare or Medicaid;

10.2.1.1.7. a practitioner has had any medical staff membership, clinical privileges, certification, licensure, or registration terminated, suspended, restricted, limited, reduced, or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff membership or clinical privileges, or has voluntarily surrendered or agreed not to exercise any clinical privileges following an investigation, while under investigation or in order to avoid an investigation or disciplinary action;

10.2.1.1.8. it is determined that the practitioner made a material misstatement or omission on any pre-application questionnaire or application for appointment or reappointment;

10.2.1.1.9. a practitioner has destroyed, altered, or made false entries in any medical record or other records, or otherwise provided false information or attempted to deceive the Medical Staff and/or the hospital;

10.2.1.1.10. a practitioner abandons a patient or wrongfully fails or refuses to provide care to a patient;

10.2.1.1.11. a practitioner engages in clinical activities outside the scope of his/her approved clinical privileges; or

10.2.1.1.12. a practitioner refuses to submit to evaluation or testing relating to his/her mental or physical status, including refusal to submit to any testing related to drug or alcohol use.

10.2.1.2. Such summary suspension will become effective immediately upon imposition and the CEO in collaboration with the COS or designee will promptly give special notice of the suspension to the practitioner.

In the event of any such suspension, the practitioner's patients will be assigned to another practitioner by the department chair. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

10.2.2. MEC action

10.2.2.1. As soon as possible after such summary suspension, a meeting of the MEC will be convened to review and consider the action taken. The MEC may conduct such investigation at it deems appropriate and may require the practitioner to appear before it or designated members of the MEC for an interview. Any appearance before the MEC will not be considered to be a hearing; however, the practitioner will be entitled to representation by counsel before the MEC, provided that the practitioner is required to respond personally to any questions directed to him/her. The MEC will make a recommendation to the Board to modify, continue, or terminate the terms of the summary suspension.

10.2.2.2. The COS will prepare a report for the BOD setting forth the recommendations of the MEC and the reasons for the recommendations. A copy of the report of the MEC will be sent to the practitioner by regular and certified mail, return receipt requested, and the practitioner may, within five business days after receipt of the report, provide the BOD with any written comments or information he/she wishes the BOD to consider. If the practitioner disagrees with the recommendation of the MEC, he/she must submit to the BOD a written statement specifying the findings of fact, conclusions, and procedural matters with which he/she disagrees and the reasons for such disagreement. Failure to identify any finding or procedure with which the practitioner disagrees will be deemed a waiver of any such objection to such finding or procedure and consent to the procedures being followed or action taken.

10.2.2.3. Within 15 business days after the date of the report of the COS, the BOD, or any committee authorized to act on behalf of the BOD, will act to continue, terminate, or modify the summary action and will immediately notify the practitioner of the action taken.

10.2.3. Procedural rights

10.2.3.1. Unless the BOD terminates the summary action, the practitioner may within 30 calendar days after notification of the BOD's action request a hearing and he/she will have the right to a hearing and such related procedures as provided in the Fair Hearing and Appellate Review Plan.

10.2.3.2. The terms of the summary action as sustained or modified by the BOD will remain in effect pending further action by the BOD.

10.2.4. Other action. Any matter giving rise to a summary action will be referred to the appropriate department chair for investigation and recommendation concerning what further action, if any, should be taken with regard to the practitioner's Medical Staff membership and clinical privileges. Upon completion of such investigation the matter will be considered by the MEC and BOD in accordance with the corrective action process set forth in these bylaws. Unless any summary action is terminated by the BOD, the suspension, restriction, or conditions will remain in effect while such investigation and review takes place.

10.3. Automatic suspension

10.3.1. In the event that any practitioner fails to (a) maintain appropriate malpractice insurance, (b) maintain a current active and unrestricted Maryland state license to practice medicine, (c) is excluded from participation in Medicare or Medicaid, or (d) maintain a current active DEA certification (if required for practice), his/her Medical Staff membership and/or clinical privileges will be automatically suspended. The practitioner will be notified of the suspension and the basis of the suspension by regular and certified mail, and given 30 calendar days to produce clear and convincing evidence that the facts relied upon by the medical center in instituting automatic suspension are not correct. If the medical center does not receive such evidence from the practitioner within 30 calendar days, the practitioner will no longer be qualified for Medical Staff membership and clinical privileges. The practitioner's Medical Staff membership and clinical privileges will automatically terminate and he/she will not be entitled to a hearing as set forth elsewhere in these bylaws.

10.3.2. Medical records

10.3.2.1. An automatic suspension may, after warning of delinquency, be imposed by the COS and the CEO when a practitioner has failed to complete patient medical records in accordance with the policies and procedures adopted by the medical center.

10.3.2.2. A warning of delinquency (at least 21 days from date of patient discharge) will include a direct contact from the Medical Records Department (MRD) to the practitioner informing him/her of the status of his/her delinquent medical records and the seven-day time frame to complete them. Once the seven-day time frame has lapsed, after approval by the COS, the MRD will notify the practitioner in writing that progressive action and fines will be initiated in accordance with Policy GA-48, Medical Staff Medical Record Completion Requirements. The Medical Staff office will also report this information to the MEC via the COS if corrective action is necessary, according to Article 10.1.

10.3.2.3. In the event that a practitioner is suspended, suspension may be waived if the practitioner is on call for the ED or other types of specialty coverage unless there is otherwise adequate coverage. If the practitioner fails to complete the medical records within the stated time frames above, clinical privileges will be suspended. Such suspensions will take the form of withdrawal of the practitioner's admitting, consulting and clinical privileges to treat a patient, and will be effective until medical records are completed. For the purpose of enforcing the provisions of Article 10.3, justified reasons for delay in completing medical records may include without limitation:

10.3.2.3.1. The attending physician or any other individual contributing to the record is ill or otherwise unavailable for a period of time due to circumstances beyond his/her control. The practitioner must notify the MRD of such illness or unavailability.

10.3.2.3.2 A practitioner is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis.

10.3.2.3.3. A practitioner has dictated reports and is waiting for responsible personnel to transcribe them.

For purposes of this section, incomplete medical records include those in which the discharge diagnosis, history and physical, operative reports, discharge summary and signatures do not comply with the content and timing required by the medical record section of the rules and regulations.

10.3.3. History and Physical Examination (HPE)

10.3.3.1. A comprehensive admission HPE will be recorded within 24 hours of admission, to be completed by a credentialed physician, oral-maxillofacial surgeon, or other qualified licensed individual in accordance with state law and medical center policy or his/her qualified designee. The credentialed practitioner will be held responsible for the HPE. If a complete history has been recorded and the physical examination performed within 30 days prior to the patient's admission to the hospital, a legible copy of these reports may be used in the patient's hospital record, provided these reports were recorded or countersigned by a member of the Medical Staff. In such instances, the admitting credentialed practitioner must review the HPE document, determine if the information is compliant with the medical center's defined minimal content requirements, and obtain missing information through further assessment update information and findings as necessary, which may include, but are not limited to, inclusion of absent or incomplete required information and a description of the patient's condition and course of care since the HPE was performed. He/she must place a signature and date on any document with updated or revised information as an attestation that it is current. For patients undergoing an operative procedure, the HPE will be performed within 30 days and a signed, timed, and dated update note will be entered into the record on the day of the procedure and must be present in the chart prior to the start of the procedure.

10.3.3.2. See policy MS-44, Documentation Requirements, for details regarding HPE contents.

10.4. Attorney representation. No practitioner will be entitled to be accompanied by an attorney in connection with any investigation or interview prior to the time that he/she is entitled to a hearing in accordance with these bylaws. However, the practitioner may be accompanied by an attorney in connection with any appearance before the MEC or the BOD after disciplinary action or summary action has been recommended or taken, provided that he/she will be required to respond personally to any questions addressed to him/her. If the practitioner will be represented by counsel or another representative at any hearing or appearance, he/she shall notify the Medical Staff of the name of the attorney or other representative at least 10 days prior to the hearing or appearance. The MEC, the BOD, or other body before which a practitioner appears will be entitled to have an attorney present to represent and advise the body.

ARTICLE 11. INTERVIEWS, HEARINGS AND APPELLATE REVIEW

11.1. Interviews. When the MEC, other relevant Medical Staff committees, the Board, or any appropriate committee thereof, receives or is considering initiating an adverse recommendation concerning a practitioner, the practitioner may be afforded an interview. The interview will not constitute a hearing, will be preliminary in nature and will not be conducted according to the procedural rules provided with respect to hearings. The practitioner will be informed of the general nature of the circumstances and may present information relevant thereunto. A record of such interview will be made.

11.2. Hearings and Appellate Review

11.2.1. Adverse MEC recommendation. When any practitioner receives special notice of an adverse recommendation of the MEC, he/she will be entitled, upon request, to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the MEC following such hearing is still adverse, the practitioner will then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

11.2.2. Adverse Board recommendation. When any practitioner receives special notice delivered in person or by certified mail of an adverse decision by the Board taken either contrary to a favorable recommendation by the MEC under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the MEC, the practitioner will be entitled, upon request, to a hearing by an ad hoc committee appointed by the Board. If such a hearing does not result in a favorable recommendation, he/she will then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

11.2.3. Procedure and process. All hearings and appellate reviews will be in accordance with the procedures and safeguards set forth in the Fair Hearing and Appellate Review Plan.

11.2.4. Exceptions. Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination, or reduction of temporary privileges, nor any other actions except those specified in the Fair Hearing and Appellate Review Plan will give rise to any right to a hearing or appellate review.

11.3. Fair Hearing Plan and Appellate Review. The Fair Hearing and Appellate Review Plan is attached as ADDENDUM # 1 to these bylaws.

ARTICLE 12. STAFF DEPARTMENTS

12.1 Organization. The Medical Staff will be organized in medical center departments as authorized from time to time by the Board on recommendation of the MEC. Each department will elect a chair who has authority, duties and responsibilities as specified in Article 13.2.4. The current departments are: Anesthesia, Emergency Medicine, Cardiology, Family Medicine, Medicine, Obstetrics/Gynecology, Orthopedic Surgery (including Podiatry), Ophthalmology, Pathology and Laboratory Medicine, Pediatrics, Psychiatry, and Radiology (including all imaging modalities and Nuclear Medicine), and Surgery.

12.2. Assignment to departments. Each member of the Medical Staff and each AHP will be assigned membership in one department, but may be granted clinical privileges or specified services in one or more departments. The exercise of clinical privileges or the performance of specified services within any department will be subject to any rules and regulations of that department and the authority of the department chair.

12.3. Functions of departments. The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department will:

12.3.1. review and evaluate the quality of care within the department, in accordance with the requirements of The Joint Commission, applicable professional societies, and outside review organizations. Each department will review all clinical work performed under its jurisdiction, whether or not any particular practitioner whose work is subject to such review is a member of that department, via FPPE and OPPE.

12.3.2. establish guidelines for granting of clinical privileges and the performance of specified services within the department and submit the recommendations required under Articles 7 and 8 regarding the specific privileges each Medical Staff member or applicant may exercise and the specified services each AHP may provide.

12.3.3. conduct, participate in, and make recommendations regarding continuing education programs pertinent to changes in medical practice or in response to review, evaluation and monitoring activities.

12.3.4. continuously monitor adherence to Medical Staff bylaws and rules and regulations, and medical center policies and procedures.

12.3 5. coordinate patient care provided by the department's members with nursing and ancillary patient care services and with administrative support services.

12.3.6. submit regular written reports to the MEC concerning:

12.3.6.1. findings of the department's review, evaluation and monitoring activities, actions taken thereon and the results of such action;

12.3.6.2. recommendations for maintaining and improving the quality of care provided in the department and the medical center;

12.3.6.3. other matters as may be requested from time to time by the MEC; and

12.3.6.4. department specific clinical measures identified to follow for FPPE and OPPE.

12.3.7. meet as departments and/or committees/teams at least three times per year or as often as needed in order to discharge their Medical Staff obligations.

12.3.8. establish such committees or other mechanisms as are necessary to perform properly the functions assigned to the department.

ARTICLE 13. OFFICERS

13.1. Officers and officials of the Medical Staff

13.1.1. The officers of the Medical Staff will be: the Chief of Staff, the Vice Chief of Staff, and the Secretary/Treasurer.

13.1.2. Other officials of the Medical Staff. Other officials of the Medical Staff may include elected representatives to the Board as defined by health system corporate bylaws, members of the JQIC, department chairs, and such other officials as may be selected pursuant to these bylaws.

13.1.2.1 Medical Staff representatives to the Board of Directors. The General Medical Staff will elect two members of the active Staff to serve as at-large voting representatives to the Board of Directors. The term of office is three years each; elected directors may be nominated and re-elected for one successive term, and after one year off the Board may be re-nominated and re-elected as provided in these bylaws.

13.1.2.2 Medical Staff representatives to the Joint Quality Improvement Committee. The General Medical Staff will elect three members of the active Staff to serve as voting representatives to the Joint Quality Improvement Committee. The term of office is two years each; elected Staff representatives may be nominated and re-elected once.

13.1.2.3 Department chairs. See Article 13.2.4.

13.1.3. Qualifications. Only an Active staff member who satisfies the following criteria will be eligible to serve as an officer of the Medical Staff:

13.1.3.1. any practitioner who has served on the Active staff, in good standing without disciplinary action on record as set forth in Article 10, for at least three consecutive years, and continues to be in good standing during his/her term of office;

13.1.3.2. is recognized for a high level of clinical competence and has demonstrated an ability to work cooperatively with the other members of the Medical Staff, medical center staff and medical community;

13.1.3.3. is not presently serving as a Medical Staff officer, corporate officer, or department chair at any other health care facility and will not so serve during his/her term of office;

13.1.3.4. is willing to faithfully discharge the duties and responsibilities of the position;

13.1.3.5. has previously served in a leadership position, such as a department chair or committee chair at CHMC or another health care facility, for at least two years;

13.1.3.6. has constructively participated in Medical Staff affairs, including peer review activities;

13.1.3.7. is knowledgeable concerning the duties of the office;

13.1.3.8. attends continuing education relating to Medical Staff leadership and/or credentialing functions as appropriate during the term of the office; and

13.1.3.9. has achieved and maintains board certification in his/her specialty.

13.1.4. Nominations and elections. A nominating committee for all general and special elections will be formed consisting of at least three members of the active Medical Staff appointed by the MEC as needed.

Such a committee will convene at least 60 days prior to the general meeting of the Medical Staff at which the election will be held and will submit to the MEC one or more qualified nominees for each office or position. Notice of the nominees will be delivered to the Medical Staff at least 30 days prior to the general Medical Staff meeting at which the election will be held. Additionally, nominations may be submitted in writing by petition signed by at least two active Medical Staff members at least 10 days prior to the meeting. Nominations from the floor will be accepted, subject to eligibility criteria. All candidates for office or elected position will meet the criteria for office as set forth and specified in these bylaws. Only members of the active Medical Staff who have voting privileges will vote for Medical Staff officers, other elected positions, or other matters of the Medical Staff such as changes to the bylaws, rules and regulations, etc. Vote by proxy is not permitted.

13.1.5. Term of elected office. Each officer will serve a term of two years, commencing on the date of Board approval of the election results. Each officer will serve until the end of his/her term and until a successor is elected and approved, unless he/she resigns sooner or is removed from office.

13.1.6. Removal of elected Medical Staff officers and officials

13.1.6.1. Elected officers and officials will be removed for cause, defined as failure to maintain active Medical Staff status in good standing and/or failure to fulfill the duties as defined in these bylaws, including engaging in conduct which is detrimental to, or reflects adversely on, the Medical Staff or hospital; mental or physical impairment or incapacity; failure to perform the necessary functions of the office held; or any action or conduct which would form the basis for corrective action, even if corrective action is not taken.

13.1.6.2. Removal of any officer of the Medical Staff may be initiated by the BOD, the MEC, or upon petition of at least 10 members of the Active Medical Staff. Removal by the BOD will be subject to the approval of a Conflict Management Joint Conference Committee. Removal by the MEC will be by two-thirds vote of the members of the committee with the approval of the BOD. Removal by members of the Active Medical Staff will be effective upon a two-thirds vote of the members of the Medical Staff eligible to vote for Medical Staff officers. Written notice of any meeting at which removal of an officer is to be considered will be delivered by regular mail to all Medical Staff members entitled to vote at the meeting and the medical center CEO at least 10 calendar days before the meeting date.

13.1.6.3. In the event that the Medical Staff membership or clinical privileges of an officer are suspended or terminated at any time, other than temporary suspension of admitting privileges due to failure to complete medical records in a timely manner, such suspension and termination will operate as an automatic removal of the practitioner as an officer of the Medical Staff for the duration of the suspension.

13.1.7. Vacancies in elected office. A vacancy in the office of Secretary/Treasurer will be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve out the remaining term. A vacancy in the office of Vice Chief of Staff will be filled by a special election conducted as reasonably soon as possible after the vacancy occurs, according to the provisions of this Article.

13.2. Roles and responsibilities of Medical Staff officials

13.2.1. Chief of Staff. As the principal elected official of the Medical Staff, the Chief of Staff will:

13.2.1.1. work collaboratively with the medical center leadership in coordinating the activities and concerns of the medical center administration, nursing, and other organizations in patient care services with those of the Medical Staff;

13.2.1.2. communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the CEO, and other officials of the medical center staff;

13.2.1.3. be responsible for the enforcement of Medical Staff bylaws, rules and regulations, and for compliance with organizational policies and procedures;

13.2.1.4. be responsible for implementation of sanctions where these are indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

13.2.1.5. make regular reports and recommendations to the Board, in conjunction with the MEC, regarding the quality and efficiency of clinical services and Medical Staff performance within the medical center and the effectiveness of the patient care assessment and improvement functions delegated to the Medical Staff;

13.2.1.6. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

13.2.1.7. serve as chair of the MEC, as a member of the JQIC, and as an adjunct member without vote of all other Medical Staff committees;

13.2.1.8. serve as a member of the Board; and

13.2.1.9. appoint special committees as may be necessary to perform Medical Staff functions as outlined in Article 14.3 and elsewhere in these bylaws.

13.2.1.10. The COS, or the VCOS if the COS is unavailable, may perform any of the duties of any department chair or chair of any Medical Staff committee, if such individual is unavailable or otherwise fails to perform his/her necessary duties.

13.2.2. Vice Chief of Staff. The Vice Chief of Staff will be a member of the MEC and will serve as a member of the Board. In the absence, either temporary or permanent, of the Chief of Staff, he/she will assume all the duties and have the authority of the Chief of Staff. He/she will perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board. The Vice Chief of Staff will serve as chair of the Bylaws Review Committee.

13.2.3. Secretary/Treasurer. The Secretary/Treasurer or his/her designee will be a member of the MEC. His/her duties will be to give proper notice of all MEC meetings on order of the appropriate authority, prepare

accurate and complete minutes for all meetings and perform such other duties as ordinarily pertain to his/her office, including financial reports and payment of Medical Staff invoices.

13.2.4. Department chair

13.2.4.1. Qualifications: Each chair will be a member of the active Medical Staff in good standing, will have demonstrated ability in at least one of the clinical areas covered by the department and will be willing and able to discharge faithfully the functions of his/her office. All department chairs will be board certified in their specialties by an appropriate specialty board or have comparable competence affirmatively established through the credentialing process.

13.2.4.2. Selection and appointment: Each chair will be elected by the department, or by contract, from nominees submitted by the department members or designated by contract.

13.2.4.3. Term of office: A department chair will serve a two-year term commencing on the date of his/her election, or such other terms as may be defined by contract. Department chairs will serve until the end of the succeeding Medical Staff year and until his/her successor is chosen, unless he/she resigns sooner or is removed from office. Department chairs will be eligible to succeed themselves but may serve no more than two two-year terms in succession. They may be eligible for reelection after one year out of office. In any department having only one member who is a recognized specialist in the field, this bylaw will not apply. Contract physicians are exempt from this rule.

13.2.4.4. Removal from office: A department chair may be removed for cause, defined as failure to maintain active Medical Staff status in good standing and/or failure to fulfill the duties as defined in these bylaws, including engaging in conduct which is detrimental to, or reflects adversely on, the Medical Staff or medical center; mental or physical impairment or incapacity; failure to perform the necessary functions of the office held; or any action or conduct which would form the basis for corrective action, even if corrective action is not taken . Removal of a department chair from office may be initiated by the MEC or the department and may be accomplished by a two-thirds vote of committee or the department members eligible to vote on departmental matters or according to contract terms.

13.2.4.5. Roles and responsibilities. The roles and responsibilities of the department chair will be to make certain that the department carries out the functions described in Article 7, Article 8, Article 12, and the Fair Hearing and Appellate Review Plan. Department chair responsibilities are to:

13.2.4.5.1. oversee all clinically related activities of the department;

13.2.4.5.2. oversee all administratively related activities of the department, unless otherwise provided by the medical center;

13.2.4.5.3. conduct or delegate continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

13.2.4.5.4. recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

13.2.4.5.5 recommend clinical privileges for each member of the department;

13.2.4.5.6. assess and recommend to the relevant medical center authority off-site sources for needed patient care, treatment, and such services not provided by the department or the organization;

13.2.4.5.7. integrate the department into the primary functions of the organization;

13.2.4.5.8. coordinate and integrate interdepartmental and intradepartmental services;

13.2.4.5.9. develop and implement policies and procedures that guide and support the provision of care, treatment, and services;

13.2.4.5.10. recommend a sufficient number of qualified and competent practitioners to provide care, treatment, and services;

13.2.4.5.11. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

13.2.4.5.12. assure continuous assessment and improvement of the quality of care, treatment, and services;

13.2.4.5.13. maintain quality control programs as appropriate;

13.2.4.5.14. orient and assure continuing education for all persons in the department; and

13.2.4.5.15. recommend space and other resources needed by the department to perform its functions.

ARTICLE 14. COMMITTEES AND FUNCTIONS

14.1. Designation and substitution

14.1.1. There will be an MEC and such other standing and special committees of the Medical Staff responsible to the MEC as may be necessary to perform the Medical Staff functions listed in Article 2.2 and elsewhere in these bylaws. The MEC may, by resolution and upon approval of the Board, establish a Medical Staff committee to perform one or more of the required Medical Staff functions. The Medical Staff will be represented on medical center committees established to perform functions requiring participation rather than direction by Medical Staff members.

14.1.2. Whenever these bylaws require that a function be performed by, or that a report or recommendation be submitted to a named Medical Staff committee but no such committee exists, the MEC will perform such function or receive such report or recommendation or will assign the functions of such committee to a new or existing committee of the Medical Staff or to the Medical Staff as a whole. In addition, whenever these bylaws require that a function be performed by, or that a report or recommendation be submitted to the MEC

but a standing or special committee exists to perform the function, the committee will act in accordance with the authority delegated to it.

14.2. Medical Executive Committee (MEC)

14.2.1. Composition. The MEC will be a standing committee composed of the elected officers, namely the Chief of Staff, Vice Chief of Staff, and Secretary/Treasurer, plus the chairs of all the departments and the Medical Director of the Adult Hospitalist Service. The immediate past Chief of Staff will serve, without voting privileges, on the MEC in an advisory capacity for one year. Non-voting members include the medical center CEO or designee, the Vice President Medical Affairs, the Vice President Clinical Services, and the Vice President of Quality and Risk Management; these will attend all meetings, including executive sessions. Two members of the Board are invited to attend all MEC meetings, including any executive sessions. All others present at the MEC meeting will attend by invitation as the need arises, as determined by the Chief of Staff and the members of the MEC. The members of the MEC will consist of physicians and may include other practitioners and any other individuals as determined by the organized Medical Staff.

14.2.2. Duties. The duties of the MEC will be to:

14.2.2.1. receive and act upon reports and recommendations from the departments, committees and officers of the Medical Staff concerning quality improvement, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities, and recommend to the Board specific programs and systems to implement these functions;

14.2.2.2. recommend to the Board all matters relating to appointments, reappointments, Medical Staff category, department assignments, clinical privileges and corrective action;

14.2.2.3. account to the Board and to the Medical Staff for the overall quality and efficiency of patient care in the medical center;

14.2.2.4. take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted;

14.2.2.5. make recommendations on medico-administrative and medical center management matters;

14.2.2.6. participate in identifying community health needs and in setting medical center goals and implementing programs to meet those needs;

14.2.2.7. act as empowered by these bylaws for the organized Medical Staff between meetings of the organized Medical Staff, within the scope of its responsibilities as defined by the organized Medical Staff;

14.2.2.8. amend and revise the Medical Staff rules, regulations, and policies consistent with the Medical Staff bylaws.

14.2.2.9. adopt on an urgent basis an amendment to the rules and regulations to comply with law or regulation on a provisional basis. Upon adoption by the MEC and the Board, the organized Medical Staff will

be notified immediately of the change by the MEC. The Medical Staff will have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the amendment will be adopted by a vote of the Medical Staff. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and MEC is implemented as in Article 14.3. If necessary, a revised amendment is then presented to the Board for action final action.

14.2.3. Meetings. The MEC will meet regularly, but no fewer than nine times per year, and must maintain a permanent record of its proceedings.

14.2.4. Removal of committee members. Any committee member may be removed for cause by the individual or committee that appointed the committee member. Members of the MEC may be removed from the committee in the same manner as officers of the Medical Staff (Article 13.1.6), in this case by a two-thirds vote of the committee.

14.3. Conflict resolution

14.3.1. Any Medical Staff member in good standing in the active category may challenge any bylaw, rule, regulation, policy or procedure (collectively, the "Rules") established by the MEC through the following process:

14.3.1.1. The Medical Staff member submits to the COS a challenge to the Rules in writing, including any recommended changes to the Rules.

14.3.1.2. At the MEC meeting that follows such notification, the MEC will discuss the challenge and determine if it will change or recommend a change to the Rules.

14.3.1.3. If changes are adopted or proposed, 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 Rules to the Chief of Staff.

14.3.1.4. In response to a 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 by the challenge.

14.3.1.5. If a task force is appointed, the MEC will take final action or propose final action on the Rules after considering the recommendations of the task force.

14.3.1.6. Once the MEC has taken a position in response to the challenge, with or without recommendations from a task force, any Medical Staff member may submit a petition signed by 25% of the members of the active category requesting review and possible change of a Rule. After receiving a petition, the MEC will bring the matter for a vote of the entire Medical Staff either at the next regularly scheduled Medical Staff meeting or a specially called meeting.

14.3.2. If the Medical Staff votes to recommend directly to the Board an amendment to a Rule that is different from what the MEC has recommended, the following conflict resolution process will be followed:

14.3.2.1. The MEC will 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 Rule that is agreeable to both the Medical Staff and MEC.

14.3.2.2. Regardless of whether the MEC adopts or proposes to adopt modified language, the Medical Staff will have the opportunity to recommend alternative language directly to the Board. If the Board receives differing recommendations from the MEC and the Medical Staff, the Board will have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate Board action.

14.3.2.3. Regardless of whether the Board appoints such a task force, the Board will 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 the MEC regarding changes in the Rules, the Medical Staff, MEC or Board will each have the right to recommend using an outside facilitator to assist in addressing the disagreement. The final decision regarding whether to use an outside resource and the process that will be followed in so doing is the responsibility of the Board.

14.4. Medical Staff functions. The following Medical Staff functions will be performed by standing interdisciplinary committees or by the MEC, or individually within each Medical Staff department:

14.4.1. Conduct, coordinate and review quality assessment and improvement activities of departments and committees, including but not limited to the following:

14.4.1.1. blood usage;

14.4.1.2. drug usage, to include a review of adverse reactions and medication errors;

14.4.1.3. operative and invasive procedure case review to include a review of all major discrepancies or patterns of discrepancies between pre-operative and post-operative diagnosis;

14.4.1.4. infection control surveillance and prevention;

14.4.1.5. medical record content;

14.4.1.6. anesthesia-related adverse events; and

14.4.1.7. processes and outcomes related to behavior management procedures.

14.4.2. Conduct, coordinate and review or oversee the conduct of utilization review activities.

14.4.3. Conduct, coordinate and review in conjunction with the Credentials Committee investigations and recommendations regarding Medical Staff membership and granting of privileges and specified privileges.

14.4.4. Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care and other ambulatory care services.

14.4.5. Plan for response to fire and other disasters, for medical center growth and development and for the provision of services required to meet the needs of the community.

14.4.6. Direct Medical Staff organizational activities, including Medical Staff bylaws review and revision, Medical Staff officer and committee nominations, liaison with the Board and medical center administration, and review the maintenance of medical center accreditation.

14.4.7. Coordinate the care provided by practitioners with the care provided by the nursing service and with the activities of other medical center patient care and administrative services.

14.5. Committees

14.5.1. Composition and appointment. A committee established to perform one or more of the Medical Staff functions required by these bylaws will be composed of members of the active Medical Staff and will include, where appropriate, consulting staff, AHPs, and representation from medical center administration, nursing service, medical records service, pharmaceutical service, social service, and such other medical center departments as are appropriate. Unless otherwise specifically provided, the Medical Staff members will be appointed by the CEO.

14.5.2. Term and prior removal. Unless otherwise specifically provided, a committee member will continue as such until the end of his/her normal period of Medical Staff appointment and until his/her successor is elected or appointed, unless he/she sooner resigns or is removed from the committee. A Medical Staff committee member, other than one serving ex-officio, may be removed by a majority vote of the MEC. An administrative staff committee member will serve for a term equivalent to that of a Medical Staff committee member and until his/her successor is elected or appointed, unless he/she sooner resigns or is removed from the committee. An administrative staff committee member may be removed by action of the CEO.

14.5.3. Vacancies. Unless otherwise specifically provided, vacancies on any Medical Staff committee will be filled in the same manner in which original appointments to such committees are made.

14.6. Medical Staff committees. Refer to Policy MD 049, Committees.

ARTICLE 15. GENERAL STAFF MEETINGS

15.1. Scheduling. A regular annual meeting will be held each year in the month of October on the second Wednesday. In addition to the annual meeting in October, regular Medical Staff meetings will be held as needed but not less than one meeting per year. Roberts Rules of Order will prevail at all meetings, both regular and special.

15.2. Order of business and agenda. The COS will determine the order of business at a regular meeting. The agenda will include at least:

15.2.1. approval of the minutes of the last regular meeting and of all special meetings held since the last regular meeting as read or circulated;

15.2.2. reports from the COS, the CEO, departments and committees;

15.2.3. the election of officers and of representatives to Medical Staff and medical center committees, when required by these bylaws;

15.2.4. reports by responsible officers, committees and departments on the overall results of patient care, evaluation and monitoring activities and on the fulfillment of the other required Medical Staff functions;

15.2.5. recommendations for improving patient care within the medical center; and

15.2.6. new business.

15.3. Special meetings. Special meetings of the Medical Staff may be called at any time by the COS, the MEC or not less than one-fourth of the members of the Active Medical Staff and will be held at the time and place designated in the meeting notice. No business will be transacted at any special meeting except that stated in the meeting notice.

15.4. Committee and department meetings

15.4.1. Regular meetings. Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution will then be required. The frequency of such meetings will be as required by these bylaws

15.2.2. Special meetings. A special meeting of any committee or department may be called by, or at the request of, the chair, the COS, or by one-fourth of the group's current members. No business will be transacted except that stated in the notice.

15.5. Quorums

15.5.1. General Medical Staff meetings. The presence of 35 percent of the voting members of the active Medical Staff at any regular or special meeting will constitute a quorum for the purposes of amendment to these bylaws. The presence of a majority of such members will constitute a quorum for the transaction of all other business.

15.5.2. Department and committee meetings. Those voting members of a department or committee present, but not fewer than two members, except where the department normally consists of one member, will constitute a quorum at any meeting of such department or committee.

15.6. Manner of action. Except as otherwise specifically provided, the affirmative vote of a majority of the members present and eligible to vote at any meeting will be the action of the group. There will be no voting by proxy. Action may be taken by a department or committee without a meeting by a written statement setting forth the action taken which is signed by each member entitled to vote. The members present at the General Medical Staff meeting may permit the use of mail or electronic ballots for the amendment of the Medical Staff bylaws or any other action that is required to be taken by the full Medical Staff, other than the election of officers, which will be approved in accordance with Article 13. Section 1.5. In addition, any department or

committee may choose to have any matter voted on by mail or electronic ballot instead of at a meeting of the department or committee. The manner in which mail or electronic ballots are employed will be at the discretion of the MEC or the department or committee concerned. If mail or electronic ballots are used, the affirmed vote of a majority of the members casting ballots will be the action of the group.

15.7. Minutes. Minutes of all meetings will be the responsibility of the chair and will include a record of attendance and the vote taken on each matter. Copies of such minutes will be signed by the presiding officer, approved by the attendees, forwarded to the MEC and made available to the Medical Staff. A permanent file of the minutes of each meeting will be maintained. Refer to Medical Staff policy and procedure MS-004 for further information.

15.8. Attendance requirements. All members of the Medical Staff are encouraged to attend regular Medical Staff meetings. Members are encouraged to attend department and committee meetings of which they are members.

ARTICLE 16. CONFIDENTIALITY AND RELEASES

16.1. Special definitions. For the purposes of this Article, the following definitions will apply:

16.1 1. Information: records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures, whether in written or oral form, relating to any of the subject matter specified in this Article.

16.1.2. Malice: the dissemination of a known falsehood or of information with a reckless disregard for whether such is true or false.

16.1.3. Practitioner: a Medical Staff member or applicant.

16.1.4. Representative: a Board member or any director of a committee thereof; a CEO or his/her designees; a Medical Staff organization member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

16.1.5. Third parties: individuals and organizations providing information to any representative.

16.2. Authorizations and conditions. By applying for or exercising clinical privileges, or providing specified patient care services within this medical center, a practitioner:

16.2.1. authorizes representatives of the medical center and the Medical Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications;

16.2.2. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and

16.2.3. acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Medical Staff membership, or to his/her exercise of clinical privileges or provision of specified patient services at this medical center.

16.3. Confidentiality of information. Information pertaining to any practitioner submitted, collected or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research will, to the fullest extent permitted by laws, be confidential and will not be disseminated to anyone other than a representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality will also extend to information of like kind that may be provided by third parties. This information will not become part of any particular patient's file or of the general medical center record.

16.4. Immunity from liability

16.4.1. For action taken. No representative of the health system or Medical Staff will be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative if such representative acts in good faith without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Truth will be an absolute defense in all circumstances.

16.4.2. For providing information. No representative of the health system or Medical Staff and no third party will be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this health system or Medical Staff or to any other health care facility or organization of health professionals concerning a practitioner or AHP who is or has been an applicant to or member of the Medical Staff or who did or does exercise clinical privileges or provide specified services at this medical center, provided that such representative or third party acts in good faith and without malice.

16.5. Activities and information covered.

16.5.1. Activities. The confidentiality provided by this Article will 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:

16.5.1.1. applications for appointment, clinical privileges or specified services;

16.5.1.2. periodic reappraisals for reappointment, clinical privileges or specified services;

16.5.1.3. corrective action;

16.5.1.4. hearings and appellate review;

16.5.1.5. patient care audits;

16.5.1.6. utilization reviews; and

16.5.1.7. other medical center, department, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

16.5.2. Information. The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

16.6. Releases. Each practitioner will, upon request of the health system, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Maryland. Execution of such releases will not be deemed a prerequisite to the effectiveness of this Article.

16.7. Cumulative effect. Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information and immunities from and not in limitation thereof, and in the event of conflict, the applicable law will be controlling.

ARTICLE 17. GENERAL PROVISIONS

17.1. Staff rules and regulations. Subject to approval by the BOD, the Medical Staff (or, when expedient, the MEC) will adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these bylaws. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner or AHP in the medical center.

17.2. Departmental rules and regulations. Subject to the approval of the MEC, each department may formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations will not be inconsistent with these bylaws, the general rules and regulations of the Medical Staff or other policies of the medical center.

17.3. Policies. Policies pertaining to clinical issues will be subject to the approval of the MEC. Such policies will be consistent with these bylaws, the general rules and regulations of the Medical Staff, or other policies of the medical center.

17.4. Forms. Application forms and any other prescribed forms required by these bylaws for use in connection with Medical Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters will be subject to adoption by the Board after considering the advice of the MEC.

17.5. Transmission of reports. Reports and other information which these bylaws require the Medical Staff to transmit to the Board will be deemed so transmitted when delivered, unless otherwise specified, to the CEO.

ARTICLE 18. AMENDMENTS

18.1. **Rights and responsibilities.** Medical Staff members will have the right and responsibility to propose amendments to these bylaws consistent with current medical practice, quality of care standards, and policies and procedures of the medical center.

18.2. **Procedures**

18.2.1. Proposed bylaw amendments may be sent to the COS for consideration by the MEC, which may approve, disapprove or approve with modifications any proposed bylaw amendment.

18.2.2. Bylaw amendments approved by the MEC will be subject to approval by majority vote of the members of the active Medical Staff. Amendments may be presented for approval at the next General Medical Staff meeting.

18.2.3. Bylaw amendments approved by the MEC and members of the active Medical Staff will be forwarded to the BOD for consideration at the next regularly scheduled BOD meeting immediately following, which will approve, disapprove, or approve with modification the proposed amendments. Proposed amendments tabled or postponed for action by the BOD for whatever reason will be taken up again at the next regularly scheduled meeting of the BOD. If the BOD approves with modifications any bylaws amendments approved by the MEC and members of the active Medical Staff, such amendments as modified will be returned to the MEC, which may accept or reject the modifications adopted by the BOD. If the MEC rejects the modifications, the amendment will again be submitted to the BOD, which then may either approve or disapprove the amendment as adopted by the MEC. The MEC or the BOD may require that any disputes regarding proposed bylaw amendments be referred to a Conflict Management Joint Conference Committee composed of equal numbers of Medical Staff and BOD members for discussion and further recommendation to the MEC and the BOD.

18.2.4. The MEC will have the authority to adopt amendments to the Medical Staff bylaws without approval of the full active Medical Staff if such amendments are solely for technical modifications or clarifications, reorganizing or renumbering, or to correct grammar, usage, spelling or punctuation errors. Such amendments will be effective when approved by the BOD. In addition, the MEC may adopt any amendments required for legal reasons or to comply with any regulatory or accreditation requirements. Such technical amendments will be effective when approved and will remain in effect unless disapproved by the BOD within 60 days or by the Medical Staff at its next general meeting.

18.2.5. Bylaw amendments may also be proposed to the BOD by the Medical Staff by majority vote of the members of the active Medical Staff entitled to vote. Proposed bylaws may be brought before the active Medical Staff by a petition signed by 20 percent of the members of the active Medical Staff. Any such

proposed bylaw amendment or rule, regulation, policy, or procedure approved by a majority of the active Medical Staff will be submitted to the MEC for review and comment before such proposed bylaw amendment is presented to the BOD.

18.2.6. Except as otherwise provided herein, these bylaws, and all amendments to these bylaws, will be effective at such time as is specified by the MEC and approved by the BOD. Any amendment will be effective immediately upon approval and will apply to all pending matters to the extent practical, unless the BOD directs otherwise, regardless of whether any particular Medical Staff member received notice of the amendment. If the MEC and the BOD do not otherwise specify when any bylaw amendments will be effective, such amendments will be effective at such time as they are finally approved by the Medical Staff and will apply to all matters pending to the extent practical.

ARTICLE 19. ADOPTION

These Medical Staff bylaws, as well as the rules and regulations adopted pursuant thereto, will become effective when approved by the Board.

_____
Chief Of Staff

_____
President and Chief Executive Officer

_____
Chair, Board of Directors

ADDENDUM # 1

To The Bylaws of the Medical Staff of

CALVERT HEALTH MEDICAL CENTER

FAIR HEARING AND APPELLATE REVIEW PLAN

in implementation of

Health Systems Corporate Bylaws Article VII

and

Medical Staff Bylaws Article 10

FAIR HEARING AND APPELLATE REVIEW PLAN FOR CALVERT MEMORIAL HOSPITAL
Implementing Article VII of the Hospital Corporate Bylaws and Article 10 of the Medical Staff Bylaws

DEFINITIONS

In addition to the definitions provided in the Medical Staff Bylaws, the following apply to the provisions of the Fair Hearing and Appellate Review Plan (FHP, or Plan):

1. Appellate review body—the group designated to hear a request for an appellate review properly filed and pursued by a practitioner.

2. Hearing panel—the committee appointed to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

3. Parties—the practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

4. Practitioner—any physician, dentist, podiatrist, or allied health professional, unless otherwise expressly limited, who applies for or exercises clinical privileges in this hospital.

ARTICLE 1: INITIATION OF HEARING

1.1. Recommendations or actions. The following recommendations or actions will, if deemed adverse pursuant to Section 1.3 of this Plan, entitle the practitioner affected thereby to a hearing:

1.1.1. denial of initial staff appointment

1.1.2. denial of reappointment

1.1.3. denial of requested clinical privileges based on professional conduct or competence

1.1.4. denial of requested advancement in staff category if such denial is the result of a professional review action

1.1.5. denial of requested department/service/section affiliation based on professional conduct or competence

1.1.6. reduction in staff category based on professional conduct or competence

1.1.7. reduction in clinical privileges based on professional conduct or competence

1.1.8. suspension or limitation of clinical privileges

1.1.9. revocation of clinical privileges

1.2. Attorneys. The affected practitioner has the right to be represented by an attorney or other person of his/her choice at any hearing or at any appellate review appearance pursuant to Section 6.4. The Medical Executive Committee (MEC) or the Board of Directors (Board) will also be allowed such representation. If the practitioner will be represented by counsel or another representative at any hearing, he/she will notify the Medical Staff of the name of the attorney or other representative at least 10 days prior to the hearing.

1.3. Adverse recommendations or actions. A recommendation or action listed in Section 1.1 will be deemed adverse only when it is a/an:

1.3.1. recommendation by the MEC;

1.3.2. action taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed;

1.3.3. action taken by the Board on its own initiative without benefit of a prior recommendation by the MEC; or

1.3.4. action requiring a report to the National Practitioner Data Bank or a state licensing or disciplinary agency.

1.4. Notice of adverse recommendation or action. A practitioner against whom an adverse recommendation or action has been or will be taken must promptly be given special notice of such action, which notice must:

1.4.1. advise the practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff bylaws and of this Fair Hearing and Appellate Review Plan;

1.4.2. advise the practitioner that any request for a hearing must be submitted in writing to the hospital CEO within 30 calendar days after the practitioner receives notice of the recommendation or action that entitles the practitioner to a hearing;

1.4.3. state that failure to request a hearing within the specified time period will constitute a waiver of rights to a hearing and to an appellate review on the matter; and

1.4.4. state that upon receipt of his/her hearing request the practitioner will be notified of the date, time, and place of the hearing and the grounds upon which this adverse action is based.

1.5. Hearing request. A practitioner will have 30 days following his/her receipt of a notice pursuant to Section 1.4 to file a written request for a hearing. Such request will be delivered to the CEO either in person or by certified or registered mail.

1.6. Waiver by failure to request a hearing. A practitioner who fails to request a hearing within the time and in the matter specified in Section 1.5 waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

1.6.1. an adverse action by the Board will constitute acceptance of that action, which will thereupon become effective as the final decision of the Board; or

1.6.2. an adverse action or recommendation made other than by the Board will constitute acceptance of that action or recommendation, which will thereupon become and remain effective pending the final decision of the Board. The Board will consider the action or recommendation at its next regular meeting following waiver. In its deliberations, the Board must review all the information and material considered by the body making the adverse action or recommendation and may consider all other relevant information received from any source. If the Board's action on the matter is in accord with a recommendation by the MEC, such action will constitute a final decision of the Board. If the Board's action has the effect of changing the MEC's recommendation, the matter will be submitted to a Conflict Management Joint Conference Committee as provided in Section 7.2 of this Plan. The Board's action on the matter following receipt of the recommendation of the Conflict Management Joint Conference Committee will constitute its final decision. The CEO will promptly send the practitioner special notice informing him/her of each action taken, pursuant to Section 1.4, and will notify the Chief of Staff and the MEC of each such action.

ARTICLE 2: HEARING PREREQUISITES

2.1. Notice of time and place for hearing. Upon receipt of a timely request for a hearing, the CEO will deliver such request to the Chief of Staff or to the Board, depending upon whose recommendation or action prompted the request for a hearing. At least 30 days prior to the hearing, the CEO will send the practitioner special notice of the time, place, and date of the hearing.

2.2. Appointment of hearing panel members

2.2.1. by the Medical Staff. Upon receipt of a request for a hearing under circumstances that entitle a practitioner to a hearing, the Chief of Staff, in consultation with the hospital CEO or designee, will appoint three impartial peer members of the Medical Staff to serve on a hearing panel. The Chief of Staff may also appoint one or more alternate impartial peer members to the hearing panel. Alternatively, as long as issues do not involve matters of quality of care, the Chief of Staff, with the agreement of the hospital CEO, may elect to have the hearing held before (i) a single arbitrator mutually acceptable to the practitioner and the hospital, or (ii) a hearing officer who is not in direct economic competition with the practitioner to conduct the hearing. Any member of the hearing panel, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the panel member was not in personal attendance, will be permitted to participate in the deliberations and to vote on the recommendations of the hearing panel.

2.2.2. by the Board. A hearing occasioned by an adverse action of the Board pursuant to Section 1.3.2 or 1.3.3 will be conducted by a hearing panel appointed by the Chair of the Board at his/her discretion and composed of three persons. At least one Medical Staff member must be included on this panel when feasible. One of the appointees to the panel will be designated as the chair. Impartiality is a prerequisite for all members.

2.2.3. service on hearing panel. No person will be a member of any hearing panel if that person has had any prior involvement as a healthcare provider in the specific cases to be considered by the panel or is in direct economic competition with the practitioner involved.

2.2.4. notification of prospective panel members. The practitioner will be notified or the prospective members of the hearing panel; if the practitioner has any objection to any proposed panel member, the practitioner will, within 10 calendar days after notification, state the objection in writing and the reasons for the objection. The Chief of Staff and the hospital CEO will, after considering such objections, decide at their discretion whether to replace any person affected by said objections and notify the practitioner of the final constitution of the hearing panel.

ARTICLE 3: CONDUCT OF THE HEARING

3.1. Personal presence. The practitioner who requested the hearing must appear in person. A practitioner who fails without good cause to appear and proceed at such a hearing will have waived his/her rights in the same manner and with the same consequences as provided in Section 1.5.

3.2. Hearing officer. The Chief of Staff and the hospital CEO will select a hearing officer to preside over the hearing. The hearing office must be an attorney or other individual familiar with procedures relating to peer review hearings.

3.2.1. The practitioner must be notified of the proposed hearing officer; if the practitioner has any objection to the proposed hearing officer, he/she will, within 10 calendar days after notification, state the objection in writing and the reasons for the objection. The Chief of Staff and the hospital CEO will, after consideration of the objection, decide at their discretion whether to replace any hearing officer so objected and notify the practitioner of the decision.

3.2.2. The hearing officer will rule on all procedural matters at the hearing, rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration, rule on requests for postponements or extensions of time, and will generally be responsible for regulating the proceedings.

3.2.3. The hearing officer will conduct a pre-hearing conference unless all concerned parties agree to waive the pre-hearing conference. At this pre-hearing conference, the hearing officer may:

3.2.3.1. require that all documentary evidence and exhibits be exchanged and will resolve any objections to proposed documentary evidence and exhibits;

3.2.3.2. assure that the names of all proposed witnesses have been provided and that report or summaries of opinions of any experts have been provided;

3.2.3.3. establish the amount of time that will be allotted to each side for the examination and cross-examination of witnesses, unless agreed upon by the parties; and

3.2.3.4. address any other issues relating to the conduct of the hearing.

3.2.4. The hearing officer will have the authority to resolve all issue regarding scheduling of hearings, and will have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, to limit the number of witnesses to be called by the Medical Staff or practitioner, and to advise the members of the hearing panel concerning legal and procedural issues.

3.2.5. The hearing officer will be available to the members of the hearing panel after the conclusion of the hearing to advise them on any procedural or legal matters and to assist the panel with the preparation of their report and recommendations, but may not vote on any recommendations.

3.3. Representation. The practitioner who requested the hearing will be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing, an attorney, or by a member of his/her local professional society. If such an individual will accompany and represent the practitioner, the practitioner will provide the Medical Staff with the name of said individual at least 10 business days prior to the hearing. The MEC will appoint an individual to represent the facts in support of its adverse recommendation or action and to examine witnesses. Representation of either party by an attorney will be governed by the provisions of Section 1.2 of this Plan.

3.4. Discovery. Except as specifically provided in this Fair Hearing and Appellate Review Plan, there will be no right to conduct discovery in connection with any hearing, and no practitioner will be permitted access to any peer review records, minutes, or other documents relating to any other member of the Medical Staff. The practitioner requesting a hearing will, however, be entitled to receive copies of any documents relied on by the MEC or Board of Directors, any documents to be introduced at the hearing, and any medical records relied on or introduced at the hearing, so long as the practitioner agrees in writing to keep all such documents confidential. The production of such documents will not constitute a waiver of any peer review protection for those documents or any other documents.

3.4.1. At least 15 business days prior to the hearing, the practitioner involved must be sent by certified and regular mail a statement:

3.4.1.1. setting forth the reasons for the proposed recommendation or action;

3.4.1.2. identifying any witnesses expected to testify before the panel in support of the recommendation or action under consideration; and

3.4.1.3. identifying all medical records or documents expected to be submitted to the panel for consideration.

3.4.2. If any expert witness is to be called as a witness in support of the recommendations of the Medical Staff at the hearing, the practitioner must be told the identities of the experts to be called, provided a copy of each expert’s curriculum vitae, provided a copy of any written report setting forth the opinions of the expert(s), or provided in writing a description of the substance of the opinions of the expert(s), and provided copies of all documents or materials provided by the hospital for expert review.

3.4.3. At least seven business days prior to the hearing, the practitioner must provide to the Medical Staff and to any attorney representing the Medical Staff with the following:

3.4.3.1. a list of any witnesses the practitioner will call to testify, and summaries of the subject matter of the testimony of all witnesses;

3.4.3.2. a copy of all documents the practitioner intends to introduce at the hearing;

3.4.3.3. identification of any and all expert witnesses the practitioner intends to call at the hearing and copies of each expert's curriculum vitae, copies of any reports from the expert(s) or a written description of the substance of the opinions of the expert(s), and copies of all documents or materials provided by the practitioner for review by the expert(s); and

3.4.3.4. a written statement setting forth the reasons for the practitioner's contention that the adverse recommendation lacks any factual basis or is arbitrary, unreasonable, or capricious.

3.4.4. No witness may be called on behalf of the practitioner or the Medical Staff, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section unless the hearing officer determines that any failure to disclose was unavoidable. The failure of the practitioner requesting a hearing to comply with the requirements related to the disclosure or exchange of information set forth in this Fair Hearing Plan, or ordered by the hearing officer, will be deemed to be a withdrawal of the request for a hearing, the waiver of the right to a hearing, and agreement to and acceptance of the recommendation or action that is the subject of the hearing.

3.5. Rights of parties. During a hearing, each of the parties will have the right to:

3.5.1. call and examine witnesses,

3.5.2. introduce exhibits,

3.5.3. cross-examine any witness on any matter relevant to the issues,

3.5.4. impeach any witness,

3.5.5. rebut any evidence, and

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

If the practitioner who requested the hearing does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

3.6. Procedure and evidence. The hearing need not be conducted strictly according to rule of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs will be admitted regardless of the admissibility of such evidence in a court of law. Each party will, prior to or during the hearing, be entitled to submit

memoranda concerning any issue of law or fact, and such memoranda will become part of the hearing record. The hearing officer may, but will not be required to, order that oral evidence be taken only under oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.7. Official notice. In reaching a decision the hearing panel make take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing will be informed of the matters to be noticed and those matters will be noted in the hearing record. Any party must be given timely opportunity to request that a matter be officially noticed and to refute the officially noted matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer. The panel will also be entitled to consider all other information that can be considered, pursuant to the Medical Staff bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

3.8. Burden of proof. The practitioner who requested the hearing will have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. It will not be a defense to any action proposed by the MEC or the Board that different action has been taken in the past with regard to any other practitioner.

3.9. Court reporter. Unless all parties agree otherwise, the hearing will be recorded by a court reporter. The record of the hearing need not be transcribed unless specifically requested and the person or body requesting the transcript will be responsible for bearing the cost of transcription.

3.10. Postponement. Requests for postponement of a hearing will be granted by the hearing officer only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

3.11. Recesses and adjournment. The hearing panel may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing will be closed. The hearing panel will thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of the panel’s deliberations, the hearing will be declared finally adjourned.

ARTICLE 4: HEARING PANEL REPORT AND FURTHER ACTION

4.1. Hearing panel report. Within 15 days after final adjournment of the hearing, the hearing panel will make a written report of its findings and recommendation in the matter and will forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. All findings and recommendations by the hearing panel will be supported by reference to the hearing record and the other documentation the panel considered. The time for submitting the

report and recommendations may be extended by the hearing panel if additional time is needed. A copy of the report and recommendations must be delivered to the practitioner.

4.2. Action on hearing panel report

4.2.1. Practitioner response to report and recommendations. Within 15 business days after the MEC and the practitioner receive the report and recommendations of the hearing panel, the practitioner may submit a written statement to the MEC specifying the findings of fact, conclusions, and procedural matters with which the practitioner disagrees and the reasons for such disagreement. The practitioner may not submit new information or evidence not previously considered by the hearing panel except as may be requested by the MEC. The failure to identify any factual or procedural matter or any findings or conclusions with which the practitioner disagrees will be deemed a waiver of any such objection and consent to the facts, conclusions, and procedures being followed or action being taken.

4.2.2. With 15 days after receipt of the report of the hearing panel, the MEC or the Board, as the case may be, will consider the same and affirm, modify, or reverse the panel's recommendation or action in the matter. The MEC or the Board will transmit the result, together with the hearing record, the report of the hearing panel, and all other documentation considered to the hospital CEO.

4.2.3. MEC action. If the matter involves a recommendation or action by the MEC, the MEC will consider the entire case and, if additional information is needed, may remand the case back to the hearing panel for any further proceedings the MEC deems appropriate. After receipt of the report of the hearing panel and any additional information requested, the MEC will consider the entire case and vote on its recommendations to the Board. Any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report.

4.2.4. Board action. The Board will take final action in accordance with the provisions of the Medical Staff Bylaws and Article 5 (Appellate Review) of this Fair Hearing and Appellate Review Plan. If the Fair Hearing is based on an adverse recommendation of the Board and the hearing panel report is adverse, the practitioner may request appellate review in accordance with Article 5 of this Fair Hearing and Appellate Review Plan. If the hearing panel report is favorable to the practitioner, the Board will review the hearing report and take action to accept, reject, or modify the hearing panel recommendation or send the matter back to the MEC or hearing panel for further review and action. If the Board's action is adverse to the practitioner following a favorable hearing panel report, the practitioner may request appellate review in accordance with Article 5 of this Fair Hearing and Appellate Review Plan.

4.3. Notice and effect of result

4.3.1. The hospital CEO will promptly send a copy of the result to the practitioner by special notice and to the Chief of Staff, the MEC, and the Board.

4.3.2. Effect of favorable result by the MEC. If the MEC's result is favorable to the practitioner, the hospital CEO will promptly forward it, together with all supporting documentation, to the Board for its final

action. The Board will take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back must state the reasons, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board will take final action. The hospital CEO will promptly send the practitioner special notice informing him/her of each action taken pursuant to this section (4.3.2). Favorable action will become the final decision of the Board and the matter will be considered finally closed. If the action of the Board is adverse in any of the respects listed in Section 1.1 of this Plan, the special notice will inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 5.1 of this Plan.

4.3.3. Effect of an adverse result by the MEC. If the result of the MEC continues to be adverse to the practitioner in any of the respects listed in Section 1.1 of the Plan, the special notice required by Section 4.3.1 will inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 5.1 of this Plan.

ARTICLE 5: INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.1. Request for appellate review. A practitioner will have seven days following his/her receipt of a notice pursuant to Sections 4.2.4, 4.3.2, or 4.3.3 of this Plan to file a written request for an appellate review. Such request will be delivered to the hospital CEO either in person or by certified or registered mail postmarked before the expiration of the seven-day period and may include a request for a copy of the report and record of the hearing panel and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

5.2. Waiver by failure to request appellate review. A practitioner who fails to request an appellate review within the time and in the manner specified in Section 5.1 of this Plan waives any right to such review. Such waiver will have the same force and effect as that provided in Section 1.6 of this Plan.

5.3. Notice of time and place for appellate review. Upon receipt of a timely request for appellate review, the hospital CEO will deliver such request to the Board. As soon as is practicable, the Board will schedule and arrange for an appellate review. At least seven days prior to the appellate review, the hospital CEO will send the practitioner special notice of the time, place, and date of the review. The time for the appellate review may be waived voluntarily by the practitioner or may be extended by the appellate review body for good cause and if the request thereunto is made as soon as is reasonably practical.

5.4. Appellate review body. The Board will determine whether the appellate review will be conducted by the Board as a whole or by an appellate review committee comprised of five members of the Board appointed by its chair. If a committee is appointed, one of its members will be designated as the chair.

ARTICLE 6: APPELLATE REVIEW PROCEDURE

6.1. Nature of proceedings. The proceedings of the review body will be in the nature of an appellate review based upon the record of the hearing before the hearing panel, the panel's report, and all subsequent results and actions thereupon. The appellate review body will also consider the written statements, if any, submitted pursuant to Section 6.2 of this Plan and such other material as may be presented and accepted under Sections 6.4 and 6.5 of this Plan.

6.2. Written statements. The practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement must be submitted to the appellate review body through the hospital CEO at least 10 days following the adverse recommendation or action for which the appellate review is requested, except if such time limit is waived by the appellate body. A written statement in reply may be submitted by the MEC or by the Board and, if submitted, the hospital CEO will provide a copy thereof to the practitioner at least seven days prior to the scheduled date of the appellate review.

6.3. Presiding review officer. The chair of the appellate review body will be the presiding office and will determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4. Oral statement. The appellate review body, at its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing will be required to answer questions put to him/her by any member of the appellate review body.

6.5. Consideration of new or additional matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record will be introduced at the appellate review only at the discretion of the appellate body and for good cause shown, following an explanation by the party requesting the consideration of such matter or evidence as to the reason it was not or could not be presented earlier.

6.6. Standard of appellate review. Appellate review by the Board or any committee of the Board designated by it will be limited to determining whether the practitioner has established by clear and convincing evidence that:

6.6.1. there has been a substantial failure to comply with the Medical Staff bylaws during the course of the corrective action which has materially prejudiced the practitioner,

6.6.2. the recommendation is arbitrary or unreasonable, or

6.6.3. the recommendation is not supported by any reliable evidence.

6.7. Presence of members and vote. A majority of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, he/she will not be permitted to participate in the deliberations or the decisions.

6.8. Recess and adjournment. The appellate body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review will be closed. The appellate review body will thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of these deliberations, the appellate review will be declared finally adjourned.

6.9. Action taken.

6.9.1. Appellate review body recommendations to the Board. The appellate review body may recommend that the Board affirm, reverse, or modify the previous adverse result or action taken by the MEC or by the Board pursuant to Sections 4.2 or 4.3.2 of this Plan, or at its discretion refer the matter back to the hearing panel for further review and recommendation, to be returned to it within seven days and in accordance with its instructions. Within seven days after receipt of such recommendation after referral, the appellate review body will make its recommendation to the Board as provided in this Section.

6.9.2. Board action. Within 30 days after the conclusion of the appellate review, the Board will render in writing its final decision in the matter and send notice thereof to the practitioner by special notice, to the Chief of Staff, and to the MEC. If this decision is in accord with the MEC's last recommendation in the matter (if any), it will be immediately effective and final. If the action of the Board has the effect of changing the MEC's last recommendation (if any), the Board will refer the matter to a joint conference as provided in Article 7.7.6.3 of the Medical Staff bylaws. The action of the Board on the matter following receipt of the joint conference recommendation will be immediately effective and final.

6.10 Conclusion. The appellate review will not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

ARTICLE 7: GENERAL PROVISIONS

7.1. Timely objections to actions. In the event that any practitioner has any objection to any action taken or procedures followed by the hospital, the Medical Staff, or any individual, hearing panel, or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or practitioner will immediately state in writing such objection and the reasons for the objection to the individual or body concerned, or verbally if the objection arises during any recorded proceedings, in order to permit the body before whom the matter is pending to address the objection and take any corrective action deemed appropriate. The failure to give such notice of any objection will be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

7.2. Number of hearings and reviews. Notwithstanding any other provision of the Medical Staff bylaws or of this Plan, no practitioner will be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

7.3. Release and immunity. By requesting a hearing or appellate review under this Fair Hearing and Appellate Review Plan, a practitioner agrees to be bound by the provisions of Article 14 in the Medical Staff bylaws relating to immunity from liability in all matters relating thereunto. All practitioners and all those participating in or providing information to any department, section, committee, hearing panel, or office of the Medical Staff will, to the fullest extent permitted by law, not be liable for any actions taken or information provided in connection with the review, granting, or denial of Medical Staff membership or clinical privileges, or any other action taken pursuant to the bylaws of the Medical Staff or this Plan.

7.4. Confidentiality and privilege. All information received, notes, records, minutes, documents, or materials of any kind which are obtained, reviewed, or considered in connection with any matters considered or action or investigation taken pursuant to the bylaws and this Fair Hearing and Appellate Review Plan relating to Medical Staff membership or clinical privileges will be confidential and privileged, will not be admissible or discoverable in any legal proceedings, and will be subject to all other protection afforded to such documents or proceedings by law.

7.5. Waiver. If at any time after receipt of special notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance, or otherwise fails to comply with this Fair Hearing and Appellate Review Plan or to proceed with the matter, he/she will be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff bylaws then in effect or under this Plan with respect to the matter involved.

ARTICLE 8: ADOPTION AND AMENDMENT

8.1. Adoption

8.1.1. Medical Staff. The foregoing Fair Hearing and Appellate Review Plan was adopted and recommended to the Board of Directors and the MEC in accordance with and subject to the Medical Staff bylaws.

_____ _____

Chief of Staff Date Signed

8.1.2. Board of Directors. The foregoing Fair Hearing and Appellate Review Plan was approved and adopted by resolution of the Board of Directors after considering the MEC's recommendation and in accordance with and subject to the Hospital Corporate bylaws.

_____ _____

Secretary of the Board Date Signed

8.2 Amendment. This Fair Hearing and Appellate Review Plan may be amended or repealed, in whole or in part, by a resolution of the MEC, recommended to and adopted by the Board of Directors, subject always to the bylaws of the respective bodies.

8.3 Medical Staff responsibility and Board of Directors initiative. The principles stated in the Medical Staff and Hospital Corporate bylaws regarding Medical Staff responsibility and authority to formulate, adopt, and recommend Medical Staff bylaws, and amendments thereunto, and the circumstances under which the Board of Directors may resort to its own initiative in accomplishing those functions will apply as well to the formulation, adoption, and amendment of this Fair Hearing and Appellate Review Plan.

Original: 7/79

(Fair Hearing and Appellate Review Plan)

Reviewed/Revised: 5/96, 12/04, 10/09, 1/11, 5/11, 5/17

No changes with bylaws revision: 5/12, 6/15, 9/16, 2/19, 3/20