HOLY CROSS GERMANTOWN HOSPITAL

BYLAWS OF THE MEDICAL STAFF

Approved by Holy Cross Health, Inc.
Board of Directors:

July 18, 2019
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITIONS</td>
<td>4</td>
</tr>
<tr>
<td>PREAMBLE</td>
<td>5</td>
</tr>
<tr>
<td>ARTICLE I NAME</td>
<td>5</td>
</tr>
<tr>
<td>ARTICLE II PURPOSE AND RESPONSIBILITIES</td>
<td>6</td>
</tr>
<tr>
<td>A. Purpose</td>
<td>6</td>
</tr>
<tr>
<td>B. Responsibilities</td>
<td>6</td>
</tr>
<tr>
<td>C. Self Governance</td>
<td>7</td>
</tr>
<tr>
<td>ARTICLE III MEDICAL STAFF MEMBERSHIP</td>
<td>7</td>
</tr>
<tr>
<td>ARTICLE IV CATEGORIES OF THE MEDICAL STAFF</td>
<td>18</td>
</tr>
<tr>
<td>ARTICLE V CONSULTANTS AND HOUSE OFFICERS</td>
<td>24</td>
</tr>
<tr>
<td>ARTICLE VI AFFILIATES</td>
<td>24</td>
</tr>
<tr>
<td>ARTICLE VII PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT</td>
<td>31</td>
</tr>
<tr>
<td>ARTICLE VIII DETERMINATION OF CLINICAL PRIVILEGES</td>
<td>44</td>
</tr>
<tr>
<td>ARTICLE IX CORRECTIVE ACTION</td>
<td>46</td>
</tr>
<tr>
<td>A. Routine Corrective Action</td>
<td>46</td>
</tr>
<tr>
<td>B. Summary Suspension</td>
<td>48</td>
</tr>
<tr>
<td>C. Automatic Suspension</td>
<td>49</td>
</tr>
<tr>
<td>D. Modified Due Process</td>
<td>51</td>
</tr>
<tr>
<td>ARTICLE X INTERVIEWS, HEARINGS AND APPELLATE REVIEW</td>
<td>52</td>
</tr>
<tr>
<td>A. Interviews</td>
<td>52</td>
</tr>
<tr>
<td>B. Hearings and Appellate Review</td>
<td>53</td>
</tr>
<tr>
<td>C. Initiation of Hearing</td>
<td>53</td>
</tr>
<tr>
<td>D. Adverse Action</td>
<td>54</td>
</tr>
<tr>
<td>E. Notice of Adverse Recommendation or Action</td>
<td>54</td>
</tr>
<tr>
<td>F. Waiver by Failure to Request a Hearing</td>
<td>55</td>
</tr>
<tr>
<td>G. Hearing Prerequisites</td>
<td>55</td>
</tr>
<tr>
<td>H. Hearing Procedure</td>
<td>56</td>
</tr>
<tr>
<td>I. Hearing Committee Report and Further Action</td>
<td>58</td>
</tr>
<tr>
<td>J. Initiation and Prerequisites of Appellate Review</td>
<td>59</td>
</tr>
<tr>
<td>K. Appellate Review Procedure</td>
<td>60</td>
</tr>
<tr>
<td>L. Final Decision of the Board</td>
<td>61</td>
</tr>
<tr>
<td>M. General Provisions</td>
<td>62</td>
</tr>
<tr>
<td>N. Report to State Board</td>
<td>62</td>
</tr>
</tbody>
</table>
ARTICLE XI   STAFF DEPARTMENTS ................................................................................. 63
A. Organization of Staff Departments and Clinical Services .............................................. 63
B. Designation .................................................................................................................... 63
C. Assignment to Departments and Clinical Services ......................................................... 63
D. Functions of Departments ............................................................................................ 64
E. Departmental Review Committee ................................................................................. 65
F. External Peer Review .................................................................................................... 65

ARTICLE XII   OFFICERS .................................................................................................. 65
A. Officers of the Staff ....................................................................................................... 65
B. Department Officers ..................................................................................................... 71

ARTICLE XIII   COMMITTEES AND FUNCTIONS ............................................................... 74
A. Designation and Membership ....................................................................................... 74
B. Committees and Functions .......................................................................................... 74
1. Medical Executive Committee ............................................................................... 74
2. Credentials Committee ............................................................................................... 76
3. Special Committees ..................................................................................................... 77
4. Physician Health Committee ..................................................................................... 77
5. Physician Advisor(s) ................................................................................................. 77

ARTICLE XIV   MEETINGS .................................................................................................. 78
A. General Staff Meetings .................................................................................................. 78
B. Committee and Department Meetings ............................................................................ 79
C. Notice of Meetings ....................................................................................................... 79
D. Quorum ........................................................................................................................ 79
E. Manner of Action .......................................................................................................... 79
F. Minutes ........................................................................................................................ 80
G. Attendance Requirements ............................................................................................ 80

ARTICLE XV   CONFIDENTIALITY AND LIABILITY ........................................................... 81
A. Special Definitions ........................................................................................................ 81
B. Authorizations and Conditions .................................................................................... 81
C. Confidentiality of Information ..................................................................................... 82
D. Access to Medical Staff Files ..................................................................................... 82
E. Immunity from Liability ............................................................................................... 82
F. Activities and Information Covered ............................................................................ 82
G. Releases ...................................................................................................................... 83
H. Cumulative Effect ....................................................................................................... 83

ARTICLE XVI   GENERAL PROVISIONS ........................................................................ 83
A. Staff Rules and Regulations ........................................................................................ 83
B. Departmental Rules and Regulations ......................................................................... 83
C. Medical Staff Dues and Funds .................................................................84
D. Construction of Terms and Headings .....................................................84
E. Transmittal of Reports ..............................................................................84

ARTICLE XVII   ADOPTION AND AMENDMENT ..............................................84

A. Medical Staff Responsibility and Authority ...........................................84
B. Methodology ............................................................................................85
DEFINITIONS

1. AFFILIATES means those allied health professionals who are authorized to practice at the Hospital and who possess Clinical Privileges. Affiliates are psychologists, physicians' assistants, nurse midwives, certified registered nurse anesthetists, and nurse practitioners. Affiliates include those who are permitted to provide patient care services independently within the Hospital without direct supervision within the scope of his/her licensure and designated Clinical Privileges (e.g., psychologists) and those who are dependent upon an employment relationship with a Staff Member or the Hospital that requires supervision (e.g., physicians' assistants and nurse practitioners).

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

3. BOARD OF DIRECTORS or BOARD means the governing body of Holy Cross Health, Inc.

4. BYLAWS means the bylaws, rules and regulations of the Medical Staff, including the rules and regulations of the applicable department (unless the context requires otherwise) as validly adopted and as amended from time to time.

5. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Staff Member or Affiliate to render specific diagnostic, therapeutic, medical, dental or surgical services.

6. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

7. HOLY CROSS HEALTH means Holy Cross Health, Inc.

8. HOSPITAL means Holy Cross Germantown Hospital.

9. MEDICAL STAFF means the formal organization entitled "Medical Staff of Holy Cross Germantown Hospital," comprised of all licensed physicians and dentists who are privileged to attend patients in the Hospital. It does not include Affiliates as members.

10. MEDICAL STAFF TERM OR TERM OF APPOINTMENT means the period for which the Practitioner is appointed to the Medical Staff or granted Clinical Privileges prior to the next period of reappointment.

11. MEDICAL STAFF YEAR means the period from January 1 to December 31.

12. PRACTITIONER means, unless otherwise expressly limited, Staff Members and Affiliates.

13. PREROGATIVE means a participatory right granted, by virtue of Medical Staff category or otherwise, to a Staff Member or Affiliate and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

14. PRESIDENT means the individual appointed to serve as President of the Hospital in the overall administrative management of the Hospital.
15. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt requested, or by a nationally recognized overnight delivery service, with confirmation of delivery.

16. STAFF MEMBER means, unless otherwise expressly limited, any appropriately licensed physician or dentist having membership or Clinical Privileges on the Medical Staff. It does not include Affiliates.

17. STATE means the State of Maryland unless the context of these Bylaws stipulates otherwise.

PREAMBLE

WHEREAS, Holy Cross Germantown Hospital is a charitable institution organized under the laws of the State of Maryland; and

WHEREAS, its purpose is to serve as a general community hospital providing patient care, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the Medical Staff is to strive for quality patient care in the Hospital, that the Medical Staff must work with and is subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, Hospital administration and the Board of Directors are necessary to fulfill the Hospital's aims and goals in providing patient care; and

WHEREAS, it is the intention of the Medical Staff to render medical care with compassion for human suffering, respect for dignity and diversity of each person, and a sharing of trust and support.

THEREFORE, the physicians and dentists practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Holy Cross Germantown Hospital (referred to herein as the "Medical Staff").
ARTICLE II - PURPOSE AND RESPONSIBILITIES

A. PURPOSE

The purpose of the Medical Staff is:

1. To be the formal organizational structure through which: a) the benefits of membership on the Medical Staff may be obtained by individual Practitioners; and b) the obligations of Medical Staff membership may be fulfilled.

2. To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of Hospital Practitioners and to strive toward a pattern of patient care in the Hospital which is maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

3. To provide a means through which members may participate in the Hospital's policy-making and planning process.

4. To cooperate with affiliated institutions in providing undergraduate and postgraduate education.

B. RESPONSIBILITIES

The responsibilities of the Medical Staff are:

1. To account for the quality and appropriateness of patient care rendered by all Practitioners and podiatrists through the following measures:

   a. A credentials program, including mechanisms for appointment and re-appointment and the matching of Clinical Privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated performance of the Applicant, Staff Member or Affiliate;

   b. A continuing education program, based in part on the needs demonstrated through the patient care quality maintenance programs;

   c. Participation in utilization review for the purpose of allocating inpatient medical and health services based upon patient-specific determinations of medical needs;

   d. An organizational structure that allows continuous monitoring of patient care practices;

   e. Review and evaluation of the quality of patient care through valid and reliable quality maintenance activities and participation in the Hospital performance improvement program.

2. To recommend to the Board action with respect to appointments, reappointments, termination of appointments, staff category, department and service assignments, Clinical Privileges, specified services for Affiliates and corrective action.
3. To account to the Board for the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of the patient care quality maintenance activities.

4. To initiate and pursue corrective action with respect to Practitioners and Affiliates, when warranted.

5. To develop, administer and seek compliance with these Bylaws, the rules and regulations and policies of the Medical Staff, and other Hospital policies.

6. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

7. To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

8. To approve an annual operating budget as developed and proposed by the Treasurer, the Medical Staff office and outside accounting consultants, as needed.

9. To approve all non-budgeted discretionary spending not covered in Article XII Section A(7)(a)(8) or Article XIII Section B(1)(a)(12).

C. SELF-GOVERNANCE

The Medical Staff’s right to self-governance includes, but is not limited to: establishing in its Bylaws and rules and regulations the criteria and standards for Medical Staff membership; selecting and removing Medical Staff officers; and developing and adopting Bylaws, rules and regulations and policies governing the Medical Staff (subject to Board approval).

ARTICLE III - MEDICAL STAFF MEMBERSHIP

A. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege, which shall be extended only to professionally competent physicians and dentists who continuously meet the qualifications, standards and requirements set forth in the Bylaws. Appointment to and membership on the Medical Staff shall confer on the appointee or member only such Clinical Privileges and prerogatives as have been granted by the Board in accordance with these Bylaws.

B. BASIC QUALIFICATIONS FOR MEMBERSHIP

1. Basic Qualifications: Only physicians and dentists holding unrevoked and unsuspended current licenses to practice in the State of Maryland:

   a. Who demonstrate his/her experience, background, training, current competence, ability, to care for the types of patients they seek to care for at the Hospital, and physical and mental health status, with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive care of professional quality and efficiency.
Evidence of current competence must be established through the Practitioner's utilization of a facility that is accredited by The Joint Commission (TJC), National Committee for Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC) with such frequency as would afford an opportunity for the Practitioner's performance and clinical competence to be reasonably observed. This paragraph shall not be applicable to Practitioners with consulting only privileges, dermatologists with admitting privileges, or academic staff without admitting privileges; provided, however, that such Practitioners must otherwise provide evidence of current competence in their respective fields; and

b. Who are determined, on the basis of documented references, to adhere strictly to the ethics of his/her respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Medical Staff responsibilities; and

c. Who are primarily in the active clinical practice of medicine or dentistry or are actively associated with a teaching program at the Hospital as a member of a medical school affiliated with the Hospital, and practice in the community or the immediate adjacent area within reasonable distance of the Hospital so as to be able to provide continuous patient care; and

d. Who provide evidence of continuous and adequate professional liability insurance coverage to include “prior acts” coverage as necessary to avoid any gaps. Coverage must be provided by a company authorized to do business in Maryland with an A.M. Best Company rating of A- (excellent) or higher and in amounts to be determined from time to time by the Medical Executive Committee (MEC) and approved by the Board. (Currently $1,000,000/$3,000,000)

The Staff Member or Applicant must agree that he/she will notify the Medical Staff services office when he/she or his/her carrier cancels or does not renew for any reason a professional liability insurance policy, when the limits of a policy are reduced, and when the scope of clinical privileges insured is reduced. In the following instances, the Hospital may require any individual who has been or is currently a Medical Staff member to purchase additional malpractice insurance to cover claims for events arising out of treatment rendered at the Hospital but not asserted until after the cessation of privileges of the Medical Staff member at the Hospital (i.e., "tail" coverage):

1) Voluntary resignation or leave of absence from the Medical Staff;

2) Revocation of Medical Staff membership and/or Clinical Privileges; and

3) Other termination of Medical Staff membership and/or Clinical Privileges.

Such requirement shall be a condition which the Hospital may enforce by not accepting a tendered voluntary resignation, or by taking disciplinary action under the Bylaws, neither of which shall entitle the Practitioner to any hearing rights under Article X of the Bylaws, and/or by judicial process, if necessary; and
e. Whose membership on the Medical Staff has not been revoked, for reasons other than those set forth in Article IX, Sections C.1, C.2, C.3, C.4, and C.5 of the Bylaws during the five-year period prior to his/her application for membership; and

f. Who shall, within 5 years of having completed their training, have attained primary Board certification in his/her specialty. Applicants must be board-certified by the applicable specialty board of the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Podiatric Surgery (ABPS), the American Board of Oral and Maxillofacial Surgery (ABOMS) or The United Council For Neurologic Subspecialties (UCNS)

An Applicant who is not board-certified but who has completed postgraduate training within 5 years prior to the date of his/her request is eligible to request an application. If granted initial appointment, the Staff Member must attain appropriate board certification within 5 years of having completed his/her training. If the Staff Member does not become board-certified within the 5-year period, the Staff Member shall be allowed to complete the existing term of appointment but shall not be eligible for reappointment.

If an Applicant requests an application and it is determined by review of the pre-application that he/she completed training more than 5 years prior to the date of the pre-application and has not attained board certification as required by this Section, an application for medical staff membership and clinical privileges will not be offered to the Applicant.

Due process rights shall not be extended to any Applicant or staff member who is refused an initial or renewal application under this section. Upon attaining board certification, an Applicant may again request an initial application upon providing evidence of board certification.

An initial Applicant who has a time-limited certification that expired prior to the request for an application and who has not attained recertification shall not be eligible to request an application. If the time-limited certification expires during the pendency of the application and the Applicant has not attained recertification prior to action by the Board of Directors, the Applicant shall not be eligible for initial appointment. An Applicant shall not be entitled to any due process rights for actions taken under this Section; and

g. Who, if he/she possesses a time-limited board certification, shall be required to maintain board certification; failure to become recertified by the end of one additional term of appointment after the date that the time-limited certification expires shall result in automatic termination and non-renewal of Medical Staff membership and Clinical Privileges at the end of one additional term of appointment without any due process appeal rights.

h. Who, at the time of his/her application, has not been debarred, excluded, or otherwise sanctioned by the Medicare and/or Maryland Medical Assistance programs shall be qualified for membership on the Medical Staff. Every such physician and dentist shall be responsible for providing to the Medical Staff services office evidence of current licensure, professional liability insurance coverage and Drug Enforcement Administration certification and other such information as may be required hereunder.
i. The Medical Executive Committee (MEC) may, at their option, accept a current unrevoked and unsuspended license from another state or the District of Columbia for an active duty military practitioner on federal assignment. The military practitioner may only treat active duty military personnel, dependents, and military retirees who are eligible for military medical care as part of an ongoing program carried out in co-operation with the Hospital. The MEC may, at their option, accept a federal / military DEA certificate in lieu of a Maryland Controlled Dangerous Substance registration. The military practitioner must abide by these Bylaws as well as all Rules, Regulations, and Policies of the Medical Staff along with all other credentialing requirements.

2. **Effect of Other Affiliations:** No physician or dentist is automatically entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership or privileges at another health care facility or in another practice setting.

3. **Nondiscrimination:** Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of gender, race, age, creed, color, national origin, or sexual orientation or any other criterion not related to the delivery of quality patient care in the Hospital, professional ability and judgment, or community need.

4. **Administrative and Medico-Administrative Officers:** A physician or dentist employed by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a Member of the Medical Staff. A medico-administrative officer (i.e., one with clinical responsibilities) must be a Member of the Medical Staff, achieving this status by the procedure provided in Article VI of these Bylaws. His/her Clinical Privileges must be delineated in accordance with Article VII of these Bylaws. The Medical Staff membership and Clinical Privileges of any medico-administrative officer shall not be contingent on his/her continued occupation of that position, unless otherwise provided in his/her employment agreement. The employment of a medico-administrative officer shall be terminable solely in accord with the terms of his/her employment agreement.

5. **Hospital-Based Physicians:** A Hospital-Based Physician is a Practitioner engaged either by the Hospital or by a group under an exclusive contract with the Hospital, who is either full- or part-time, whose activities include clinical responsibilities, such as direct patient care or supervision of the patient care activities of other Practitioners, and may include administrative responsibilities. A Hospital-Based Physician must achieve and maintain Medical Staff membership and Clinical Privileges appropriate to his/her clinical responsibilities, and discharge Medical Staff obligations appropriate to his/her category in the same manner applicable to all other Medical Staff members.

The effect of the termination, withdrawal or removal of the Hospital-Based Physician under his/her contract on his/her Medical Staff membership status and Clinical Privileges, and the effect of an adverse change in his/her Medical Staff membership status or Clinical Privileges on continuance in his/her contract status as a Hospital-Based Physician, are governed solely by the terms of the contract between the Hospital-Based Physician (or his/her group) and the Hospital, including waivers of due process rights.
In the absence of a contract or where the contract is silent on the matter, termination or expiration of a contract alone will have no effect on the membership status or clinical privileges of a Hospital-Based Physician, except the Hospital-Based Physician may not thereafter exercise Clinical Privileges in the Hospital for which exclusive contractual arrangements have been made.

C. BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

1. Provide his/her patients with care at a generally recognized level of professional quality and efficiency;

2. Abide by the Medical Staff Bylaws, Rules and Regulations and Policies;

3. Discharge such Medical Staff, department, service, committee and Hospital functions for which he/she is responsible by appointment, election, or otherwise.

4. Prepare and complete in timely manner the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

5. Abide by the Principles of Medical Ethics of the American Medical Association (AMA) or by the Code of Ethics of the American Dental Association (ADA), or whatever association is applicable, as well as the Ethical and Religious Directives for Catholic Health Care Services (ERDs) and the values and principles inherent in the medical-moral teachings of the Catholic Church, as appended to and made a part of the Bylaws.

6. A complete history and physical examination shall be recorded within 24 hours of admission to the Hospital or prior to surgery, whichever is earlier. The History and Physical examination should be recorded by a Practitioner, as stated below, who has been granted privileges to do so through the credentialing process.

If a History and Physical examination has been completed within 30 days prior to admission or surgery, that examination may also be used to satisfy the requirement, provided the Practitioner reviews and updates the assessment at the time of admission (within 24 hours) and records any changes that have occurred since the examination was conducted. This update must be signed and written on or attached to the original assessment. If the history and physical examination is performed by a practitioner who is not a member of the Holy Cross Medical Staff, the attending physician of record will review the history and physical examination, co-sign and date it.

Before outpatients receive sedation or general anesthesia, a history and physical examination must be conducted and documented in accordance with the requirements for inpatients (described in the previous paragraph). Pain Management patients will have a history and physical examination conducted and documented at the time of their first series visit.

A complete history and physical examination includes the following elements:
Details of present illness and review of systems
Medical History, including all allergies
Family History
Relevant physical, psychological and social evaluation
Physical examination
Pain (site, character, frequency, duration, intensity and modifying factors)
Assessment and Treatment Plan

The history and physical examination is authenticated by the Practitioner who performed or supervised the history and physical examination and is filed in the patient’s medical record.

7. Abide by these Bylaws and the Rules and Regulations and Policies of the Medical Staff including without limitation the Code of Conduct of the Medical Staff, the Conflict of Interest Policy of the Medical Staff, the sexual harassment statement in the Medical Staff Rules and Regulations and the CHE Trinity Health Corporate Compliance Plan.

8. Conduct him/herself in a professional manner that does not disrupt relationships with peers, Hospital personnel, or patients, and does not detract from good patient care.

9. Retain responsibility within his/her area of professional competence for the adequate management (which shall include but not be limited to at least one visit every twenty-four hours for inpatients by the attending physician assuming primary responsibility for the inpatient). A progress note is to be recorded at the time of the visit. (The exception to this is normal newborn infants, which are governed by applicable Departmental Rules and Regulations.) In the absence of the primary attending physician, "suitable alternative" arrangements for such care and supervision may be made; "suitable alternative" is defined as care by a Member of the Medical Staff in good standing with Clinical Privileges appropriate to the care of that patient.

10. Promptly cooperate with any medical, psychiatric, neuro-psychological, and/or other forms of testing requested by the Medical Executive Committee and/or the Board in order to assure fitness to render services in the Hospital.

11. Complete all medical record documentation and all orders in the Hospital's electronic medical record (EMR) systems consistent with Hospital policy.

12. Be available to furnish emergency care at the Hospital in accordance with the Medical Staff Rules and Regulations governing Emergency Medicine.

D. NATURE AND DURATION OF APPOINTMENTS

1. Initial Appointments: All initial appointments to the Medical Staff (except Honorary and Academic memberships) shall be provisional in nature for a period not to exceed 1-year, renewable for an additional 1-year period in the event that additional time is required to observe the Practitioner's performance and clinical competence. Provided, however, that these Bylaws include certain provisions to allow for the formation of an initial Medical Staff
in connection with the Hospital opening and commencing operation (e.g., permitting initial
MEC members to be individuals who have been Staff Members for less than 1 year).

2. **Reappointments**: Reappointments to any category of the Medical Staff (except for
Honorary Staff without admitting privileges) shall be for a period of not more than 2 years.

E. PROVISIONAL APPOINTMENT

1. **Conditions**: Each newly appointed Practitioner shall be assigned to a department where
his/her performance and clinical competence shall be observed by the Chair or chief of
the department/service or his/her designee. If, by the end of the provisional period or
any extension thereof, the Practitioner has not satisfied the requirements for continued
Medical Staff membership, or has not utilized this Hospital or any other facility that is
accredited by the TJC or NCQA with such frequency as would afford an opportunity for
his/her performance and clinical competence to be reasonably observed, his/her staff
membership shall automatically terminate and the Practitioner shall be given Special
Notice of such termination and of his/her entitlement to the procedural rights specified in
Article IX, Section D of the Bylaws.

The utilization requirement at this Hospital or another TJC or NCQA accredited facility
shall not be applicable to Practitioners with consulting only privileges or academic staff
without admitting privileges.

2. **Review Procedure**: The Chair of the appropriate department shall determine whether the
Practitioner has met the basic responsibilities of Medical Staff membership as set forth in
Article III, Section C of these Bylaws during the provisional period. If the decision may be
adverse, the Chair shall appoint a committee of the Practitioner's peers (which committee,
if appropriate may be the supervisory committee) for the purpose of reviewing whether the
Practitioner has met his/her basic responsibilities of membership.

   a. If the Chair/committee shall find favorably to the Practitioner, its determination shall
      cause the termination of the provisional status of the Practitioner at the expiration of the
      provisional period.

   b. If the Chair/committee shall find adversely to the Practitioner, its report and
      recommendation shall be forwarded by the departmental Chair to the Medical Executive
      Committee (MEC). The MEC shall review the report and recommendation of the
      committee, and shall either adopt or reject the recommendation of the committee, which
      shall be determinative of the status of the Practitioner. In the event that the MEC rejects
      the adverse recommendation, the provisional status of the Practitioner shall terminate as
      of the expiration of the provisional period.

   In the event that the MEC shall affirm the adverse recommendation, the Practitioner's
   membership on the Medical Staff shall terminate and he/she shall be given Special Notice
   thereof. Thereafter, the Practitioner shall be entitled to the procedural rights set forth in
   Article IX, Section D of the Bylaws.

F. INTERIM PRIVILEGES
1. **Circumstances:**

   a. **Initial Application:** Interim privileges will only be granted upon completion of the processing of the Practitioner's initial application, including receipt of all primary source verifications and completion of the interview process. The interim privileges will be granted after the Credentials Committee's review and recommendation. The interim privileges may be granted for the period until the Practitioner's application is reviewed by the Medical Executive Committee and the Board and approval of appointment and clinical privileges has been made. To satisfy a specific patient care need, Interim privileges may be granted prior to the Credentials Committee meeting with the recommendation of the Chair of the Credentials Committee. These privileges will only be in effect until the Credentials Committee meeting or 120 days, whichever is shorter.

   b. **Pending Reinstatement:** A practitioner whose Medical Staff membership, including Clinical Privileges, was automatically suspended pursuant to Article IX, Section C(1) of the Bylaws and who has requested reinstatement, may be granted Interim privileges in accordance with the conditions specified in this Article, Section F.

   c. **Initial Applicants without Recent Acute Care Experience:** Initial Applicants who are otherwise qualified, but who are unable to document adequate acute care inpatient hospital experience within the last 2 years, may be approved for Interim privileges under a limited preceptorship in accordance with Article VII, Section D of these Bylaws.

2. **Conditions:** Interim Privileges shall be granted only after a Practitioner's file is deemed complete, including interviews, and the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications and ability to exercise the privileges requested. The Practitioner must also satisfy the requirements of Article III.B.1d. of these Bylaws regarding professional liability insurance, and the Practitioner must signify in writing that he/she has read and agrees to comply with the Bylaws. The Chair of the department responsible may impose special requirements of consultation, monitoring and/or supervision of a Practitioner granted Interim Privileges. The determination of whether to grant Interim Privileges is independent of any determination to accept the Applicant for privileges, and the granting of Interim Privileges shall not create any presumption that the Applicant is otherwise qualified for appointment or reappointment under the Bylaws.

3. **Termination:** Upon the discovery of any information or the occurrence of any event of a professionally questionable nature relating to a Practitioner's qualifications or ability to exercise any or all of the Interim Privileges granted, the President or designee, after consultation with the department Chair responsible for supervision of the Practitioner or the President of the Medical Staff, may terminate any or all of such Practitioner's Interim Privileges. In addition, where 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 IX of the Bylaws. In the event of such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the department Chair responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.
4. **Rights of the Practitioner:** A Practitioner shall not be entitled to the procedural rights afforded by Article X of the Bylaws because of his/her inability to obtain Interim privileges or because of any termination or suspension of Interim privileges.

G. **TEMPORARY PRIVILEGES**

For the purposes of this Section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger or when the Hospital's Emergency Management Plan is put into effect. In the case of an emergency, any Practitioner, to the degree permitted by his/her license and regardless of department, staff status or Clinical Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm.

Temporary Privileges may be granted to a practitioner who is not a member of the Medical Staff but who has unique skills or knowledge, and whom a current member of the Medical Staff wishes to participate in a specific individual procedure or render care to a specific patient. Such Temporary Privileges shall be limited to the identified procedure, patient and time period. Before privileges may be granted, the practitioner shall submit to the Medical Staff services department such information and documentation as the Hospital may require, including but not limited to the following:

- Copy of the practitioner's current Maryland license;
- Certificate from the practitioner's malpractice insurance carrier showing that the practitioner currently has in force insurance coverage in the amount approved by the Hospital;
- Confirmation that the practitioner is a member in good standing at a hospital where he/she holds similar clinical privileges as those sought at the Hospital;
- A written request from the member of the Medical Staff who is seeking the practitioner’s involvement with the patient’s care including the patient’s name and scope of involvement requested;
- Signature of the Chair of the department in which privileges are sought recommending the granting of Temporary Privileges.

All requests for Temporary Privileges shall be forwarded in writing to the Medical Staff services department, which will obtain all required information and documentation. The completed request along with all required documentation shall be sent for final action to the President of the Hospital, the Chief Medical Officer, or his/her designee, or such other person as the President of the Hospital designates. The President of the Hospital and/or Chief Medical Officer shall consult with the President of the Medical Staff with respect to the granting of any Temporary Privileges.

Temporary Privileges granted pursuant to this section shall be in effect for no more than one month.

H. **EMERGENCY (DISASTER) PRIVILEGES**
Emergency (Disaster) privileges may also be granted when the Hospital Emergency Management Plan is initiated and the Hospital is unable to handle the immediate patient needs. During a disaster, the Hospital President, Medical Staff President or his/her designee(s) may grant Emergency (Disaster) privileges on a case-by-case basis.

Verification of a practitioner’s credentials shall include verification of current state licensure, verification of current malpractice insurance coverage, other hospital privileges, and a National Practitioner Data Bank query will be accomplished as soon as the immediate situation is under control or as soon as feasible. A record of this information will be maintained in the Medical Staff services department. The Hospital President, the President of the Medical Staff or his/her designee(s) may grant disaster privileges upon the presentation of any of the following: a current hospital picture ID from any Montgomery County or Washington DC hospital; a current license to practice and a valid picture ID issued by a state, federal or regulatory agency; or confirmation of the practitioner’s privileges by use of the medical staff directory from another hospital and a valid picture ID.

Practitioners volunteering disaster services will be required to sign an Emergency (Disaster) Privilege form agreeing to abide by Hospital and Medical Staff policies and procedures and waiving due process rights. Emergency (Disaster) Privileges may be revoked at any time and will expire not more than 24 hours following the close of the Emergency Management Plan. The practitioner will be assigned to a peer practitioner who is a member of the Medical Staff.

I. TELEMEDICINE PRIVILEGES

All health care practitioners who provide patient care services to Hospital patients via telemedicine link must be credentialed and licensed to practice in the State of Maryland. In addition, the health care practitioner providing patient care services to Hospital patients via telemedicine link must either be granted clinical privileges for such services as though they were providing services on site at the Hospital, or must have clinical privileges under the terms of a telemedicine services agreement with a Medicare-participating distant-site hospital.

Health care practitioners providing patient care services via telemedicine link under the terms of a telemedicine services agreement must have privileges at the distant-site hospital and the distant-site hospital must provide a current list of the individual health care practitioner’s privileges. Furthermore, the Hospital will provide the distant-site hospital periodic appraisals and information regarding adverse events and complaints resulting from the health care services provided by the telemedicine practitioner.

Telemedicine privileges shall be for a period of not more than 2 years. Individuals seeking to renew telemedicine privileges will be required to complete an application and provide evidence of current clinical competence. This information may include, but is not limited to, a copy of the individual’s quality profile from his or her primary practice affiliation. Once all credentialing information is received, an application to review telemedicine privileges will be processed.

Telemedicine providers and Practitioners providing only telemedicine services at the Hospital will be categorized as Telemedicine Staff and will not be eligible to vote, hold office or be required to pay medical staff dues or follow other medical staff or hospital requirements for practitioners that provide direct patient care (e.g., requiring TB immunizations, etc.).
If credentialing and privileging was performed using a contractual agreement with a distant site hospital and the distant site hospital terminates its telemedicine agreement with the Hospital or otherwise takes adverse action against the Practitioner's privileges at the distant site hospital that results in a loss of privileges, such action will result in an automatic termination of the Telemedicine Staff member's privileges consistent with the distant site's medical staff without the right to a fair hearing. The contractual agreement will also contain provisions to ensure the Telemedicine Staff had appropriate insurance to address liability concerns.

J. LEAVE OF ABSENCE

1. **Leave Status:** A Member may request a voluntary leave of absence for good cause (e.g., health reasons, additional training, or not in active practice in this geographic area) from the Medical Staff by submitting written request to the Medical Executive Committee or the President of the Medical Staff stating the reasons therefore and the exact period of time of the leave requested, which may not exceed his/her term of appointment. When circumstances require, the department Chair or the chair of the Credentials Committee may approve the request for a leave of absence immediately, pending Medical Executive Committee and Board action. The Board may grant such leave of absence upon receipt of such request. A Staff Member may apply for extension of the leave of absence, which may be approved by the Board.

2. **Termination of Leave:** The Member may request reinstatement of his/her privileges and prerogatives by submitting a written request to his/her respective department Chair in care of the Medical Staff Office. The Member shall submit a written summary of his/her activities during the leave to accompany the request for reinstatement of privileges.

   The department Chair shall then make a recommendation concerning the reinstatement of the Member's privileges and prerogatives, which is forwarded for consideration by the Credentials Committee, the Medical Executive Committee, and the Board.

   a. If the action of the Medical Executive Committee is adverse to the Member, then he/she shall be entitled to the procedural rights provided in Article X of the Bylaws;

   b. The Board shall take final action on the reinstatement request and shall send notice of such action to the Staff Member. In the event that such action shall be adverse, such notice shall be by Special Notice.

   Failure, without good cause, to request reinstatement or to provide a summary of activities as above provided shall constitute a voluntary resignation. A request for Medical Staff membership subsequently received from a Member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.
ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

A. CATEGORIES: The Medical Staff shall be divided into Provisional, Active, Courtesy, Community, Telemedicine, Honorary and Academic.

B. PROVISIONAL STAFF

All initial appointments to the Medical Staff shall be provisional in accordance with Article III, Section D & E.

Members of the Provisional Staff:

1. May not vote or hold elective office; but may serve on committees and vote on any committee to which the Member has been appointed. Provided, however, the preceding sentence shall not take effect until the first (1st) anniversary of the date upon which the initial Bylaws become effective.
2. May admit and treat patients in the Hospital consistent with the Clinical Privileges granted to the Member, including on-call rosters, if so appointed.
3. If a Member wishes to become a member of the Active Medical Staff upon completion of his/her Provisional appointment, he/she will be required to attend at least an aggregate of at least fifty percent (50%) of the meetings of the subsection and/or department to which the Member is assigned (or such other percentage as may be determined by the Chair of the subsection or department) and of the general Medical Staff meetings. If the Member wishes to become a Member of the Courtesy or Consulting staff, upon completion of the Provisional appointment, no meeting requirements need be met during the Provisional appointment.
4. Shall admit, treat, consult on or perform procedures on a sufficient number of patients, as determined by the subsection and/or department to which the Member is assigned, for the subsection and/or department Chair to be able to evaluate the quality and appropriateness of the care rendered and determine current clinical competence.
5. Shall pay any dues assessed in accordance with the Bylaws of the Medical Staff.
6. If a physician receives notification of action for investigation by the Maryland Board of Physicians or any other licensing boards, that physician must notify the Medical Staff Office immediately (and in no event in more than 3 calendar days after initial notification) in writing of such action. Any subsequent substantive action or judgment made by the Board must also be noted in writing to Medical Staff office within 5 calendar days.

C. ACTIVE STAFF

1. Qualifications: The Active Medical Staff shall consist of physicians, podiatrists and dentists, each of whom:
   a. Meets the basic qualifications set forth in Article II, Section B(1) of these Bylaws.
   b. Is well qualified in his/her field and is certified or who has satisfied training requirements for certification by his/her respective specialty boards. Further, such Staff Member complies with any requirements set forth in applicable department rules and regulations concerning board certification.
c. Regularly admits patients to or is otherwise regularly involved in the care of patients in the Hospital.

d. In order to advance to Active status from Courtesy, the Member must have a minimum number of patient contacts at the Hospital as defined by the Member’s department. The Practitioner must have attended four (4) of the appropriate department, Section and Semi-annual meetings during the preceding 12 months. Practitioners must also meet all other requirements of his/her department as set forth in the department and subsection Rules & Regulations.

e. In order to maintain Active staff status at the Hospital a Member must have a minimum number of patient encounters at the Hospital sufficient to allow appropriate evaluation of his/her qualifications. The number of encounters is to be established in the Rules and Regulations of the department and/or subsection. If a department or subsection requires meeting attendance to maintain Active staff status, the meeting requirement will be set forth in the department or subsection Rules & Regulations.

f. To be eligible for reappointment to the Active staff, a Member of the Medical Staff must attend four (4) of the appropriate department, section and Semi-Annual meetings during the preceding 12 months. Should this requirement not be met, however, the appropriate department Chair or the Credentials Committee may also consider service to the Hospital and Committee work when considering reappointment to the Active Staff.

2. **Prerogatives:** The prerogatives of the Active staff shall be to:

a. Admit patients to the Hospital:

   Dental or podiatry members may admit provided it is demonstrated at the time of admission that a physician Member of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during hospitalization.

b. Exercise such Clinical Privileges as are granted to him/her pursuant to Article VII of these Bylaws.

c. Vote on all matters presented at general and special meetings of the Medical Staff, departments and committees of which he/she is a member.

d. Hold office in the Medical Staff organization and in the department, service and committees of which he/she is a member.

3. **Responsibilities:** Each Member of the Active Medical Staff shall:

a. Discharge the basic responsibilities set forth in Article II, Section C of these Bylaws.

b. Actively participate in the quality maintenance, assessment and improvement activities required of the Staff; monitoring and reviewing provisional appointees of his/her same professional specialty; and in discharging such other Staff functions as may from time-to-time be required.
c. Satisfy the requirements set forth in Article XIV of the Bylaws and/or as set forth in the Department Rules for attendance at meetings of the staff, department, and committees of which he/she is a member.

d. Be responsible for the welfare of all patients entrusted to his/her care and supervise the professional activities of the residents, interns and students assigned to the service.

e. Have the responsibility of performing all organizational and administrative duties as appropriate.

f. If a physician receives notification of action for investigation by the Maryland Board of Physicians or any other licensing board, that physician must notify the Medical Staff office within 5 calendar days in writing. Any subsequent substantive action or judgment made by the Board must also be noted in writing to Medical Staff office within 5 calendar days

D. COURTESY STAFF

1. **Qualifications:** The Courtesy Staff shall consist of physicians, podiatrists and dentists, each of whom:

   a. Meets the basic qualifications set forth in Article III, Section B (1) of these Bylaws.

   b. Is well qualified in his/her field and is certified or who has satisfied training requirements for certification by his/her respective specialty Boards. Further, such medical staff member complies with any requirements set forth in applicable department rules and regulations concerning board certification.

   c. With respect to all relevant specialties, practices primarily here or at another Hospital with sufficient clinical activity to allow for adequate assessment of the Practitioner at reappointment.

2. **Prerogatives:** The prerogatives of a Courtesy Staff member shall be to:

   a. Admit patients to the Hospital. At times of full Hospital occupancy or of shortage of Hospital beds or other facilities, as determined by the President, the admitting privileges of Courtesy Staff Members shall be subordinate to those of Active Staff Members. Dentists and Podiatrists may admit within the limitations provided in Article IV, Section B-2(a) of these Bylaws.

   b. Attend meetings of the Medical Staff and department of which he/she is a member and any staff or Hospital education programs. However, Courtesy Staff shall not be required to attend regular staff conferences, nor be eligible to vote or hold office in the Medical Staff organization and have no responsibilities for teaching.

   c. Any member of the Courtesy Staff may be limited in his/her Hospital Privileges, including the right to admit patients, to a degree to be determined by the Credentials Committee and approved by the Medical Executive Committee and the Board, depending upon his/her training, experience, competence, proximity to the Hospital, availability for emergency...
situations within the Hospital, and the purpose for which his/her Medical Staff membership was originally requested.

d. Be eligible to submit a written request for advancement to the Active Staff after one year from the date of initial appointment; qualifications for Active Staff status in this Article, IV Section B and applicable department rules and regulations governing Active Staff must also be fulfilled.

e. If a physician receives notification of action for investigation by the Maryland Board of Physicians or any other licensing board, that physician must notify the Medical Staff Office within 5 calendar days in writing. Any subsequent substantive action or judgment made by the Board must also be noted in writing to Medical Staff office within 5 calendar days

3. **Responsibilities:** Each member of the Courtesy Staff shall:

   a. Be required to discharge the basic responsibilities specified in Article III, Section C of these Bylaws.

   b. Attend staff conferences upon request when a case treated by the Courtesy Staff member is to be presented at a meeting of the Medical Staff. The Courtesy Staff member shall be notified, and he/she shall be required to attend this particular meeting under penalty of forfeiting his/her Courtesy Staff membership. A reasonable request for postponement will be considered in the event of extenuating circumstances.

   c. If a physician receives notification of action for investigation by the Maryland Board of Physicians or any other licensing board, that physician must notify the Medical Staff Office within 5 calendar days in writing. Any subsequent substantive action or judgment made by the Board must also be noted in writing to Medical staff office within 5 calendar days

E. COMMUNITY STAFF

1. **Qualifications, Prerogatives and Responsibilities**

   The Community Staff shall consist of physicians, podiatrists and dentists who do not meet the activity requirements of his/her respective departments, but who refer patients for care at Holy Cross Hospital. Members may apply for this category only at either initial appointment or at reappointment. Members of the category would be exempt from the acute care experience requirements, and they would not be able to admit patients or write orders.

   a. **Qualifications:**

      i. Maintain current and valid licensure in the State of Maryland; a current and valid Federal DEA certificate; and, a current and valid Maryland Controlled Dangerous Substances Registration.

      ii. Maintain and provide evidence of continuous and adequate professional liability insurance coverage in the amounts of $1,000,000/$3,000,000.

      iii. Maintain board certification in keeping with Article III, Medical Staff Membership, 1. Basic Qualifications for Membership.

      iv. Provide National Provider Identification (NPI) number
v. Initial applicants must supply two (2) letters of recommendation. The reference letters may not be from those with whom the physician is in practice.
vi. Practice location must be within the Metropolitan Washington DC area

b. **Prerogatives:**
i. Referral of patients to a Medical Staff Member with admitting privileges.
ii. Visit patients in the hospital.
iii. Access to the hospital electronic medical records.
iv. Invited to attend departmental or semi-annual meetings of the medical staff, but are not required; shall not be eligible to vote.
v. Invited to serve on medical staff and hospital committees, but are not required to do so. If serving on a committee, the individual committee would decide whether or not the Community Member serves with or without a vote.

F. HONORARY STAFF

**Qualifications, Prerogatives and Responsibilities:**
The Honorary Medical Staff shall consist of physicians, podiatrists and dentists to be honored by this emeritus position. These may be physicians, podiatrists and dentists of outstanding reputation not necessarily resident in the community. Members of the Active staff, upon attaining the age of sixty-five (65) or after twenty (20) years of service on the Active staff, shall be eligible for the honorary staff upon written request.

Members of the Courtesy staff who have been members of the medical staff for thirty (30) years and are sixty-five (65) years of age shall be eligible for Honorary staff upon written request.

Honorary Staff members are not eligible to vote or hold office and shall not be required to serve on Medical Staff or departmental committees. Members of the Honorary staff shall be exempt from paying Medical Staff dues.
Honorary Staff category does not include Clinical Privileges

G. ACADEMIC STAFF

**Qualifications, Prerogatives and Responsibilities:** The Academic Staff shall consist of qualified physicians, podiatrists, dentists, scientists, and social scientists of recognized academic stature. The responsibility of the Members of the Academic Staff will primarily be academic in scope. Consultation and participation in patient care may be rendered only on the request of an attending physician. They will have no admitting privileges. Members of the Academic Staff may serve without a vote on departmental or Medical Staff committees, but they may not chair such committees. They are not eligible to serve on the Medical Executive Committee or the Credentials Committee. They may participate in departmental and staff meetings, but may not vote. Members of the Academic Staff shall be exempt from paying Medical Staff dues.

H. TELEMEDICINE STAFF
Qualifications, Prerogatives and Responsibilities: The Telemedicine Staff shall consist of qualified health care practitioners who provide patient care services to Hospital patients via telemedicine link and have met the qualifications for membership set forth above. Unless granted Clinical Privileges for such services as though they were providing services on site at the Hospital (in which case they may qualify for another category of Medical Staff membership), they must have clinical privileges under the terms of a telemedicine services agreement between the Hospital and a Medicare-participating distant-site hospital. Telemedicine Staff privileges are contingent on such an agreement being in force with the distant-site hospital. Telemedicine privileges shall be for a period of not more than 2 years. Telemedicine providers and Practitioners providing only telemedicine services at the Hospital will be categorized as Telemedicine Staff and will not be eligible to vote, hold office or be required to pay medical staff dues or follow other medical staff or hospital requirements for practitioners that provide direct patient care (e.g., requiring TB immunizations, etc.).
ARTICLE V - CONSULTANTS AND HOUSE OFFICERS

A. CONSULTANT WITH LIMITED CLINICAL PRIVILEGES

Consultants in a recognized specialty, who meet all of the criteria for appointment to the Medical Staff, may request limited clinical privileges. At the request of a Staff Member, Practitioners in this category may consult on a patient, write orders and be granted limited clinical privileges, the scope and extent shall be specifically delineated and granted in the same manner as all other clinical privileges. Practitioners requesting this category shall not have admitting privileges.

Clinical privileges granted shall be based on the Practitioner's licensure, training, experience, demonstrated current competence, and other such information as may be relevant. The process of Clinical privilege delineation includes review and approval by the Department, Credentials Committee, Medical Executive Committee and Board.

B. HOUSE OFFICER STAFF

House Officers whose services are limited to specific areas of the Hospital must meet all of the criteria set forth in these Bylaws for appointment to the Medical Staff, except the requirement for certification or training requirements for certification by specialty boards does not apply.

ARTICLE VI - AFFILIATES

A. GENERAL

1. General Description: Categories of allied health professionals eligible to obtain Clinical Privileges as Affiliates have been designated by the Board based on the Board's judgment that each category, among other things, provides appropriate assistance to Staff Members, enhances the quality and scope of patient care at the Hospital, and furthers the health care mission of the Hospital. At the time of the establishment of the Affiliate Staff, the Board's judgment is that only psychologists, physicians' assistants, nurse midwives, certified registered nurse anesthetists, and nurse practitioners fulfill these criteria. If Affiliate Staff status is sought by other allied health professionals not yet eligible for Clinical Privileges, the Board, upon recommendation of the Medical Executive Committee and Medical Staff, shall carefully consider all relevant criteria and decide whether or not to expand the Affiliate Staff to include such groups.

For Affiliates who require supervision by a physician ("dependent Affiliates"), each Department and Section may consider whether or not or under what conditions dependent Affiliates would be appropriate to practice in such Department or Section, using criteria related to the quality of patient care in such Department or Section. Any recommendation to permit or not the practice of a category of dependent Affiliates in such Department or Section, or to limit or expand the practice of a category of dependent Affiliates in such Department or Section, shall be subject to the review and approval of the Board, upon recommendation of the Medical Executive Committee, and subject to the standards of applicable laws or regulations. Any such modifications shall be reflected in the Rules and Regulations of the Department or Section.
2. **Nature of Relationship:** Affiliates may not be granted membership on the Medical Staff, regardless of whether they are independent or dependent Affiliates. However, Affiliates may apply for and obtain Clinical Privileges in the Hospital pursuant to the Bylaws. The process of applying for Clinical Privileges is set forth in Article VI of these Bylaws, where an Applicant includes an Affiliate, as appropriate. Except as otherwise expressly permitted, Affiliates do not have admitting privileges; Affiliates who are physicians’ assistants and nurse practitioners have no admitting privileges. Affiliates are assigned to specific Departments, as indicated in the sections of Article VI of these Bylaws describing Clinical Privileges for the respective Affiliates. Affiliates may not attend to patients except those to which they are assigned by the responsible physician. Affiliates may attend Departmental meetings; Affiliates may not vote at such meetings. Affiliates may attend Medical Staff semi-annual meetings and meetings of committees to which they may be assigned, if any, but shall not be entitled to vote. Affiliates may not hold elective office in the Medical Staff.

3. **Due Process Rights:** Affiliates shall be subject to the corrective action provisions of Article IX of the Bylaws, and shall be entitled to exercise the due process rights set forth in Article X of the Bylaws. Affiliates who are also employees of the Hospital shall not be entitled to exercise any of the due process rights set forth in the Bylaws; rather, any rights of redress involving the Hospital shall be governed by the Affiliate’s employment agreement with the Hospital and/or the Hospital's employment policies, whichever shall apply under the circumstances. Termination of employment shall likewise terminate any Clinical Privileges granted pursuant to the Bylaws. Affiliates who are employed by Staff Members shall be automatically and immediately terminated from exercising Clinical Privileges when either: (a) his/her employment by the Staff Member is terminated, or (b) the Staff Member's Medical Staff membership is terminated, regardless of the reason therefore. In either such event, the Affiliate shall not be entitled to exercise any of the due process rights set forth in the Bylaws; however, he or she may apply for Clinical Privileges, on his or her own behalf, as though submitting an initial application.

**B. QUALIFICATIONS**

1. **Generally:** Eligibility to exercise Clinical Privileges at the Hospital is a privilege, not a contractual right, which shall be extended only to professionally competent allied health care professionals who continuously meet the qualifications, standards and requirements set forth in the Bylaws. No allied health care professional shall be entitled to exercise Clinical Privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this State or in any other state, or that he or she is a member of any professional organization, or that he or she has in the past had, or presently has, such privileges at another hospital. No Affiliate who is otherwise qualified shall be denied privileges because of race, color, creed, age, sex, marital status, religion, or national origin. Affiliates shall present written evidence of adequate and continuous professional liability insurance (which shall include "prior acts" coverage as necessary to avoid any gaps in coverage) from an insurance carrier authorized to do business in Maryland in the required minimum amount established for Staff Members.

Each Affiliate shall document his or her continuous compliance with the following minimum qualifications with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient he or she treats or assists in the Hospital will receive care of the
type generally recognized by the Hospital as an acceptable level of professional quality and efficient care. Additional and more specific qualifications for Affiliates are described further in this subsection, as well as in the Departmental Rules and Regulations. Each Affiliate shall demonstrate that he or she at least:

a. Possesses a current, unrevoked and unsuspended license to practice his or her profession in this State of Maryland;

b. Is in good physical and mental health;

c. Has sufficient academic background, clinical experience and professional training;

d. Has current clinical and technical competence, as demonstrated by experience in the care of patients representative of those admitted to this Hospital;

e. Adheres to the ethics of his or her profession;

f. Possesses good reputation and professional character;

g. Works harmoniously with other professionals and Hospital personnel and interacts appropriately with such persons, as well as with patients and the general public;

h. Has performed adequately at other hospitals or health care facilities, if the Affiliate has held such privileges;

i. Provides sufficient documentation of pending and past liability claims, any settlements or monetary payments made, and any denials or cancellations of any professional liability insurance policy; and

j. Provides acceptable responses to such other items of information or inquiry which may be contained on the application for initial appointment or reappointment.

Any Affiliate or Applicant who possesses a malpractice insurance policy that does not meet the criteria set forth above, shall purchase a conforming policy at the time of appointment. The Affiliate or Applicant must agree that he/she will notify the Medical Staff Office when he/she or his/her carrier cancels or does not renew for any reason a professional liability insurance policy, when the limits of a policy are reduced, and when the scope of clinical privileges insured is reduced. In the following instances, the Hospital will require any Affiliate who has been or is currently a Practitioner to purchase additional malpractice insurance to cover claims for events arising out of treatment rendered at the Hospital but not asserted until after the cessation of privileges of the Affiliate at the Hospital (i.e., "tail" coverage):

1) Revocation of Clinical Privileges; and

2) Any termination of Medical Staff membership and/or Clinical Privileges.

Such requirement shall be a condition which the Hospital may enforce by not accepting a tendered voluntary resignation, by taking disciplinary action under the Bylaws, which shall
not entitle the Practitioner to any hearing rights under Article X of the Bylaws, and/or by judicial process, if necessary.

Dependent Affiliates and his/her employing or responsible Staff Member must sign an acknowledgment of the liability of the employing or responsible Staff Member for the acts or omissions of the Affiliate, and of his/her duty to notify the Medical Staff Office of any change in his/her status with respect to employment, licensure or insurance. Each Affiliate shall:

i. Provide his/her patients with care of the recognized level of professional quality and efficiency;

ii. Abide by the Medical Staff Bylaws and by all other lawful standards, policies and rules of the Hospital;

iii. Discharge such staff, department, service, committee and Hospital functions for which he/she is responsible by appointment, election, or otherwise;

iv. Prepare and complete in timely manner the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital; and

v. Abide by the principles of ethics of whatever association is applicable, as well as the values and principles inherent in the medical-moral teachings of the Catholic Church as promulgated by the National Conference of Catholic Bishops and the local Ordinary, as the same are appended to and made a part of the Bylaws.

2. Physicians' Assistants:

a. Only physicians' assistants who meet the basic qualifications as required by this Article VI of these Bylaws, who are employed or are to be employed by a Staff Member, or who, upon the recommendation of a Department, are employed or are to be employed by the Hospital, and who meet the following specific criteria, shall be eligible for physicians' assistants Clinical Privileges:

1) Have completed an American Medical Association accredited (or State-recognized equivalent) program of training and education for assistance to the physician;

2) Have passed the national certifying examination for physicians’ assistants, or have completed other nationally recognized courses and have passed a certifying examination for assistants in subspecialties;

3) If applicable, have satisfied the criteria for employment and have met all application requirements; and

4) Will be adequately supervised by his/her employing Staff Member or by the Physician designated in the State approved job description.
b. Physicians’ assistants shall be supervised by his/her employing Staff Member or by the physician designated in accordance with State law requirements. They shall be assigned to the Department where they are to have Clinical Privileges.

c. The clinical privileges for physicians’ assistants shall be set forth in the approved Departmental Rules and Regulations for each Department where a physicians’ assistant is assigned.

3. Nurse Practitioners

a. Only nurse practitioners who meet the basic qualifications as required by this Article VI of these Bylaws, who are employed or are to be employed by a Staff Member, or who, upon the recommendation of a Department, are employed or are to be employed by the Hospital or through a Hospital contract with another provider, and who meet the following specific criteria, shall be eligible for nurse practitioner Clinical Privileges:

1) Possess a current valid license to practice as a registered nurse in the State of Maryland;

2) Possess an approved written agreement with a sponsoring physician who is a member in good standing on the Medical Staff and in the area of certification/specialization. In the case of a Hospital-employed nurse practitioner, a current approved job description is also required. Such documents will be submitted with the application for Affiliate Staff membership;

3) Have completed a nurse practitioner program approved by the Maryland Board of Nursing;

4) Are certified by an appropriate certifying organization

5) If applicable, have satisfied the criteria for employment as do other Hospital employees; and

6) Will be adequately supervised by his/her employing Staff Member or by a Staff Member in the Department where they are employed.

b. Nurse practitioners shall be supervised by his/her employing Staff Member or by a Staff Member in the Department where they are employed. They shall be assigned to the Department where they are to have Clinical Privileges.

c. The clinical privileges for nurse practitioners shall be set forth in the approved Departmental Rules and Regulations for each Department where a nurse practitioner is assigned.

4. Psychologists

a. Only psychologists who meet the basic qualifications as required by this Article VI of these Bylaws, who hold a Ph.D. in psychology from an accredited institution, and who
have at least two years clinical experience in an acute care setting shall be eligible for Clinical Privileges.

b. Psychologists shall be assigned to the Department of Medicine and shall conform to Departmental Rules and Regulations.

c. Admission to the Psychiatric Unit must be by a psychiatrist on the Medical Staff.

d. Psychologists may not independently admit patients to the Hospital's acute care Psychiatric Unit or other mental health related programs at the Hospital.

e. An appropriate physician on the Medical Staff must write the admission medical history, physical examination, and appropriate orders for laboratory and x-ray studies. This physician will be responsible for the medical care of the patient while on the Psychiatric Unit.

f. Should there be a disagreement between the admitting physician and the psychologist concerning the patient's care, the decision of the admitting psychiatrist who has ongoing responsibility for the patient shall immediately govern.

g. Any physician possessing Clinical Privileges may request a consultation from a psychologist for a non-Psychiatric Unit patient without the requirement of supervision by a psychiatrist but under the supervision of the attending physician who requested the consultation.

h. Competence in each requested privilege must be established by documentation of at least two years full-time education, training and experience in an acute care setting (general hospital, ambulatory care, outpatient clinic, emergency setting) sufficient enough to demonstrate current clinical competence. This may include, at the discretion of the Hospital, specific clinical summaries (anonymous) of treated patients in specific settings or other documentation as considered necessary to demonstrate clinical competence.

i. The applicant, by checking any or all of the items on the approved Delineation of Privileges form indicates his/her belief that he/she has the requisite basic training and competence in these areas and is willing to supply appropriate requested documentation when requested. Categories 1 and 2 on the Delineation of Privileges form assume that the applicant has received training in these areas in his/her clinical training. Category 3 requires specific additional documentation of postgraduate training and current clinical expertise.

5. Nurse Midwives

Only nurse midwife applicants who meet the basic qualifications as required by this Article VI of these Bylaws and who meet the following specific criteria, shall be eligible for nurse midwife Clinical Privileges:

a. A nurse midwife applicant must be a graduate of a Nurse-Midwifery Master's program accredited by the American College of Nurse-Midwives (ACNM).
b. Applicants for initial appointment must be able to demonstrate current competency and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency.

c. The nurse-midwife applicant must be licensed to practice in the State of Maryland as a registered nurse and a nurse midwife.

d. In addition, she/he must be certified through the ACNM Certification Council or be in the active process of seeking such certification. If appointed to the Medical Staff, the nurse midwife must receive such certification within 1 year from the date of the initial appointment or the appointment will lapse.

e. At the time of reappointment, a nurse-midwife member of the Medical Staff is required to report continuing education activities. This requirement is to be satisfied through the accumulation of 15 contact hours in content areas relevant to nurse-midwifery specialty.

f. Possess an approved written agreement with a sponsoring physician who is a member in good standing on the Medical Staff of Holy Cross Germantown Hospital in the department of obstetrics and gynecology.

6. Certified Registered Nurse Anesthetists ("CRNAs")

a. Only CRNA applicants who meet the basic qualifications required by this Article VI of these Bylaws and who meet the following specific criteria shall be eligible for CRNA Clinical Privileges:

1) The CRNA applicant must be a graduate of a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs.

2) Applicants for initial appointment must be able to demonstrate current competency and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency.

3) The CRNA applicant must be licensed to practice in the State of Maryland as a registered nurse and a CRNA.

4) The CRNA must be certified by the National Board of Certification and Recertification for Nurse Anesthetists ("NBCRNA").

5) At the time of reappointment, a CRNA Affiliate of the Medical Staff is required to report continuing education ("CE") activities. This requirement is to be satisfied through the required number of CEs as specified by the NBCRNA. A CRNA Affiliate is required to participate in NBCRNA's Continued Professional Certification Program.

b. CRNAs shall be supervised by their employing (or contracting) Staff Member.
c. The Clinical Privileges for CRNAs shall be set forth in the approved Departmental Rules and Regulations and Delineation of Privileges for the Department to which the CRNA is assigned.

B. CLINICAL PRIVILEGES

1. **Generally**: Clinical Privileges granted to Affiliates shall be based on the Affiliate's licensure, training, experience, and demonstrated current competence, and where applicable, upon an examination of the records of previous cases treated, and other such information as may be relevant. The scope and extent of procedures that each Affiliate may perform shall be specifically delineated and granted in the same manner as all other Clinical Privileges. The process of Clinical Privileges' delineation includes review and approval by the Department, Credentials Committee, Medical Executive Committee and Board.

2. **Provisional Nature**: All delineations of Clinical Privileges for Affiliates shall be provisional for a period not to exceed two years, renewable for an additional two-year period in the event that additional time is required to observe the Practitioner's performance and clinical competence. If, by the end of the provisional period or any extension thereof the Affiliate has not satisfied the requirements for continued Clinical Privileges, or has not utilized the Hospital with such frequency as would afford an opportunity for his/her performance and clinical competence to be reasonably observed, his/her Clinical Privileges may be terminated and the Affiliate shall be given special notice of such termination and of his/her entitlement to the procedural rights specified in Article X of the Bylaws.

3. **Specific Clinical Privileges**: The particular requirements, prerogatives and limitations for each Affiliate are set forth in the Departmental Rules and Regulations, as amended from time to time, as well as in the current appropriate Clinical Privileges delineation form for each Affiliate.

ARTICLE VII - PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

A. GENERAL PROCEDURE

The Medical Staff, through its designated departments, services, committees and officers, shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of Medical Staff membership status and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform these same investigation, evaluation and recommendation functions in connection with any individual who seeks to exercise Clinical Privileges or provide specified services in any department or service of the Hospital, including Affiliates, whether or not such professional or individual is eligible for Medical Staff membership. The recommendation of the Medical Executive Committee shall be transmitted to the Board within 6 months from the time that an application for membership, complete in every detail, is received.
The President (or his/her designated representative) shall contact and obtain from primary sources the documentation necessary for appointment and reappointment. These primary sources include, but shall not be limited to: the American Medical Association Physician Profile which includes education and training, all state licensure, Federal Drug Enforcement Agency certificate (DEA), board certification from an American Board of Medical Specialty approved agent, claims history from all malpractice insurance carriers for the previous five (5) years (including training), Medicare/Medicaid sanctions from the Office of the Inspector General, and the National Practitioner Data Bank (NPDB) for adverse action reports and malpractice payment reports.

The results of such queries shall constitute an integral portion of the application, but they shall not alone be dispositive. Performance of such queries shall be the sole responsibility of the NPDB's authorized representative at the Hospital, who shall be designated by the President. The President (or his/her designee) should not transmit the application and supporting materials to the appropriate department unless he/she includes the NPDB's report regarding such Applicant. The Applicant may, but need not, be provided with a copy of the results of the query to the NPDB.

B. PRE-APPLICATION FORM

Upon initial application, Applicants, except those who clearly do not meet the criteria for Staff Membership and/or Clinical Privileges, shall be provided with an Application Request Form promptly upon request. The Application Request Form shall request very general information about the Applicant's licensure status, malpractice insurance, office location, and similarly objective criteria. The Applicant's return of the completed Application Request Form and curriculum vitae shall constitute a request for an application. If the Application Request Form indicates that the Applicant does not qualify for Medical Staff membership and/or Clinical Privileges pursuant to Article III, Section B(1) of these Bylaws, the, Medical Staff office, or a designee, shall not forward an application form to the Applicant and no due process rights shall apply nor shall such rights apply if the Applicant does not qualify to receive an Application Request Form.

C. APPLICATION FOR INITIAL APPOINTMENT

1. **Application Form and Process:** Each application for Clinical Privileges shall be in writing, submitted on the prescribed form, and signed by the Applicant. The Applicant is responsible for producing adequate information for a proper evaluation of his/her qualifications and for resolution of any questions or concerns about his or her qualifications. The Applicant shall notify the Medical Staff office immediately in writing of any change to information contained in the application or related matters. The Applicant may be required to appear for an interview regarding his application or related matters and/or to submit answers to written questions.

2. **Content:** The application form, appendices thereto, and all subsequent substantive changes shall be approved by the Board after approval by the Medical Executive Committee but shall contain at least the following:

   a. **Acknowledgement and Agreement:** A statement that the Applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges, and
to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted membership and/or Clinical Privileges.

b. **Qualifications:** Detailed information concerning the Applicant's qualifications, including, but not limited to, information in satisfaction of the basic qualifications specified in Article III, Section B(1) of these Bylaws and of any additional qualifications specified in the Bylaws for the particular Medical Staff category to which the Applicant may be appointed.

c. **Requests:** Specific requests stating the department and Clinical Privileges for which the Applicant wishes to be considered.

d. **Licensure and Registration:** Information concerning any license or registration to practice a health occupation ever held by the Applicant, including a license to practice medicine, dentistry, podiatry or other health occupation. Evidence of drug enforcement registration shall also be provided. This information will be verified through the state licensing agencies and through the Drug Enforcement Administration.

e. **Education and Board Certification:** Information concerning the Applicant's training, including medical, dental or other relevant professional education, internship, residencies, fellowships, and current appointments. Information concerning the Applicant's specialty board status shall also be provided. Verification of education and training will be obtained through the AMA Physician Profile for physicians and from the primary source for other types of practitioners. Board certification will be obtained from an authorized American Board of Medical Specialties agent.

f. **Professional Sanctions:** Information as to whether the Applicant's membership status and/or Clinical Privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, limited, denied, or not renewed at any other hospital or health care institution; whether any of the preceding have ever been voluntarily or involuntarily suspended, revoked, denied or not renewed; whether any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) have ever been filed against the Applicant or whether the Applicant has ever voluntarily relinquished such licensure or registration; and whether a complaint or report has ever been filed against the Applicant with the Board of Physician (BOP) or any other state discipline agency, a state medical society, or a professional/specialty association. If any such actions were ever taken or are presently pending, the particulars thereof shall be included.

g. **Professional Liability Insurance:** Evidence that the Applicant has carried continuous and adequate professional liability insurance coverage as required by Article III of these Bylaws. Evidence of the current limits of coverage, current types of coverage, restrictions on coverage and continuous professional liability insurance (which shall include "prior acts" coverage as necessary) shall be provided as well as the name of the present professional liability insurance carrier.

Information shall be submitted of the Applicant's malpractice experience during the previous five years, including consent to release of information by his/her present and past malpractice insurance carrier(s). At a minimum, final judgments or settlements involving the
Applicant must be reported, as well as any lapses in coverage during any time in the Applicant's career. This information will be verified from each professional liability insurance carrier and from the NPDB.


i. Physical and Mental Health Impairments: Information concerning the Applicant's current mental and physical health status within the past two years including all health impairments, if any, affecting the Applicant's ability to perform professional and Medical Staff duties fully, pertinent hospitalizations or other institutionalization’s for significant health problems; and any pertinent continuing health problems requiring current therapy.

j. Practice History: The location of offices; names and addresses of other health care professionals with whom the Applicant is or was associated with and inclusive dates of such association; names and locations of any other hospital, clinic or health care institution or organization where the Applicant was appointed or employed, provides or provided clinical services and the inclusive dates of each affiliation. Practice history should be provided in its entirety, and without any time limit.

k. Criminal History: Information concerning any current criminal charges (excluding minor traffic offenses) pending against the Applicant and any previous such arrests or charges, including its resolution.

l. Alternate Coverage: Names of two Practitioners with appropriate Clinical Privileges at the Hospital who will serve as alternates when the Applicant is unavailable. In unusual circumstances, the Credentials Committee may elect, at his/her sole discretion, to require only one alternate.

D. INITIAL APPLICANTS WITHOUT RECENT ACUTE CARE EXPERIENCE

Credentialing of physicians who have not had recent acute care experience in a hospital, surgicenter or acute care facility at the residency/fellowship physician level, as determined by the department/subsection supervisory committee:

1. For those physicians who have not had acute care experience at the attending physician level within two (2) years, 50 hours of Category I CME in his/her specialty over the last two years with 25 Category I CME hours in his/her specialty within the last year is required, provided all the other conditions of Medical Staff membership are met.

2. For those physicians who have been without acute care clinical experience at the attending physician level for greater than two years but less than five years, or who fall below a minimal amount of clinical activity as defined by the department/subsection supervisory committee, CME requirement of 50 hours Category I in his/her specialty during the most recent two (2) years of clinical inactivity is necessary. In addition, these physicians are required to have an approved co-attending designated by the department/subsection supervisory committee admit and concurrently review the care provided during a minimum number of admissions/procedures to be determined by the department/subsection supervisory
committee representing the new physician’s specialty. That minimum number will be greater than or equal to 3 admissions/procedures. The new physician will be the primary physician caring for the patient and will write all the orders. The new physician will review orders with the proctor on admission/procedures and after a change in patient status. These cases will be subject to retrospective review by a department/subsection supervisory committee to assure appropriate clinical care.

3. Physicians who have had no acute clinical care experience for greater than five (5) years or who fall below a minimal amount of clinical activity as defined by the department/subsection supervisory committee in the five years before application, must have certification or current recertification in his/her specialty within five (5) years of applying for privileges. If that is not available, they must certify/recertify in his/her specialty. In addition, these physicians should have a formal training program of three months’ duration at an accredited training institution approved by the department chair. For those specialists in fields that do not offer a recertification exam, the formal training requirement is required. Furthermore, these physicians are required to have a department approved co-attending admit and concurrently review the care provided during a number of admissions/procedures to be determined by the department subsection supervisory committee representing the new physician’s specialty. The new physician will be the primary physician caring for the patient and will write all the orders. The new physician will review orders with the proctor on admission and after a change in patient status. These cases will be subject to retrospective review by a department supervisory committee to assure appropriate clinical care.

E. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Focused Professional Practice Evaluation (FPPE) shall be performed in accordance with the Holy Cross Germantown Hospital Medical Staff Performance Assessment Plan, which is incorporated into these Bylaws by this reference.

F. REFERENCES

The application must include the names of 3 individuals of like education who have personal knowledge of the Applicant’s current clinical competence, ethical character, health status and ability to work cooperatively with others. The named individuals must have acquired the requisite knowledge through recent observation within the preceding two years of the Applicant’s professional practice over a reasonable period of time, and at least one must have had organizational responsibility for his/her performance. None of the individuals should be related to the Applicant by family or professional partnership/financial association. (Suggested sources: chief of training program, health care professionals in same specialty unless there is a financial relationship, referring practitioners.) If possible, one of these individuals should be a Staff Member.

If the Applicant completed his/her training program (residency or fellowship) within the two years preceding the date of application, two reference names must be provided on the application form of practitioners in a supervisory capacity (not another resident/fellow). For a recently trained Applicant, no other references will routinely be required unless there is some basis to need further information.
G. EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the Applicant:

1. Is willing to appear for interviews in regard to his/her application and agrees to submit to medical and/or psychiatric evaluation, if requested, for the purpose of resolving any significant question raised which relates to the ability of the Applicant to fully perform his/her professional and medical duties.

2. That he/she will submit complete and accurate information as requested for the Medical Staff application process.

3. He/she may be summarily dismissed from the Medical Staff, with modified due process rights as set forth in Article IX, Section D of the Bylaws, if a material misstatement or omission is made in the application or information provided by the Applicant.

3. Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her professional and ethical competence and qualifications.

4. Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the Clinical Privileges he/she requests, as well as his/her professional and ethical qualifications for Medical Staff membership.

5. Agrees to abide by the terms of the Bylaws, Rules and Regulations, policies and procedures of the Medical Staff and those of the Hospital if granted membership and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted.

6. To the fullest extent permitted by law, releases all Medical Staff and Hospital representatives from any liability for his/her acts performed in good faith and without malice in connection with evaluating the Applicant and his/her credentials.

7. To the fullest extent permitted by law, releases from any liability all individuals and organizations who provide information, including otherwise privileged and confidential information, to Hospital representatives in good faith and without malice concerning the Applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and Clinical Privileges.

8. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with professional performance and the quality and efficiency of patient care with any information relevant to such matters the Hospital may have concerning him/her, and releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.
9. Agrees that, when an adverse ruling is made with respect to his/her membership, staff status, and/or Clinical Privileges, he/she will exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action.

For the purpose of this Section, the term "hospital representative" includes the Hospital, the Board, its members, committees and contracted agent; the President; all Medical Staff, departments and committees which have responsibility for collecting or evaluating the Applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

H. PROCESSING THE APPLICATION

1. **Applicant’s Burden**: The Applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and, upon request of the Medical Executive Committee or of the Board, physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications set forth in the Bylaws. Failure to complete the application and/or to submit any additional requested information within 30 calendar days of a request may be deemed a failure to meet this burden and a voluntary withdrawal of his/her application.

2. **Changes in Application**: Changes in information submitted by the Applicant on his/her application for appointment or reappointment which occur during the processing of an application shall be promptly transmitted by the Applicant to the President (or his/her designee) immediately. The Applicant has this obligation at all times while his/her application is pending until its final approval by the Board of Directors.

3. **Verification of Information**: The completed application shall be submitted to the President (or his/her designated representative, e.g. the Medical Staff office) or agent who collects or verifies the references, licensure and other information submitted including inquiries to available federal and/or state data banks, as permitted or required by law, and promptly notifies the Applicant of any problems in obtaining the information required. Upon such notification, it is the Applicant's obligation to assist in obtaining the required information within 30 calendar days of such a request.

The identity of the practitioner shall be verified by viewing a picture identification, such as the applicant’s driver’s license, to assure that the individual requesting privileges is the same individual identified in the documents.

When collection and verification is accomplished, the completed application and all supporting materials shall be promptly transmitted to the Chairs of each Department or Subsection in which the Applicant seeks clinical privileges.

4. **Interview**: Applicants for initial appointment will be interviewed by a member of the supervisory committee of the appropriate department and a member of the Credentials Committee, either in combined or separate interviews, unless the Applicant is well known to a member of the supervisory committee.

5. **Department Action**: Upon receipt, the department Chair shall promptly review the application and supporting documentation. If the department Chair contemplates an
unfavorable recommendation, the department supervisory committee shall review the application and supporting documentation. Upon completion of such review, the department Chair shall transmit to the Credentials Committee a written recommendation as to staff appointment, and if appointment is recommended, as to privileges to be granted, and any special conditions to be attached to the appointment. A department Chair may also recommend that the Credentials Committee defer action on the application. The reason for a recommendation of deferral or modification of the initial request shall be stated and supported by reference to the completed application and all other documentation considered by the Credentials Committee, all of which shall be transmitted with the report. Any minority views shall be reduced to writing and transmitted with the majority report.

Once a nurse practitioner application is complete, the chief nurse executive shall promptly review the application and supporting documentation and interview the Applicant. The department Chair shall then review the application and supporting documentation. If either the chief nurse executive or the department Chair contemplates an unfavorable recommendation, the application and supporting documentation shall be transmitted to the Credentials Committee with a written recommendation from the chief nurse executive and/or the department Chair as to staff appointment.

6. **Credentials Committee Action:** At its next regular meeting after receipt of the departmental report and recommendations, the Credentials Committee shall review the application, the supporting documentation, the departmental recommendations, and such other information available to it that may be relevant to consideration of the Applicant's qualifications for the Medical Staff category, department affiliation, and Clinical Privileges requested. Notwithstanding the preceding sentence, if the application contains no potentially adverse information (as defined in policies to be approved by the Board of Directors), the Chair of the Credentials Committee may act on behalf of the Committee to review and approve the application, provided that he/she shall make a report of any such actions to the Credentials Committee at its next regularly scheduled meeting. Upon completion of such review, the Credentials Committee (or the Chair acting on its behalf) shall promptly transmit to the Medical Executive Committee a written report and recommendation as to Medical Staff appointment, and if appointment is recommended, as to staff category, department and service affiliations, Clinical Privileges to be granted and any special conditions to be attached to the appointment. The reason for a recommendation of modification of the initial request shall be stated and supported by reference to the completed application and all other documentation considered by the Credentials Committee, all of which shall be transmitted with the report. Any minority views shall be reduced to writing, supported by reasons and references, and transmitted with the majority report. If a negative recommendation is contemplated, the Credentials Committee may interview an Applicant to gather additional information. If a negative recommendation is made, a letter should be delivered to the Applicant by the President of the Medical Staff for informational purposes only.

7. **Medical Executive Committee Action:** At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall consider the report and such other relevant information available to it. Notwithstanding the preceding sentence, if the application contains no potentially adverse information (as defined in policies to be approved by the Board of Directors), the President of the Medical Staff may act on behalf of the Committee to review and approve the application, provided that he/she shall make a report of any such actions to the Credentials Committee at its next regularly
scheduled meeting. The Committee (or the President of the Medical Staff) shall then forward to the President for transmittal to the Board a written report and recommendation as to Medical Staff appointment, and if appointment is recommended, as to Medical Staff category, department and service affiliations, Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also defer action on the application subject to this Article, Section 9(a) below. The reasons for a recommendation of modification of the initial request shall be stated and supported by reference to the completed application and all other documentation considered by the Committee, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references and transmitted with the majority report.

8. **Effect of Medical Executive Committee Action:**

   a. **Deferral:** Action by the Medical Executive Committee to defer the application for further consideration must be followed up within sixty-five (65) days with an express recommendation for provisional appointment with specified Clinical Privileges or for rejection of the application for Medical Staff membership and/or Clinical Privileges.

   b. **Favorable Recommendation:** When the recommendation of the Medical Executive Committee is favorable to the Applicant, the President of the Medical Staff shall promptly forward it to the Board.

   c. **Adverse Recommendation:** When the recommendation of the Medical Executive Committee is adverse to the Applicant, the President of the Medical Staff shall inform the Applicant by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article X of the Bylaws. If, however, the recommendation is based on failure of the Applicant to meet the basic qualifications under Article III, Section B1(c, d, e or f) of these Bylaws, or the Applicant's failure to submit a complete and unaltered application form, or the Applicant's failure to meet established deadlines for submission of information, or inability of the Hospital to obtain adequate references and evaluations, the Applicant shall not be entitled to the procedural rights under Article X of the Bylaws.

9. **Board Action:**

   a. **On Favorable Medical Executive Committee Recommendation:** The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the Applicant, the President shall promptly so inform the Applicant by Special Notice, and he/she shall be entitled to the procedural rights as provided in Article X of the Bylaws, except the Applicant shall not be entitled to any procedural rights for those recommendations or actions that are based on information and documentation deficiencies stipulated in paragraph 8(c) above.

   b. **Without Benefit of Medical Executive Committee Recommendation:** If the Board does not receive a Medical Executive Committee recommendation within the time period specified hereinabove, it may take action on its own initiative. If such action is adverse, the President shall promptly so inform the Applicant by Special Notice, and he/she shall
be entitled to the procedural rights as provided in Article X of the Bylaws, except the Applicant shall not be entitled to any procedural rights for those recommendations or actions that are based on information and documentation deficiencies stipulated in paragraph 8(c) above.

c. **On Adverse Medical Executive Committee Action:** In the event of an adverse Medical Executive Committee recommendation pursuant to this Article, Section H (8)(c) or an adverse Board decision pursuant to this Article, Section H(8)(c) the Board shall take final action in the matter only after the Applicant has exhausted or has waived his/her procedural rights, if so entitled under the Bylaws, as provided in Article X of the Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, and shall set a time limit within which a subsequent submission of new evidence in the matter, if any, shall be made. The Board shall make a final decision either to grant or deny Medical Staff membership and/or Clinical Privileges.

9. **Denial for Hospital's Inability to Accommodate Applicant:** A recommendation by the Medical Executive Committee, or decision by the Board, to deny Medical Staff membership, Medical Staff category assignment, or particular Clinical Privileges on the basis of the Hospital's present inability as supported by documented evidence to provide adequate facilities or supported services for the Applicant and his/her patients.

10. **Conflict Resolution:** Whenever the Board's proposed decision will be contrary to the Medical Executive Committee's recommendation, the Board shall submit the matter to the Quality and Patient Satisfaction Committee of the Board (as established in Article XIII of the Bylaws) for review and recommendation as provided in Article X of the Bylaws before making its final decision and giving Notice of Final Decision required by this Article.

11. **Notice of Final Decision:**

   a. Notice of the Board's final decision shall be given through the President to the Chairs of the Medical Executive Committee and Credentials Committee, to the Chair of the appropriate department, and to the Applicant by means of Special Notice.

   b. A decision and notice to appoint shall include 1) the Medical Staff category to which the Applicant is appointed; 2) the department and service to which he/she is assigned; 3) the Clinical Privileges he/she may exercise; and 4) any special conditions attached to the appointment.

13. **Reapplication After Adverse Appointment Decision:** An Applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Hospital for a period of 2 years. Any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional information as the Medical Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.
I. REAPPOINTMENT PROCESS

1. **Reappointment Form for Reappointment**: The President of the Medical Staff, or his/her designee, shall, prior to the expiration date of the present appointment of each Practitioner, cause to be provided to such Practitioner a reappointment form for use in requesting reappointment. Each Practitioner who desires reappointment shall, prior to a date certain furnished to the Practitioner, send his/her information form to the President of the Medical Staff or his/her agent. Failure, without good cause, to so return the form shall result in non-reappointment of membership.

2. **Content of Reappointment Form**: The reappointment form, appended thereto, and all subsequent substantive changes shall be approved by the Board after approval by the Medical Executive Committee, and shall contain information necessary to maintain as current the Medical Staff file on the Practitioner's health-care related activities. This information shall include at least and without limitation, information concerning:
   
a. Continuing training, education and experience that qualify the Practitioner for the privileges sought on reappointment. All individuals with delineated clinical privileges must participate in continuing education which are documented and considered in decisions about reappointment. At a minimum, each individual must fulfill the continuing education requirements for licensure in the State of Maryland.

b. Current physical and mental health status.

c. The name and address of any other health care organization or practice setting where the Practitioner provided clinical services during the preceding period. Information regarding voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital/health care institution;

d. Sanctions of any kind imposed by any other health care institution, professional health care organization, or licensing authority including previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;

e. Details about malpractice insurance coverage, claims, suits, and settlements, as well as information about any lapses in or cancellation of the Practitioner's malpractice insurance coverage. At a minimum, final judgments or settlements are reported.

f. Such other specific information about the Practitioner's professional ethics, qualifications, current competence, and ability that may bear on his/her ability to provide good patient care in the Hospital.

Evidence of current competence must be established through the practitioner's utilization of a facility that is accredited by TJC or National Committee on Quality Assurance (NCQA) or the Accreditation Association for Ambulatory Health Care with such frequency as would afford an opportunity for the practitioner's performance and clinical competence to be reasonably observed. This paragraph shall not be applicable to practitioners with consulting only privileges, or academic staff without admitting privileges; provided,
however, that such Practitioners must otherwise provide evidence of current competence in his/her respective fields.

g. Peer recommendations.

3. **Verification of Information:** The President of the Medical Staff, or his/her designee or agent, may seek to collect or verify the additional information made available on each reappointment form and to collect any other materials or information deemed pertinent, including information regarding the Practitioner's professional activities and performance and conduct in the Hospital. When collection and verification is accomplished, the President of the Medical Staff shall transmit the reappointment form and supporting materials to the chairperson of each department in which the Practitioner requests privileges.

4. **Department Action:** The department Chair shall review the reappointment form and supporting materials and shall transmit to the Credentials Committee a recommendation that appointment either be renewed, renewed with modified staff category, department and service affiliation and/or Clinical Privileges, or not renewed. If the department Chair contemplates an unfavorable recommendation, the application and supporting documentation shall be reviewed by the department supervisory committee. The department supervisory committee may also recommend that the Credentials Committee defer action. Each request for deferral or modification of the terms of the Practitioner's reappointment shall be stated and supported by reference to the reappointment form and supporting documents, all of which shall be transmitted with the report. Each report shall satisfy the requirements of Section 8, herein below.

5. **Credentials Committee Action:** The Credentials Committee shall review each reappointment form and all other pertinent information available on each Practitioner being considered for reappointment, including the recommendation of each department in which the Practitioner has requested privileges, and shall transmit to the Medical Executive Committee its recommendation that appointment be either renewed, renewed with modified Medical Staff category, department and service affiliation and/or Clinical Privileges, or not renewed. The Credentials Committee may also recommend that the Medical Executive Committee defer action. Each request for deferral or modification shall be stated and supported by reference to the reappointment form and supporting documents, all of which shall be transmitted with the report. Each such report shall satisfy the requirements of Section 8, herein below. Any minority views shall also be reduced to writing and transmitted with the majority report. If a negative recommendation is contemplated, the Credentials Committee may interview an Applicant to gather additional information. If a negative recommendation is made, a letter should be delivered to the Applicant by the President of the Medical Staff for informational purposes only.

6. **Medical Executive Committee Action:** The Medical Executive Committee shall review each reappointment form and all other relevant information available to it and shall forward to the President for transmittal to the Board its report and recommendation that the appointment be either renewed, renewed with modified Medical Staff category, department and service affiliation and/or Clinical Privileges, or not renewed. The Committee may also recommend that the Board defer action. Each request for deferral or modification shall be stated and supported by reference to the reappointment form and supporting documents, all of which shall be transmitted with the report. Each such report shall satisfy the requirements of this
Section 8, herein below. Any minority views shall also be reduced to writing and transmitted with the majority report.

7. **Final Processing and Board Action**: Thereafter, the procedure provided in Section G (8, 9, 11 and 12) herein above shall be followed. For purposes of reappointment, the terms "Applicant" and "appointment" as used in those Sections shall be read, respectively, as "Practitioner" and "reappointment".

8. **Basis for Recommendations**: Each recommendation concerning the reappointment of a Practitioner and the Clinical Privileges to be granted upon reappointment shall be based upon such Practitioner'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 his/her health status and other matters bearing on his/her ability and willingness to contribute to good patient care practices in the Hospital.

10. **Time Periods for Processing**: Transmittal of the reappointment form to a Practitioner and his/her return of it shall be carried out as set forth hereinabove. Thereafter and except for good cause, each person, department and committee required by the Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a Practitioner shall have been transmitted to the Medical Executive Committee for its consideration and action, and to the Board for its action prior to the expiration date of the Medical Staff membership or Clinical Privileges of the Practitioner being considered for reappointment. In the event, however, that the Practitioner is notified of any information inadequacies or verification problems, the Practitioner then has the burden of producing adequate information and resolving any doubts about the data. Failure, without good cause, to provide this information by the end of the current Medical Staff term and following Special Notice, shall result in the Practitioner being placed on temporary suspension. Once all supporting documentation is received, the Practitioner shall remain on voluntary suspension until the Board of Directors approves the application for reappointment. If all supporting documentation is not received by the end of the term, the Practitioner will be deemed to have voluntarily resigned and no due process rights shall apply. Thereafter, if the Practitioner wishes to continue his/her Staff Membership and/or Clinical Privileges, he/she must submit an application form as an initial Applicant.

10. **Reapplication After Adverse Appointment Decision**: An Applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Hospital for a period of two years. Any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional information as the Medical Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

Members of the Medical Staff, whose privileges expire for failure to complete the reappointment process by the second anniversary of the last appointment period, may reapply for membership and clinical privileges immediately.

**J. FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION**

Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) shall be performed as set forth in the Hospital Medical Staff Performance Assessment...
Plan.

K. REQUESTS FOR MODIFICATION OF APPOINTMENT

A Practitioner 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 a written application to the Chair of the appropriate department; provided, however, that a Practitioner may not apply for an elevation in Medical Staff status within six months following his/her demotion in Medical Staff status pursuant to Article XIV, Section G-2 of the Bylaws. Such request shall be processed, to the extent appropriate, in substantially the same manner as provided in this Article for reappointment. The department Chair shall recommend approval on a timely basis, rejection or reason for deferment of a request for elevation in staff category within three months of receipt of the initial request.

L. WITHDRAWAL OF APPLICATION

An Applicant for appointment or reappointment may withdraw his/her application without prejudice at any time prior to its consideration by the Medical Executive Committee. Further, an Applicant for initial appointment or reappointment recommended for denial on the basis of his/her failure to meet minimum objective eligibility criteria (e.g., malpractice insurance, board eligibility or certification) may withdraw his/her application at any time prior to action by the Board. Otherwise, an Applicant for appointment or reappointment may withdraw his/her application only with the consent of the Medical Executive Committee (or, if the Board has already considered the application, with the consent of the Board), which may deem such withdrawal to be with prejudice. "With prejudice" shall invoke the bars to reapplication set forth in Article VII, Section H (14) of these Bylaws. Report(s) of the withdrawal to the appropriate State licensing board and NPDB shall be submitted if required by State and federal law and regulation.

ARTICLE VIII - DETERMINATION OF CLINICAL PRIVILEGES

A. EXERCISE OF PRIVILEGES

Every Staff Member providing direct clinical services at this Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those Clinical Privileges or specified services specifically granted. Determination of Clinical Privileges for Affiliates is addressed in Article VI of these Bylaws.

B. DELINEATION OF PRIVILEGES

1. Requests: Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the Applicant. A request by a Medical Staff Member for a modification of Clinical Privileges must be supported by documentation of training and/or experience supportive of the request.

   a. Basis for Privileges Determination: Requests for Clinical Privileges shall be evaluated on the basis of the Staff Member's education, training, experience, demonstrated ability and judgment in caring for the types of patients the Staff Member is likely to care for at the Hospital and such other criteria as are set forth in these
Bylaws and/or required by accreditation standard or law. The basis for privilege determinations to be made in connection with periodic reappointment, or otherwise, shall include observed clinical performance and the documented results of the patient care quality maintenance activities required by these and the Hospital Corporate Bylaws to be conducted at the Hospital. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Staff Member exercises Clinical Privileges. This information shall be added to and maintained in the Medical Staff file established for a Staff Member. In addition to the above, an application may also evaluate the following:

- Challenges to any licensure or registration;
- Voluntary and involuntary relinquishment of any license or registration;
- Voluntary and involuntary termination of medical staff membership;
- Voluntary and involuntary limitation, reduction, or loss of medical staff membership;
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;
- Documentation as to the applicant’s health status;
- Relevant practitioner-specific data, as compared to aggregate data, when available;
- Morbidity and mortality data, when available.

2. **Procedure:** All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in Article VII of these Bylaws.

**C. SPECIAL CONDITIONS FOR DENTAL PRIVILEGES**

Requests for Clinical Privileges from dentists shall be processed in the manner specified in this Article, Section B. Surgical procedures performed by dentists shall be under the overall supervision of the chairperson of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

**D. SPECIAL CONDITIONS FOR PROCTOR/VISITING PROFESSOR PRIVILEGES**

Upon written request from the Subsection and Department Chairs, submitted with appropriate documentation as outlined in the “Criteria for Proctoring/Visiting Professors”, an appropriately licensed practitioner with special expertise in a particular procedure/treatment modality who is not an applicant for membership may be granted privileges in a particular procedure/treatment modality on a patient specific basis or for a specific period of time for purposes of training Hospital staff regarding the procedure/treatment modality. The practitioner will not be permitted to admit, write orders or otherwise act as the attending physician and shall act at all times under the supervision or observation of a member of the Medical Staff.

Upon approval of the Subsection and Department chairs, the applicant must submit a current curriculum vitae and details of any pending malpractice case(s). Verification of education,
training, board certification, current State licensure, National Practitioner Data Bank, and primary hospital affiliation will occur in the same manner as set forth in Article VII, Section C. If the practitioner is not licensed to practice in the State of Maryland, the Maryland Board of Physicians must grant approval for an exception from licensing if the practitioner is to provide any patient care services.

The practitioner shall not be entitled to any procedural rights under the Bylaws for any failure to approve his/her application or termination of his/her privileges as a proctor/visiting professor.

E. PHYSICIAN MONITORING

All Staff Members shall be subject to the Holy Cross Germantown Hospital Medical Staff Performance Assessment Plan.

ARTICLE IX - CORRECTIVE ACTION

A. ROUTINE CORRECTIVE ACTION

1. **Criteria for Initiation:** Whenever the activities or professional conduct of any Practitioner are, or are reasonably probable of being detrimental to patient safety or to the delivery of quality patient care, or are reasonably probable of being disruptive to Hospital operations, (including but not limited to the conduct proscribed by Section 14-404 of the Health Occupations Article of the Annotated Code of Maryland), corrective action against such Practitioner may be initiated by any officer of the Medical Staff, by the Chair of the Practitioner’s department, President of the Medical Staff, the President or Chief Medical Officer of the Hospital or the Board.

2. **Requests and Notices:** All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct which constitutes the grounds for the request. If a member of the Medical Executive Committee is the subject of a request for corrective action, that member shall not participate in the Medical Executive Committee’s discussions, decisions, or actions related to the request. Complaints regarding a Practitioner lodged by an individual other than those listed shall be directed to the Chair of the department. The Chair of the Medical Executive Committee shall promptly notify the President of the Hospital in writing of all requests for corrective action received by the Committee and shall continue to keep the chief executive officer fully informed of all action taken in conjunction therewith.

   If the Medical Executive Committee (MEC) does not have a regularly scheduled meeting within ten (10) days of receipt of the request for corrective action, or if the Chair otherwise determines that initiation of an immediate investigation is warranted. The Chair of the MEC, in consultation with the other officers of the Medical Staff and the Chair of the appropriate department, will initiate an investigation of the specific activities or conduct noted in the request an investigation of the specific activities or conduct noted in the request for corrective action.

3. **Investigation by a Department:** The Medical Executive Committee shall forward the request for corrective action to the Chair of the department to which the Practitioner is assigned. The Chair of such department shall immediately investigate the matter or appoint an ad hoc committee to investigate it. Within 21 business days after the receipt of the request, the
department Chair or the ad hoc committee shall forward a written report of the investigation to the Medical Executive Committee.

4. **Medical Executive Committee Action:** Within 31 business days following receipt of the department report, the Medical Executive Committee (MEC) shall take action upon the request. The President shall be apprised of all action taken in conjunction with any investigation. Such action may include, without limitation:

   a. Rejecting the request for corrective action, stating the reasons therefore.

   b. Issuing a letter of warning or reprimand.

   c. Recommending terms of probation or requirements of education (in clinical or non-clinical professional skills), consultation and/or monitoring.

   d. Recommending reduction, suspension or revocation of Clinical Privileges.

   e. Recommending reduction or limitation of any Medical Staff prerogatives directly related to patient care, including reports to the MEC or its designee.

   f. Recommending suspension or revocation of Medical Staff membership or affiliation.

   g. Requiring a health assessment of the affected practitioner by a health professional or at a facility selected by the MEC and/or requiring the affected practitioner to undergo appropriate treatment.

5. **Procedural Rights:** Except as stipulated in this Article, Section A(6), any recommendation by the Medical Executive Committee pursuant to this Article, Section A(4c, d, e or f), together with all supporting documentation shall be acted upon as provided in Article X, Section D as applicable. However, the issuance of a letter of warning or reprimand shall not give rise to any right to a hearing or appellate review, to the extent action is not reportable.

6. **Report to the Board:** All Medical Executive Committee (MEC) actions relating to a corrective action request shall be reported promptly to the Board. If the MEC recommends any of the actions specified above (with the exception of a letter of warning or reprimand), the Board will not act on the recommendation until the affected Practitioner has either waived or completed a hearing. The Board may then adopt, modify, or reject the MEC’s recommendation.

   In addition to considering and acting upon recommendations of the MEC, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Practitioner, subject to the Practitioner’s right, if applicable, to Due Process.

7. **Exceptions to Procedural Rights:** The following recommendations or actions shall not entitle the Practitioner to a full hearing and appellate review under Article X, Section D but rather shall entitle the Practitioner to more limited rights described in this Article IX, Section D. These actions are those which do not merit or require the extensive efforts associated with other hearing rights. This Article's Section D applies to the following:

   a. Reduction in Medical Staff category for failure to meet attendance requirements;
b. Denial of requested advancement in Medical Staff category for failure to fulfill Medical Staff and/or department-related attendance requirements, clinical activity requirements or other specified criteria;

c. Denial of requested department/subsection affiliation for failure to substantiate qualifications;

d. Denial or reduction in requested clinical privileges for failure to document training or current competence (including but not limited to inability to document utilization in a facility accredited by TJC or by NCQA with such frequency as would afford an opportunity for the Practitioner's performance and clinical competence to be reasonably observed);

e. Termination of a provisional Practitioner who has had no activity at the Hospital during his/her provisional appointment (or other facility accredited by TJC or the NCQA, with such frequency as would afford an opportunity for the Practitioner's performance and clinical competence to be reasonably observed) during his/her provisional appointment.

f. Misstatement or omission from application of information supplied by an Applicant for appointment or reappointment.

B. SUMMARY SUSPENSION

1. **Criteria and Initiation:** The following individuals and bodies have the authority to suspend or restrict summarily all or any portion of the Clinical Privileges of a Practitioner whenever it is determined that that immediate action is necessary to protect the life of a patient or to reduce the likelihood of immediate injury or damage to the health or safety of a patient or to protect the best interests of the Hospital: (a) any two of the following individuals: the President of the Medical Staff, the Chair of a department, the President, and the Chief Medical Officer (CMO); or (b) the Medical Executive Committee, or (c) the Executive Committee of the Board, or the Board of Directors. Such summary suspension shall become effective immediately upon imposition, and the President of the Medical Staff, or his/her designee if he/she is unavailable, shall promptly give oral notice and Special Notice of the suspension to the Practitioner.

2. **Medical Executive Committee Action:** Unless such suspension is made by the Medical Executive Committee, as soon as reasonably possible after such summary suspension, but in no event later than within seven (7) calendar days, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may modify, continue or rescind the summary suspension, or may recommend to the Board that the summary suspension be modified, continued or rescinded.

3. **Procedural Rights:** Unless the Medical Executive Committee rescinds or recommends the rescission of the suspension or cessation of all further corrective action, a Practitioner shall be entitled to the procedural rights as provided in Article X. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board.

4. **Care of Patients:** Immediately upon imposition of a summary suspension, the Chief Medical Officer, or his or her designee, shall have the authority to provide for alternate medical coverage
for patients of the suspended Practitioner who are still in the Hospital. The wishes of the patients shall be considered, as feasible, in the selection of an alternate Practitioner.

C. AUTOMATIC SUSPENSION

1. **License and Insurance:** A Practitioner whose license, certificate or other legal credential authorizing him/her to practice in this State is revoked, suspended, expired or whose professional liability insurance coverage as required by Article III, Section B-1 of the Bylaws is cancelled, expires or otherwise no longer meets the specified criteria shall be suspended from Medical Staff membership, including Clinical Privileges, as of the date of revocation, suspension, expiration or upon determination that the insurance coverage does not meet the criteria of the Medical Staff.

   a. When an expired license, certificate, other legal credential or insurance policy has been renewed by the Practitioner, the automatic suspension shall cease. The Practitioner must provide written proof of renewal of expired license, certificate, other legal credential or insurance policy.

   b. A Practitioner whose license has been suspended or revoked must request in writing reinstatement of his/her Medical Staff membership or Clinical Privileges upon the conclusion of the license suspension or license reinstatement. The Medical Staff membership and Clinical Privileges suspension shall continue until final action by the Board on the reinstatement request (unless Interim Privileges are granted pursuant to Article III, Section F (1b) of these Bylaws.

2. **Drug Enforcement Agency (DEA) Number and Maryland Controlled Dangerous Substances (CDS) License:** A Practitioner who possesses a DEA number and/or a CDS license and whose DEA number or CDS license is revoked, suspended or expired shall immediately and automatically be suspended with respect to his/her Privileges to prescribe medications covered by such number and/or license. As soon as possible, after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number or CDS license was revoked or suspended. The Medical Executive Committee may then take such corrective action as is appropriate to the facts disclosed in its investigation, including further corrective action or reinstatement of Privileges if the DEA number or CDS license is reinstated. If the expired DEA number or CDS license has been renewed by the Practitioner, the automatic suspension shall cease.

3. **Failure to Satisfy Special Appearance Requirement:** A Practitioner who fails to satisfy the requirements of Article XIV, Section G(4) shall immediately and automatically be suspended from exercising all or such portion of his/her Clinical Privileges in accordance with the provisions of said Article XIV, Section G(4).

4. **Failure to Complete Medical Records:** If a Practitioner does not complete the medical record of a discharged patient within 30 days of the allocation date assigned by Medical Records, his/her Clinical Privileges shall be automatically suspended in accordance with the applicable provisions of the Rules and Regulations of the Medical Staff attached hereto and made a part of these Bylaws. Except for any fine(s) imposed by the remainder of this Section or if this is the 5th
suspension in a calendar year, a Practitioner's Clinical Privileges shall be automatically reinstated when the deficient medical records have been completed.

If, during a calendar year a practitioner has three occurrences of suspension for failure to complete medical records, at the third such occurrence, a fine of $250.00 will be assessed. At the fourth such occurrence a fine of $500.00 will be assessed. At the fifth such occurrence in a calendar year, the Practitioner's Medical Staff and Clinical Privileges will be revoked without due process except as outlined in Section D. of this Article.

Practitioners who receive a "Five Day Letter" as outlined in the Rules and Regulations of the Medical Staff will be assessed a fine of $250.00. This fine is in addition to fines noted above for 3rd and 4th suspensions.

Fines must be paid at the time the records are completed or within five days of completion of the records. Privileges will not be reinstated until all fines associated with the suspension are paid and all delinquent records have been completed, including signatures.

Accommodations for extended leave are outlined in the Rules and Regulations of the Medical Staff, "Medical Records - Responsibilities and Requirement". Requests for accommodation must be made in writing.

Monies collected from fines associated with medical record suspensions will be deposited to the general Medical Staff account.

During the period of automatic suspension under this Section, the Practitioner may continue to treat inpatients already under his/her care at the time of suspension, and perform surgical procedures on patients already scheduled at the time of suspension. The Practitioner may not admit or treat any new patients nor schedule additional surgical procedures for the duration of the suspension.

5. **Sanctions under Medicare/Medicaid Programs and Other Federal Government Programs:** If a Practitioner is excluded from participation under the Medicare and/or Medicaid programs, or any other federal government program, or terminates his/her participation in these programs in lieu of being sanctioned, the Practitioner's Medical Staff membership, including Clinical Privileges, shall be immediately and automatically suspended.

If a Practitioner is reinstated into the Medicare and/or Medicaid programs, or other federal government program, after such sanctions have expired or otherwise terminated, the Practitioner must request in writing reinstatement of his/her Medical Staff membership and Clinical Privileges. The Medical Staff membership and Clinical Privileges suspension shall continue until final action by the Board of Directors on the reinstatement request (unless Interim Privileges are granted pursuant to the Bylaws).

6. **Misuse of Electronic Signature:** If a Practitioner fails to abide by the Hospital policy and procedure regarding electronic signatures, or violates any applicable legal requirement regarding the use of an electronic signature, the Practitioner's Clinical Privileges shall be automatically suspended.
7. **Procedural Rights:** Any suspension of Clinical Privileges pursuant to paragraphs 1, 2, 3, 4, 5 and 6 of this Section, shall not be considered adverse in nature and shall not entitle the Practitioner to the procedural rights provided in Article X. However, any adverse action by the Medical Executive Committee or Board of Directors on a request for reinstatement under paragraph 1 of this Section shall entitle the Practitioner to the procedural rights provided in Article X.

8. **Revocation of Membership:** In the event that a Practitioner shall fail to remedy the deficiency or deficiencies upon which automatic suspension under paragraphs 1, 2, 3 or 6 of this Section has been based within thirty (30) days following commencement of the automatic suspension, the Medical Executive Committee may recommend to the Board that the Practitioner's Medical Staff membership and/or Clinical Privileges be revoked without entitlement to any of the procedural rights under these Bylaws.

D. **MODIFIED DUE PROCESS PROCEDURE**

Notice: Notice of a Practitioner’s right to exercise this Section's modified due process procedures as the sole process to challenge a recommendation shall be promptly provided by the President of the Medical Staff by Special Notice. The Special Notice shall state:

1. That a professional review action has been initiated against the Practitioner;

2. The reasons for the proposed action, with specific reference to any deficiencies;

3. A brief summary of the Practitioner's rights under this Section D; and

4. That any election to utilize these due process procedures must be made in writing, accompanied by a written statement detailing the facts or conclusions with which the Practitioner disagrees and sent to the President of the Medical Staff within thirty (30) days of the Practitioner's receipt of this notice. Failure to request these modified due process procedures shall constitute a waiver of the Practitioner's right to due process.

5. If the Practitioner timely elects to utilize this modified due process procedure, the President of the Medical Staff shall promptly forward such request to the Practitioner's department Chair, who shall invite the Practitioner and other appropriate personnel to an informal meeting to discuss the intended professional review action. They shall attempt to resolve the matter informally. This meeting should be arranged through the Medical Staff office as soon as reasonably possible.

This informal meeting is not a hearing; accordingly, there shall be no transcripts made, no hearing officer or hearing committee designated or attending, no legal counsel present, and no formal evidentiary or other procedural rules applicable.

6. Within ten (10) business days after the conclusion of this informal meeting, the Chair of the applicable department or other appropriate personnel shall submit a brief written report and recommendation to the Credentials Committee. In the event the Practitioner and the department Chair or other appropriate personnel reach such an agreement, the matters shall be presented to the Credentials Committee as a joint recommendation. In the event the Practitioner and the department Chair or other appropriate personnel fail to reach an
agreement, the Practitioner may submit a brief written statement to the Credentials Committee within ten (10) business days after the conclusion of the meeting with the department Chair or other appropriate personnel.

7. The Practitioner may be invited to appear before the Credentials Committee, which shall consider this matter at its next regularly scheduled meeting after it receives the department Chair’s report and recommendation and the Practitioner’s statement, provided that the Credentials Committee's agenda has not already been distributed to its members. The Credentials Committee shall consider the matter and make a decision to uphold, revise or withdraw the recommended professional review action. The decisions shall be reflected in the Credentials Committee's minutes and shall be considered by the Medical Executive Committee and the Board in the same manner as other committee matters is considered. The Credentials Committee meeting is not a hearing and none of the formalities attendant to a hearing shall apply.

8. A Practitioner against whom adverse action has been taken as a result of his/her failure to meet the attendance requirement set forth in Article XIV, Section G, shall be promptly given Special Notice of such action. Such action shall:

a. Advise the Practitioner of his/her right to contest the sole issues of whether or not the Practitioner has, in fact, failed to satisfy such attendance requirements, or whether the Practitioner was duly excused from attendance at one or more meetings to the extent that he/she has, in fact, satisfied the attendance requirements:

b. Specify that the Practitioner shall have fourteen (14) days following receipt of such notice to deliver to the President of the Medical Staff a written request to contest such issues;

c. State that the failure to request an opportunity to contest such issues shall constitute a waiver of the Practitioner's right with regard to such issues.

Upon receipt of a timely request for an opportunity to contest the Practitioner's alleged failure to meet such attendance requirements, the President of the Medical Staff shall promptly appoint the Chair of the department where the Practitioner is a member as ad hoc officer for the purpose of receiving from the Practitioner any and all evidence and testimony which the Practitioner may care to present bearing solely upon the issues of whether the Practitioner has, in fact, failed to satisfy such attendance requirements, or has been duly excused from attendance. The modified due process procedures in #6 and #7 above shall be followed.

9. No Article X evidentiary hearing or appellate review is available under this Section, and the decision of the Credentials Committee, when affirmed by the Medical Executive Committee and the Board shall be final and conclusive.

ARTICLE X - INTERVIEWS, HEARINGS AND APPELLATE REVIEW

A. INTERVIEWS
When the Medical Executive Committee or the Board receives or considers initiating an adverse recommendation concerning a Practitioner, the Practitioner may be afforded an interview with the Medical Executive Committee. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto.

**B. HEARINGS AND APPELLATE REVIEW**

1. **Adverse Medical Executive Committee Recommendation:** Except as otherwise stipulated in these Bylaws, when any Practitioner receives Special Notice of an adverse recommendation of the Medical Executive Committee, he/she shall be entitled, upon request made within 30 days, to a hearing before a hearing committee constituted as provided in these Bylaws (the "Hearing Committee").

2. **Adverse Board Decision:** Except as otherwise stipulated in these Bylaws, when any Practitioner receives Special Notice of an adverse decision by the Board taken either contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed, or on the Board's own initiative without benefit of a prior recommendation by the Medical Executive Committee, such Practitioner shall be entitled, upon request made within 30 days, to a hearing by a Hearing Committee appointed by the Board. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request within 30 days, to an appellate review within 90 days by the Board before a final decision is rendered.

3. **Procedure and Process:** All hearings and appellate reviews shall be in accordance with the procedure and safeguards set forth in this Article.

4. **Exhaustion of Remedies:** If an adverse ruling is made with respect to an Applicant's or a Staff Member's membership or Clinical Privileges at any time, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital, the Medical Staff, or any individuals involved in the process.

**C. INITIATION OF HEARING**

1. **Recommendations or Actions:**

   The following recommendations or actions shall, if deemed adverse pursuant to this Article, Section E, entitle the Practitioner affected thereby to a hearing provided, however, that, pursuant to Article IX, Section A(6), of the Bylaws, such recommendation or action shall not be covered by the modified due process procedures found in Article IX, Section D. Furthermore, notwithstanding the foregoing, a Practitioner shall not be entitled to a hearing based solely on a recommendation or decision by the Medical Executive Committee or Board that the Practitioner must undergo any form of medical, psychiatric, neuropsychological, and/or other form of testing in order to assure fitness to render services in the Hospital.

   a. Denial of initial Medical Staff appointment for grounds other than failure to meet basic qualifications pursuant to Article III, Section B(1c, d, e, f, g or h) of the Bylaws Manual,
failure to complete an unaltered application form, failure to meet established deadlines for submission of information, and inability to obtain adequate evaluations;
b. Denial of reappointment for grounds other than failure to meet basic qualifications pursuant to Article III, Section B(1c, d, e, f, g or h) of the Bylaws Manual, or failure to complete an unaltered application form, or failure to meet established deadlines for submission of information, or inability to obtain sufficient evaluations;
c. Suspension of Medical Staff membership;
d. Revocation of Medical Staff membership for grounds that have not otherwise been deemed in these Bylaws not to entitle the Practitioner to any hearing rights or that have been deemed to entitle the Practitioner to modified hearing rights only;
e. Limitation or suspension of admitting prerogatives for grounds other than those otherwise deemed in these Bylaws not to entitle the Practitioner to any hearing rights or that have been deemed to entitle the Practitioner to modified hearing rights only;
f. Denial of requested department and service affiliation for grounds other than failure to substantiate qualifications;
g. Denial or restriction of requested Clinical Privileges for grounds other than failure to document training and current competence;
h. Reduction in Clinical Privileges for grounds other than failure to document training and current competence;
i. Suspension of Clinical Privileges;
j. Revocation of Clinical Privileges for grounds other than those otherwise deemed in these Bylaws not to entitle the Practitioner to any hearing rights or that has been deemed to entitle the Practitioner to modified hearing rights only;
k. Terms of probation;
l. Requirement of prior consultation and/or concurrent monitoring of patient care activities.

D. ADVERSE ACTION

A recommendation or action listed in this Article, Section C (except as otherwise provided in the Medical Staff Bylaws), shall be deemed adverse action only when it has been:

1. Recommended by the Medical Executive Committee; or

2. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed; or

3. Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

E. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom adverse action/recommendation has been taken pursuant to this Article, Section E shall promptly be given Special Notice of such action by the President of the Medical Staff. Such notice shall state:

1. That an adverse action has been taken against or been proposed to be taken against the Practitioner;

2. The explicit reasons for the action or recommendation;
3. That the Practitioner has the right to request a hearing on the action or recommendation;

4. That the Practitioner has thirty (30) business days from the date of receipt of notice within which to request a hearing; and

5. A summary of the Practitioner's rights in the hearing.

F. WAIVER BY FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in this Article, Sections B and F 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 an adverse action by the Board, shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board. Such waiver, in connection with an adverse recommendation by the Medical Executive Committee, shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board shall review all the information and material considered by the Committee and may consider all other relevant information received from any source. The Board's action on the matter shall constitute the final decision of the Board.

The President shall promptly send the Practitioner Special Notice informing him/her of each action taken pursuant to this Section and shall notify the President of the Medical Staff of each such action.

G. HEARING PREREQUISITES

1. Notice of Time and Place for Hearing:

As soon as is reasonably possible but not more than thirty (30) business days after receipt of such request, the President of the Staff or the Board shall schedule and arrange for a hearing. Once such arrangements have been made, the President of the Medical Staff or the Board shall send the Practitioner written notice of the time, place, date of the hearing, and a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff or the Board during its case-in-chief.

The hearing date should not be less than thirty (30) days nor more than sixty (60) days after the date of the notice unless the Practitioner requests a postponement under this Article, Section I-10, or if good cause exists for extending the hearing date, as determined by the President of the Medical Staff. A hearing for a Practitioner who is under suspension that is then in effect should be held as soon as arrangements therefore may reasonably be made. In no event shall a hearing be conducted less than thirty (30) days after the date of the initial notice given pursuant to this Section unless the Practitioner voluntarily waives this timing provision.

2. Appointment of Hearing Committee:

a. By the Medical Staff: A hearing occasioned by a Medical Executive Committee recommendation pursuant to Section E(1) shall be conducted by a Hearing Committee
appointed by the President of the Medical Staff and composed of five members of the Medical Staff, none of whom are currently members of the Board of Directors. Members of the hearing committee shall be persons who have not taken an active part in any consideration of the matter contested. One of the members so appointed shall be designated as Chair.

A list of 8 potential members from the Medical Staff shall be furnished to the Practitioner against whom adverse action has been taken with the notice of the hearing, and he/she (or designee) will have the right to eliminate three members from the list; provided, however, that to the extent reasonably ascertaintable and practicable, no member of the Hearing Committee shall be in direct economic competition with the subject Practitioner. Any failure of the Practitioner to act upon the list provided and to return it to the Medical Staff Office within 7 calendar days of its date of mailing shall constitute a waiver of such selection rights.

b. **By the Board:** A hearing occasioned by an adverse action of the Board pursuant to Section E(2 and 3) shall be conducted by a Hearing Committee appointed by the Chair of the Board and composed of 5 persons. At least 2 Medical Staff members shall be included on this committee when appropriate. One of the appointees to the committee shall be designated as the Chair.

3. **Practitioner Obligations Prior to Hearing:**

At least 14 days before the hearing, the Practitioner shall, in writing, notify the President of the Medical Staff of the names of all persons who are expected to appear as witnesses in the Practitioner's case-in-chief. Failure to identify any such person shall preclude the Practitioner from calling such person as a witness on the Practitioner's behalf. Further, no less than 7 days before the hearing, the Practitioner shall provide the President of the Medical Staff with a copy of all exhibits that the Practitioner intends to use during his/her case-in-chief.

H. **HEARING PROCEDURE**

1. **Majority Vote of Committee Members:**

   There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy. A majority vote by those members entitled to vote is required in order for Hearing Committee action to be taken.

2. **Personal Presence:**

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

3. **Presiding Officer:**
Either the hearing officer, if one is appointed pursuant to Section M, or the Chair of the Hearing Committee, shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant verbal and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

4. **Representation:**

The Practitioner who requested the hearing shall be entitled to accompaniment and representation at the hearing by his/her attorney or other person of the Practitioner's choice. The Medical Executive Committee, when its recommendation has prompted the hearing, may appoint one of its members to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. The Board, when its action has prompted the hearing, may appoint a representative to represent it at the hearing, to present facts in support of its actions and to examine witnesses. Representation of either party by an attorney-at-law shall be governed by the provision of Section N (2).

5. **Rights of Parties:**

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

a. Call and examine witnesses;
b. Introduce exhibits;
c. Cross-examine any witness on any matter relevant to the issues;
d. Impeach any witnesses;
e. Rebut any evidence;

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.

6. **Procedure and Evidence:**

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. Oral evidence shall be taken only on oath or affirmation.

7. **Official Notice:**

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or specific 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 shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party
shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or verbal presentation of authority, the manner of such refutation to be determined by the hearing committee. The Hearing Committee shall also be entitled to consider any pertinent material contained on file in the Hospital, and 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.

8. **Burden of Proof:**

The Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn there from are either arbitrary or capricious, based on the information that was available to the Medical Executive Committee or the Board at the time it made the recommendation or decision that occasioned the hearing.

9. **Record of Hearing:**

All proceedings shall be accurately recorded by a certified court reporter at the expense of the Hospital. A transcript(s) shall be prepared at the expense of the party or parties ordering or requesting same.

10. **Postponement:**

Postponement of a hearing beyond the time set forth in these Bylaws may be requested by the Practitioner or the Hospital. If the postponement is requested prior to the commencement of the scheduled hearing, the President of the Medical Staff shall decide whether good cause exists for postponing the hearing. A request for postponement shall be made to the President of the Medical Staff at least 10 business days prior to the scheduled hearing date. If the postponement is requested after the hearing has commenced, then the Hearing Committee shall decide whether good cause exists for a postponement.

11. **Recesses and Adjournment:**

The hearing committee 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 verbal and written evidence, the hearing shall be adjourned. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The hearing will be limited to no more than three hours in a single session.

I. HEARING COMMITTEE REPORT AND FURTHER ACTION

1. **Hearing Committee Report:**

Within 15 business days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward same, together with all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. All findings and recommendations by the
hearing committee shall be supported by reference to any documentation considered by the hearing committee. The President of the Medical Staff shall forward the report to the Practitioner.

2. **Action on Hearing Committee Report:**

The Medical Executive Committee or the Board, as the case may be, shall consider the same at its next regularly scheduled meeting, and affirm, modify or reverse its recommendation or action in the matter. It shall transmit such result, together with the report of the hearing committee and all other documentation considered, to the chief executive officer, who shall forward the same to the Board.

3. **Effect of Result:**

The Board shall take action on the Medical Executive Committee result by adopting or rejecting the Medical Executive Committee's result in whole or in part, by seeking to obtain additional information before making a decision (e.g., by interviewing the Practitioner, which interview shall not constitute an Appellate Review of the matter), or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons therefore, 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 subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President shall promptly send the Practitioner special notice informing him/her of each action taken pursuant to this Section, including a statement of the basis for the decision. Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse in any of the respects listed in Section C (1), the special notice shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section K.

**J. INITIATION AND PREREQUISITES OF APPELLATE REVIEW**

1. **Request for Appellate Review:**

A Practitioner shall have thirty (30) business days following his/her receipt of a notice pursuant to Section J (3) to file a written request for an appellate review. Such request shall be delivered to the chief executive officer by certified or registered mail and a copy shall be sent to the President of the Medical Staff. Such notice may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable that was considered in making the adverse action or result.

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 J (1) waives any right to such review. Such waiver shall have the same force and effect as that provided in Section F.

3. **Notice of Time and Place for Appellate Review:**
Upon receipt of a timely request for appellate review, the chief executive officer shall deliver such request to the Board. As soon as is reasonably possible but not more than 30 days after receipt of such request, the Board shall schedule and arrange for an appellate review which should be not less than 30 days nor more than 90 days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made. At least 10 business days prior to the appellate review, the President shall send the Practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause.

4. **Composition for Appellate Review Body:**

   The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of five members of the Board appointed by the chairman. If possible, one member shall be a physician Board member. In the event the physician Board member cannot serve, the Board shall appoint a member of the Medical Staff who has not taken an active part in the consideration of the matter contested.

K. **APPELLATE REVIEW PROCEDURE**

1. **Nature of Proceedings:**

   The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section L (2) and such other materials as may be presented and accepted under Sections L(4 and 5).

2. **Written Statements:**

   The Practitioner seeking the review shall 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. The statement shall be submitted to the appellate review body through the President at least 5 business days prior to the scheduled date of the appellate review.

3. **Presiding Officer:**

   The Chair of the appellate review body shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings and maintain decorum.

4. **Verbal Argument:**

   The appellate review body shall allow the parties or his/her representatives to personally appear and make verbal argument in favor of his/her position. Any party or representative so
appearing shall be required to answer questions put to him/her by any member of the appellate review body.

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 shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole Discretion, shall determine whether such matters or evidence shall be considered or accepted.

6. **Recesses and Adjournment:**

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants. Upon the conclusion of verbal argument, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

7. **Action Taken:**

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board pursuant to Section J or, in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within fifteen (15) business days and in accordance with its instructions. Within 15 business days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided in this Section.

8. **Conclusion:**

The appellate review shall not be deemed concluded until all of the procedural steps provided in this Article have been completed or waived.

L. **FINAL DECISION OF THE BOARD**

Within 10 business days after its next regularly scheduled meeting after the conclusion of the appellate review, the Board shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner (by special notice), to the President of the Medical Staff and to the Medical Executive Committee. The decision of the Board shall be immediately effective and final.
M. GENERAL PROVISIONS

1. **Hearing Officer Appointment and Duties:**

   The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Board or the Medical Executive Committee. A hearing officer may or may not be an attorney-at-law. He/she shall act in an impartial manner as the presiding officer of the hearing. If requested by the hearing committee, he/she may participate in its deliberations in the capacity of procedural advisor, but he/she shall not be entitled to vote.

2. **Attorneys:**

   In the event that a Practitioner is represented by legal counsel or other representative at a hearing held hereunder, the attorney or other representative shall be required at all times to conduct himself/herself in an orderly and courteous manner. In the event that the presiding officer shall determine that such conduct is not being observed, he/she shall, after first warning the attorney or other representative, require the attorney or other representative to remove himself/herself from the area in which the hearing is being held.

3. **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 Article, he/she shall 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 these Bylaws with respect to the matter involved.

4. **Number of Reviews:**

   Notwithstanding any other provision of the Medical Staff Bylaws or of this Article, no Practitioner shall be entitled as a matter of right to more than one (1) evidentiary hearing and appellate review with respect to an adverse recommendation or action.

5. **Release:**

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

N. REPORT TO STATE BOARD

For purposes of this section, "adverse action" is defined as a professional review action which: (1) has an effect of longer than 30 days; and (2) is related to professional competence or conduct. After an adverse action regarding a Practitioner is signed by an authorized official, the President (or his/her designated representative) shall, within 15 days of such signature, prepare a report of the adverse recommendation or action and submit such report to the State Board of Physicians, State Board of Dental Examiners or other appropriate entity (the "State Board") for forwarding to the National Practitioner Data Bank, in accordance with federal law.
If errors or omissions in such report are found after the report's submission, the President (or his/her designated representative) shall immediately forward an appropriate addition or correction to the State Board.

The President (or his/her designated representative) shall also report to the State Board any revisions of the adverse action originally reported within 15 days of such revision(s), including the results of any appellate or other review.

The President (or his/her designated representative) shall also report to the State Board any surrender of Clinical Privileges or any restriction of such Privileges by a Practitioner:

(a) while the Practitioner is under investigation by the Hospital relating to possible professional incompetence or improper professional conduct; or
(b) if such surrender or restriction occurs in return for the Hospital's agreement not to conduct such an investigation or proceeding.

It is the intent of this Medical Staff to report to a State Board and the NPDB any matter required under applicable law to be reported to it/them and, consistent with that intent, this Subsection N. shall be deemed amended to the extent required to comply with any changes in applicable law.

ARTICLE XI - STAFF DEPARTMENTS

A. ORGANIZATION OF STAFF DEPARTMENTS AND CLINICAL SERVICES

Each department shall be organized as a separate part of the Medical Staff and shall have a chair who is elected and has the authority, duties and responsibilities as specified in Article XII, Section B.

Each clinical service may be organized as a specialty subdivision within a department, and shall be directly responsible to the department within which it functions. The function and responsibilities of the subsection shall be set forth in the subsection rules and regulations.

B. DESIGNATION

1. **Current Departments and Clinical Services:** The current departments are: Medicine, Surgery, Obstetrics & Gynecology, Pediatrics, Emergency Medicine and Anesthesiology.

2. **Future Departments and Clinical Services:** When deemed appropriate, the Medical Executive Committee and the Board, by their joint action, may create new, eliminate, subdivide, further subdivide or combine departments.

C. ASSIGNMENT TO DEPARTMENTS AND CLINICAL SERVICES

Each Practitioner shall be assigned membership in at least one department and clinical service, but may be granted membership and/or Clinical Privileges in one or more of the other departments. The exercise of Clinical Privileges within each department and service shall be subject to the rules
and regulations thereof and to the authority of the department chair. In the event that more than one department is involved, the rules and regulations of both departments must be satisfied.

D. FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct specific review, educational and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by members of the department. To carry out this responsibility, each department shall:

1. Participate in the performance improvement program established by the Hospital;

2. Establish guidelines for the granting of Clinical Privileges within the department and submit the recommendations required under Articles VII and VIII regarding the specific Privileges each Practitioner may exercise;

3. Conduct or participate in and make recommendations regarding the need for continuing education programs pertinent to changes in the state-of-the-art and to findings of review and evaluation activities;

4. Monitor, on a continuing and concurrent basis, adherence to:
   a. Medical Staff and Hospital policies and procedures;
   b. Requirements for alternate coverage and for consultations;
   c. Sound principles of clinical practice;
   d. Other regulations designed to promote patient welfare.

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

6. Foster among its members and affiliates an attitude of professional decorum, strongly discouraging behavior that may be considered to be sexual discrimination or harassment and further discouraging any attitude or action disruptive to harmony in the hospital environment.

7. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning:
   a. Findings of the department's review and evaluation activities, actions taken thereon, and the results of such action;
   b. Recommendations for maintaining and improving the quality of care provided in the department and the Hospital;
   c. Such other matters as may be requested from time-to-time by the Medical Executive Committee;

8. Meet at least every other month for the purpose of conducting a thorough review and analysis of the clinical work done by the members of the department, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis, and results of treatment from among significant cases in the Hospital at the time of the meeting and analysis of clinical reports from each department and reports of committees of the Medical Staff.
E. DEPARTMENTAL REVIEW

All Staff Members shall be subject to the Hospital Medical Staff Performance Assessment Plan.

F. EXTERNAL PEER REVIEW

1. **Generally:** External Peer review is performed by a physician(s) external to the Medical Staff who possesses a certain expertise in the matter under consideration. External peer review is initiated by the following process upon agreement by 2 of 3 individuals:

   a) The department Chair recommends that an external peer review occur; and
   
   b) The President of the Medical Staff agrees with the Department Chair’s recommendation; and
   
   c) The President of the Hospital, or his/her designee, concurs with the recommendation of the department chair and the President of the Medical Staff.
   
   d) The department Chair recommends the source to conduct the external review with the concurrence of the President of the Medical Staff.

2. **Criteria:** Peer review by an external peer reviewer may be recommended if any of the following criteria are met:

   a) The Practitioner or event being reviewed involves medical expertise beyond that possessed by other members of the Medical Staff (e.g., only one or two practitioners on the Medical Staff are expert in the particular event being reviewed); or
   
   b) The Practitioner or event being reviewed cannot be accomplished in an objective or reasonably impartial manner; or
   
   c) The department Chair and/or the President of the Medical Staff, and/or the President of the Hospital determines that it is in the best interest of the department, or the Medical Staff, or the Practitioner, or the Hospital to have the matter reviewed.

All Staff Member shall be subject to the Hospital Medical Staff Performance Assessment Plan.

ARTICLE XII - OFFICERS

A. OFFICERS OF THE MEDICAL STAFF

1. **Identification:** The officers of the Medical Staff shall be:

   a. President
   
   b. Vice President
   
   c. Secretary/Treasurer

2. **Qualifications:** Except for initial Medical Staff officers, officers: must:
a. Be members of the Active Medical Staff for a minimum of 2 years;

b. Be members of the Active Medical Staff at the time of nomination and through election and remain members of the Active Medical Staff in good standing during his/her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved;

c. Be board-certified;

d. Have demonstrated interest in maintaining quality medical care at the Hospital and have constructively participated in Medical Staff affairs, such as peer review activities;

e. Not be presently serving as a medical staff or corporate officer, department chief/Chair, or committee chair at another hospital, and shall not so serve during the term of office;

f. Possess and have demonstrated an ability for harmonious interpersonal relationships;

g. Be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed; and

h. The President and Vice-President must be Staff Members with demonstrated qualifications of his/her ability to direct the activities of the Medical Staff.

3. Nominations

a. **Nominating Body Membership:** The nominating body shall be comprised initially of 6 members; one member of the Active Medical Staff elected by each of the following departments: Medicine, OB/GYN, Pediatrics and Surgery. The contract departments, Anesthesia and Emergency Medicine, will meet in September of each year to pick one member, on a rotating basis, to serve on the Nominating Committee. The Immediate Past President of the Medical Staff shall act as Chair of the Committee with a vote. Departmental representatives to the Nominating Committee shall be elected by the departments in September of each calendar year. The term of the Nominating Committee shall be from January 1 to December 31 of the following calendar year. In the event the Immediate Past President is unable or unwilling to serve as Chair, the Medical Staff President may appoint a former Medical Staff President to serve as Chair. The initial Nominating Committee will serve from the date it is constituted through December 31, 2015.

b. **Duties:** The duties involved in presenting the Medical Staff qualified candidates for elective positions in the Medical Staff organization include:

1) Consulting with members of the Medical Staff and Hospital administration concerning the qualifications and acceptability of prospective nominees;

2) Circulating to the members of the Active Medical Staff, at least 30 days prior to the annual election in December, or the initial meeting of the Medical Staff and election of officers, one or more nominations for:

   a) Each elective office of the Medical Staff that is to be filled;
c) Such other elective positions or vacancies in any office or positions as may be required by these Bylaws; and

c. **Meetings:** The Nominating body shall meet as often as necessary, but not less than yearly.

d. **By Nominating Body:** The nominating body shall convene at least 40 days prior to the November general meeting and shall submit to the Secretary of the Medical Staff one or more qualified nominees for each office. The names of such nominees shall be reported to the Medical Staff at least 30 days prior to the November general meeting.

4. **Election:** Officers shall be elected at the November general meeting of the Medical Staff each year. Only Staff Members accorded the Prerogative to vote for Medical Staff officers under Article IV shall be eligible to vote. Voting shall be by secret written ballot, on request, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. The names of the Medical Staff Officers elected shall be forwarded to the Board.

5. **Term of Elected Office:** Each officer shall serve a two-year term, commencing on the first day of the Medical Staff Year following his/her election. Each officer shall serve until the end of his/her term or until a successor is elected. No Member of the Medical Staff shall serve as President for more than two consecutive years. In the event the office of Vice President becomes vacant during the second year of the current President’s term, the Medical Staff may vote to elect the current President for one additional year.

6. **Vacancies in Elected Office:** If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term. A vacancy in the office of the Vice-President shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible following the general mechanism outlined in this Article, Sections A (3 and 4). Vacancies in the office of Secretary/Treasurer shall be filled by appointment by the Medical Executive Committee.

7. **Duties of Officers of the Staff:**

   a. **President:** The President shall serve as principal elected official of the Medical Staff. As such, s/he shall:

      1) Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality, efficiency and effectiveness of clinical maintenance and monitoring activities within the Hospital, which are delegated to the Medical Staff.

      2) Aid in coordinating the activities and concerns of the Hospital administration, nursing and other patient care services with those of the Medical Staff.
3) Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff with appropriate Board and Hospital persons.

4) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and policies, for implementation where these are indicated, and for the Staff’s compliance with procedural safeguards as required by these Bylaws.

5) Call, preside at and be responsible for the agenda at all general Medical Staff meetings.

6) Serve as Chair of the Medical Executive Committee and as an ex-officio member without vote of all Medical Staff committees, except the nominating committees.

7) Perform all other duties as delineated in these Bylaws.

8) Approve non-budgeted discretionary spending of up to $1,000.00 per incident and up to $10,000 in aggregate for a fiscal year.

b. **Vice President:** The Vice President shall, in the absence of the President of the Medical Staff, assume all the duties and have the authority of the President. He/she shall also be expected to perform such duties as may be assigned to him/her by the President. He/she will attend all meetings of the Medical Executive Committee. The Vice President will also be Chair of the Credentialing Committee of the Medical Staff.

c. **Secretary/Treasurer:** The Secretary/Treasurer shall, in the absence of the President and Vice President of the Medical Staff, assume all the duties and have the authority of the President. He/she shall also be expected to keep accurate and complete minutes of all Medical Staff meetings, call meetings on order of the President, attend to all correspondence and perform such other duties as ordinarily pertain to this office. He/she shall have custody of all Medical Staff funds and render a monthly account of these funds to the Medical Executive Committee. The Secretary/Treasurer shall serve as Vice Chair of the Credentials Committee.

8. **Recall of Officers:**

a. Recall of an officer of the Medical Staff may be considered following a motion to recall and a second made at a general Medical Staff meeting or at a special meeting of the Medical Staff. Following such a motion and second, no immediate discussion will take place. A special meeting of the Medical Staff will be called within 2 weeks for the purpose of discussion and vote on the recall question. Voting members of the Medical Staff shall be advised of the special meeting by written notice no less than 10 days prior to the meeting. Two-thirds majority vote of a quorum at this special meeting shall effect immediate recall. The recalled official shall immediately relinquish all duties, privileges and responsibilities of the office.

b. In the event of recall of the President of the Medical Staff, the Vice-President shall immediately become the President and shall, within 1 month, appoint a Vice-President to fill the vacancy for the remainder of the term. If a Medical Staff officer, other than the
President, is recalled, the President shall appoint a successor, within 1 month, for the remainder of the term.

c. An officer who has been recalled may request an appeal hearing by the Medical Executive Committee in the event he/she feels the decision was in error, unreasonable, arbitrary or capricious. Such request shall be made in writing to the President of the Medical Staff within 10 days of the recall action. Failure to make such a request in 10 days shall be considered a waiver by the individual of the right to a hearing.

d. Within 10 days of receiving a request for a hearing, the President of the Medical Staff shall call a special meeting of the Medical Executive Committee to be held within 31 days following such request and shall preside and conduct a hearing. The hearing shall be completed within a 2-week period.

9. **Removal of Officers:** Removal of an officer of the Medical Staff may be initiated by:

   a. Any voting member of the Board of Directors;

   b. Any voting member of the Medical Executive Committee; or

   c. By a two-thirds vote at a regular Medical Staff meeting of those members present and eligible to vote.

Requests for removal of an elected officer shall be promptly submitted to the Medical Executive Committee for consideration at its next regularly scheduled meeting. If the Medical Executive Committee takes no action at that meeting, the Board of Directors may take action at its next regularly scheduled meeting, or at a special meeting convened to address the matter.

Valid causes for removal from office include:

   a. Continued gross or willful neglect of the officer's duties under these Bylaws;

   b. Unreasonable failure or refusal to disclose necessary information on matters of Medical Staff business;

   c. Misrepresentation of the Medical Staff and its officers to outside persons;

   d. Failure to attend 50% of Medical Staff meetings; and

   e. Conviction of any crime.

10. **Conduct of the Appeal Hearing:** The conduct of the hearing shall be carried out as follows:

   a. All evidence shall be taken only on oath or affirmation. The recalled officer shall have these rights:

      1) To call and examine witnesses.
2) To cross-examine opposing witnesses on any matter relevant to the issues, even though that matter was not covered in the direct examination.

3) To introduce exhibits.

4) To rebut the evidence against him/her.

If the Staff Member who has been recalled from office does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

b. The hearing need not be conducted according to the technical rules related to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objections in civil actions. In reaching a decision, the Medical Executive Committee may take official notice of any generally accepted technical or scientific matter within the Medical Executive Committee's special field of competence, and of any facts that may be judicially noticed by the courts of this State. The recalled officer shall be informed of the matters to be officially noticed, and those matters shall be noted in the record. The recalled officer shall be given a reasonable opportunity, on request, to refute the officially-noticed matters, by evidence or by written or verbal presentation of authority. Such refutation shall be furnished to the Medical Executive Committee within 7 days of being informed of the officially noticed matters noted above.

c. All proceedings shall be accurately recorded by a certified reporter, at the expense of the Hospital. A transcript shall be prepared at the expense of the party or parties ordering or requesting same.

d. Following the completion of the hearing, vote will be taken within the Medical Executive Committee. A majority vote of the Medical Executive Committee shall be necessary to reverse a recall action. In the event a recall is reversed, the officer will immediately resume all duties and responsibilities of his/her office and all changes in officers caused by the recall action shall immediately be reversed.

e. Failure of the recalled officer to appear at a recall hearing which he/she has requested shall be deemed to constitute waiver of his/her right to appeal. He/she may, however, request a short postponement at the discretion of the Medical Executive Committee in the event of illness or the development of personal responsibilities deemed worthy of postponement by the Medical Executive Committee.

11. **Waiver of Personal Rights to Redress:** Each Staff Member waives any right to personal redress against the Hospital, the Medical Staff, the Medical Executive Committee, or any member thereof for any disciplinary action resulting from a recall hearing.
B. DEPARTMENT OFFICERS

1. **Identification**

   The officers of each department of the Medical Staff shall be:

   a. Chair
   b. Vice-Chair
   c. Secretary/Treasurer

2. **Qualifications:**

   Each officer shall be a member of the Active Medical Staff, shall be a member of the department and shall be willing and able to faithfully discharge the functions of his/her office. The chair shall be certified by the appropriate specialty board or equivalent competence should be determined through the credentialing process.

3. **Election:** Except for chairs appointed by contract with the Hospital, the chair, vice chair and secretary/treasurer shall be elected annually by the Active Medical Staff members of the department in the following manner:

   a. A nominating committee will be formed of the following:

      1) The two immediate past chairs of the department of whom the senior will be the chair of the committee;
      2) Three Active Medical Staff department members who shall be elected to the committee at the September departmental meeting;

   The nominating committee shall meet and nominate 1 person for each office whose names will be circulated to the Active Medical Staff members of the department at least 3 weeks prior to the November meeting of the department. Twenty percent of the members of the department may place other names in nomination by petition presented to the Secretary/Treasurer of the department no less than 2 weeks prior to the date of the election. Thereafter, the nominations shall be closed. The name(s) of the member(s) of the department so nominated shall be posted and circulated to the Active members of the department no less than 1 week prior to the November meeting of the department.

   Votes for department Officers will be collected electronically or in writing by the Medical Staff office up to one week prior to the date of the November meeting. These votes will be totaled during the meeting. Only the Active Medical Staff members of the department will be eligible to vote. Nominees must receive a majority of votes cast to be elected to the office. If no member receives a majority of votes cast, the department will immediately proceed to a run-off election between the two members receiving the highest vote totals. Only members of the department present at the November meeting, including via telephone, will have their votes counted in the event of a run-off for any office. The names of the department Officers elected shall be forwarded to the Board of Directors.

4. **Term of Office:** Except for chairs appointed by contract with the Hospital, officers shall serve a term of 1 Medical Staff Year or until his/her successor is chosen. A department Chair may
serve for no more than 3 consecutive terms (except the chairman of Anesthesiology and Emergency Medicine).

a. **Vacancy in Office:** In the event that a departmental office shall become vacant during the term for which such officer was elected, such vacancy shall be filled as follows: in the event that the office of chairman shall become vacant, the vice-chairman shall immediately become the chairman of the department and shall at the next regular meeting of the department appoint a vice-chairman to fill the vacancy for the remainder of the term; if a departmental office other than the chairman becomes vacant, the chairman shall appoint a successor at the next regular departmental meeting for the remainder of the term.

5. **Duties of Department Officers:**

   a. **Chair** - The responsibilities of the department Chair shall include:

      1) All clinically related activities of the department/service;
      2) All administratively related activities of the department/service, unless otherwise provided for by the Hospital;
      3) The integration of the department/service into the primary functions of the organization;
      4) The coordination and integration of interdepartmental and intradepartmental services.
      5) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
      6) Recommendations for a sufficient number of qualified and competent persons to provide care/service;
      7) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;
      8) Recommending to the Medical Staff the criteria for Clinical Privileges in the department;
      9) Recommending Clinical Privileges for each member of the department;
      10) The determination of the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services;
      11) The continuous assessment and improvement of the quality of care and services provided;
      12) The maintenance of quality assurance programs, as appropriate;
      13) The orientation and continuing education of all persons in the department/service;
14) Recommendations for space and other resources needed by the department/service.

15) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or the organization.

b. **Vice-Chair:** The responsibility of the Vice-Chair shall be to act as chair in the absence of the Chair and, when so acting, he/she shall have all the authority and powers of the Chair.

c. **Secretary/Treasurer:** The responsibilities of the secretary/treasurer shall include recording of departmental minutes, preparing departmental budget and other duties as enumerated in the Bylaws. The responsibilities of the Secretary/Treasurer shall be to act as Chair, in the absence of the Chair and Vice Chair and, when so acting, he/she shall have all the authority and powers of the Chair.

6. **Department Supervisory Committee:** The Chair, Vice-Chair, and Secretary/Treasurer shall constitute the departmental supervisory committee.

The duties of each supervisory committee shall be as follows:

a. To formulate departmental policies for approval by the department members and the appropriate reviewing bodies;

b. To assist in the administration of the department, including review of departmental committee reports, maintaining of discipline, and encouraging suitable educational efforts;

c. To make recommendations to the credentialing body regarding Clinical Privileges and Medical Staff membership status;

d. To ensure that requirements of the TJC or other accrediting bodies are fully met by the department concerned.

e. To review, investigate and evaluate the quality of care provided in particular cases by members of the department and to make recommendations to the department regarding these issues.

7. **Recall of Department Officers:**

a. Recall of a department officer may be considered following a motion to recall and a second made at a department meeting. Following such motion and second, no immediate discussion will take place. A special meeting of the department will be called within 2 weeks for the purpose of discussion and vote on the recall question. Voting members of the department shall be advised of the special meeting by written notice no less than 10 days prior to the meeting.

b. A two-thirds majority vote of a quorum at the special meeting shall effect immediate recall. The recalled officer shall immediately relinquish all duties, Privileges and responsibilities of the office following such a vote. In the event of recalling the chairman of the department,
the vice-chairman shall immediately become the chairman of the department and shall at
the next regular meeting of the department appoint a vice-chairman to fill the vacancy for
the remainder of the term. If a departmental officer other than the chairman is recalled,
the chairman shall appoint a successor at the next regular departmental meeting for the
remainder of the term.

c. An officer who has been recalled may request an appeal hearing in the event he/she feels
the decision was in error, unreasonable, arbitrary or capricious. Such requests shall be
made in writing to the President of the Medical Staff within ten days of the recall action.
Failure to make such request in ten days shall be considered a waiver by the individual of
the right to a hearing.

d. Within 10 days of receiving a request for a hearing, the President of the Medical Staff shall
call a special meeting of the Medical Executive Committee within 31 days following such
request and shall preside and conduct the hearing. The hearing shall be completed within
a 2 week period. The hearing shall be conducted and final action taken in the same
manner as set forth in Article XII, Section A(10) of these Bylaws.

ARTICLE XIII - COMMITTEES AND FUNCTIONS

A. DESIGNATION AND MEMBERSHIP

There shall be a Medical Executive Committee (sometimes referred to herein as “MEC”) and such
standing committees as enumerated in this section. The President of the Medical Staff, in
consultation with the other officers of the Medical Staff, may establish committees as may from
time to time be necessary and desirable. The President of the Medical Staff, in consultation with
the other officers of the Medical Staff (and in consultation with the Hospital President or designate
concerning non-physician committee members), shall appoint the members of the committees.
Committee members shall be Members of the Medical Staff who hold Active or Honorary with
Clinical Privileges status; Courtesy Members may be requested to attend Medical Staff committee
meetings and to participate without vote. Wherever non-physician individuals are designated to be
committee "members," such individuals shall serve ex-officio and without vote.

B. COMMITTEES AND FUNCTIONS

7. 1. Medical Executive Committee

The Medical Executive Committee shall consist of the following:

- President of the Medical Staff
- Vice President of the Medical Staff
- Secretary/Treasurer of the Medical Staff
- Chairs of each of the departments listed above in Article XI Section B
- President, Holy Cross Germantown Hospital, ex-officio without vote

In addition to the other Committee members, the Committee Chair shall have the authority to
appoint a physician who has a particular area of expertise needed by the Committee to serve
on the Committee ex officio, without vote. Such appointment shall be for a defined time to provide assistance with particular matters.

The President of the Medical Staff shall chair and preside at meetings of the Medical Executive Committee.

a. **Duties**

The duties of the Medical Executive Committee shall be to:

1) Receive and act upon reports and recommendations from the departments, committees and officers of the Medical Staff concerning performance improvement activities and other performance improvement activities.

2) Coordinate, approve and recommend approval of the activities of and policies adopted by the Medical Staff, departments and committees.

3) Recommend to the Board on all matters relating to appointments, reappointments, Medical Staff category, departmental and service assignments, Clinical Privileges, specified services and corrective action.

4) Request evaluations of Practitioners where there is doubt about a Practitioner's ability to perform the privileges requested.

5) Account to the Board for the Medical Staff's performance improvement activities and mechanisms designed to conduct, evaluate and revise such activities.

6) Initiate and pursue corrective action in accordance with Article IX.

7) Make recommendations on medico-administrative and Hospital management matters.

8) Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.

9) Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

10) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws, between regularly scheduled Medical Staff meetings.

11) Review and provide feedback and accept the clinical contracts on a yearly basis.

12) To approve non-budgeted discretionary spending of the Medical Staff of up to $5,000 per incident and up to $50,000 in aggregate for a fiscal year.

b. **Meetings:** The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.
8. 2. Credentials Committee:

The Credentials Committee shall be appointed by the President of the Medical Staff and shall consist of at least one member from the Departments of Medicine, Surgery, Obstetrics/Gynecology and Pediatrics. The Secretary/Treasurer of the Medical Staff must be a member of the Credentials Committee. The Chair shall have served on the Credentials Committee for at least 2 years prior to becoming Chair, except for the initial Chair (who shall serve a 2 year term). The term of the Chair shall be for no more than two years. The Chair will be elected from amongst the members of the committee. The Secretary/Treasurer of the Medical Staff will serve as Vice Chair of the Committee. The Secretary/Treasurer will prepare and submit the Credentials Committee report to the Medical Executive Committee monthly. In the absence of the Secretary/Treasurer, the Chair of the Credentials Committee will make the report. In addition to the other Committee members, the Committee Chair shall have the authority to appoint a physician who has a particular area of expertise needed by the Committee to serve on the Committee ex officio, without vote. Such appointment shall be for a defined time to provide assistance with particular matters.

a. Duties: The duties involved in coordinating and reviewing credentials investigations and recommendations are to:

1) Review and evaluate the qualifications of each Applicant for initial appointment, reappointment or modification of appointment and for Clinical Privileges, and in connection therewith to obtain and consider the recommendations of the appropriate departments.

2) Submit a report, in accordance with Articles VII and VIII, to the Medical Executive Committee on the qualifications of each Applicant for Medical Staff membership or particular Clinical Privileges and of each professional for specified services in accordance with all applicable requirements. Such report shall include recommendations with respect to appointment, Medical Staff category, departmental affiliation, Clinical Privileges or specified services, and special conditions attached thereto.

3) Investigate, review and report on matters, including the clinical or ethical conduct of any Practitioner assigned or referred to it by: 1) the President of the Medical Staff; 2) the Medical Executive Committee; or 3) those Medical Staff persons responsible for quality maintenance activities.

4) Maintain a permanent record of all recommendations made and reported to the Medical Executive Committee.

b. Meetings: The Credentials Committee shall meet as often as necessary to accomplish its purpose.
3. **Special Committees:**

The President of the Medical Staff, Medical Executive Committee, or the Chief Medical Officer of the Hospital may form and appoint Members to special committees on an ad hoc basis and when necessary and advisable. The purpose and duties of the special committees shall be defined and shall not overlap with the authority and duties of any other committee. The Medical Executive Committee shall dissolve special committees upon completion of the activity for which the committee was formed. Examples of special committees may include the following: Bylaws Committee, Cancer Committee, Critical Care Committee, Medical Education Committee, etc.

4. **Physician Health Committee:** The Physician Health Committee shall consist of at least 3 and not more than 5 members, who shall be appointed by the President of the Medical Staff. The President of the Medical Staff shall review the membership on an annual basis. If at any time an apparent conflict of interest exists between a member of the Committee and a reported Medical Staff member, the President of the Medical Staff may replace that Committee member.

   In selecting members of the Physician Health Committee, the President of the Medical Staff shall construe the following qualifications as a positive factor:
   - Distinguished senior medical staff member
   - Addictionist
   - Psychiatrist
   - High-risk area representative (anesthesiology, surgery, emergency medicine)
   - Physician with substantial personal recovery experience

   a. **Duties.** The duties of the Physician Health Committee shall be to:

      1) Review and act upon reports of potential physician impairment;
      2) Upon the request of the Medical Executive Committee, conduct ongoing monitoring of the health status of individual Medical Staff members;
      3) On an annual basis, coordinate Medical Staff education regarding physician health issues.
      4) Allow for referral of a Medical Staff Member by an appropriate referral source or by self-referral;
      5) Ensure a process to identify and manage matters of individual health for Medical Staff Members, which may be separate from actions taken for disciplinary purposes.

   b. **Meetings:** The Physician Health Committee shall meet as often as necessary, but not less frequently than quarterly.

5. **Physician Advisor(s):** The President of the Medical Staff will appoint a physician from the Active Medical Staff as Physician Advisor(s) in the following areas: Blood Utilization, Case Management, and Infection Control.

   The Physician Advisor(s) will serve for an indefinite period of time, but must be reappointed annually on January 1 by the President of the Medical Staff. The Physician Advisor(s) will advise the President of the Medical Staff on matters pertaining to the area under his/her jurisdiction.

   The Physician Advisor(s) will work with members of the Medical Staff and Hospital staff to
the extent necessary to accurately advise the President of the Medical Staff. The Physician Advisor(s) will report to the President of the Medical Staff as often as necessary, but will issue a written summary at least quarterly. These reports shall be forwarded to the Medical Executive Committee for information or approval.

At the discretion of the President of the Medical Staff or the Physician Advisor(s), an advisory group can be formed to address particular issues. This advisory group will consist of physicians and/or hospital personnel with expertise in an area of concern and will be chaired by the appropriate Physician Advisor. The group shall meet as often as necessary to resolve or study the issue and submit a written report to the President of the Medical Staff, which will be forwarded to the Medical Executive Committee for information or approval.

The President of the Medical Staff will consult with the Hospital President to recommend members of the Medical Staff to serve on Hospital committees whose recommendations are forwarded to the Medical Executive Committee.

ARTICLE XIV - MEETINGS

A. GENERAL STAFF MEETINGS

1. Semi-Annual Meetings: Semi-annual Medical Staff meetings shall be held the second Tuesday of November and May.

2. Order of Business and Agenda: The order of business at the annual meeting and all regular meetings shall be determined by the President. The agenda shall include at least:

   a. Acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

   b. Administrative reports from the Hospital President, the President of the Medical Staff, departments and committees;

   c. The election of officers when required by these Bylaws;

   d. Reports by responsible officers, committees and departments on the overall results of patient care quality maintenance activities of the Medical Staff (including recommendations for improving patient care) and on the fulfillment of the other required Medical Staff functions; and

   e. New business.

3. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Board, the President of Medical Staff, the Medical Executive Committee or not less than one-third of the Active Medical Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.
B. COMMITTEE AND DEPARTMENTAL MEETINGS

1. **Regular Meetings**: Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws, provided, however, that the Medical Executive Committee shall meet monthly and Medical Staff departments shall meet at least bimonthly.

2. **Special Meetings**: A special meeting of any committee or department may be called by, or at the request of, the chairman thereof, the Board, the President of the Medical Staff, or by one-third of the group’s current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

C. NOTICE OF MEETINGS

Written notice stating the place, day and hour of any general Medical Staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution shall be delivered either personally, by fax, e-mail or mail to each person entitled to be present at such meeting not less than 4 days, nor more than 35 days, before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered 48 hours after deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Notice of committee meetings shall be given at least 1 day prior to the meeting.

D. QUORUM

1. **General Staff and Department Meetings**: For purposes of conducting all business, a quorum is those members of the Active Medical Staff who are present at the meeting. Presence shall be determined by completion of a sign-in sheet at the beginning of the meeting.

2. **Committee Meetings**: Fifty percent (50%) of the voting members of a committee who are present at the meeting, but not less than 2 members, shall constitute a quorum at any meeting of such committee.

E. MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Action may be taken by a department or committee without a meeting by a writing setting forth the action so taken; such action must be signed by each member entitled to vote.
F. MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance and the result of the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer (or his/her designee), forwarded to the Medical Executive Committee, and made available to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained.

G. ATTENDANCE REQUIREMENTS

1. **General Staff and Department Attendance:** For the first 2 years after achieving Active Staff status, each member of the Active staff shall be required to attend four (4) the aggregate Medical Staff meetings held during the calendar year, including general Medical Staff meetings, department meetings and meetings of standing or ongoing ad hoc committees to which the member has been assigned.

   Notwithstanding the foregoing, each department, in its rules and regulations may adopt more stringent attendance requirements.

2. **Committee Attendance:** Each member of the Active Staff shall be required to attend fifty (50%) percent of the meetings of standing or ongoing ad hoc committees to which the member has been assigned.

3. **Absence from Meetings:** For the first 2 years after achieving Active Staff status, any Staff Member who is compelled to be absent from any general Medical Staff, department, service or committee meeting for reasons of illness, medical emergency, or attendance at an educational conference shall provide, in writing, to the regular presiding officer thereof, no later than 30 days following the absence, the reason for such absence. The presiding officer may, for good cause, excuse the Staff Member from attendance at such meeting. In addition, the President of the Medical Staff may also excuse, when notified in writing, the Staff Member for just cause. Unless excused for good cause by the presiding officer or President of the Medical Staff, failure to meet the attendance requirements of this Article, Section G(1) shall be grounds for any of the corrective actions specified in Article IX, Section A(4a, b, and e), and including, in addition, removal from such committee and reduction in Medical Staff category.

4. **Special Appearance:** A Practitioner whose patient’s clinical course of treatment is scheduled for discussion at a regular department, service or committee meeting, and where suspected deviation from standard clinical practice may be involved, shall receive at least 7 calendar days advance written notice of the time and place of the meeting, which notice shall include a statement of the issues involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he/she was given such notice shall, unless excused by the Medical Executive Committee or the appropriate committee or department chairman upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner's Clinical Privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or of the Board or through corrective action, if necessary.
ARTICLE XV - CONFIDENTIALITY AND LIABILITY

A. SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

1. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matters specified in this Article, Section E(2).

2. MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

3. PRACTITIONER means a Practitioner or Applicant.

4. REPRESENTATIVE means the Board and any member, officer or committee thereof; the President of the Hospital or his/her designee; the Medical Staff and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

5. THIRD PARTIES means both individuals and organizations providing information to any representative.

B. AUTHORIZATIONS AND CONDITIONS

1. By applying for, or exercising, Clinical Privileges or providing specified patient care services within the Hospital, a Practitioner:
   a. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications.
   b. 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.
   c. Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Medical Staff membership, and/or his/her exercise of Clinical Privileges or provision of specified patient service at this Hospital.

2. No representative of the Hospital or Medical Staff and no third party shall be liable to any Practitioner in any administrative or judicial proceedings for damages or other relief by reason of providing information to a representative of this Hospital or Medical Staff, to the Maryland Board of Physicians or to any other hospital or professional organization concerning a Practitioner who is or has been an Applicant to or member of the Medical Staff or who did or does exercise Clinical Privileges or provides specified services at this Hospital, provided that such representative or third party acts in good faith and without malice.
C. CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any representative of the Hospital or any other health care 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 shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative and shall not be used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Hospital records.

The provisions of this section regarding confidentiality shall apply to all manner of information regarding a Practitioner, specifically including (but not limited to) any activity in the nature of peer review, and to all proceedings, deliberations, and records of such peer review activity.

D. ACCESS TO MEDICAL STAFF FILES

To preserve and protect the confidentiality of credentialing, peer review and disciplinary proceedings, as required by the Bylaws and State law, neither an Applicant nor a Practitioner presently or formerly practicing at the Hospital shall have access to any information in any files maintained by the Hospital President (or his/her designated representatives); provided, however, that the Practitioner shall have access to such information in the event of proceedings at the Hospital involving such Practitioner in accordance with the provisions of Article X. If the Practitioner otherwise requests access to files pertaining to his or her Medical Staff membership or Clinical Privileges, the Practitioner shall be permitted to review such file(s) in the presence of the President (or his/her designated representative) and the chair of the Practitioner's department or section.

E. IMMUNITY FROM LIABILITY

For Action Taken: No representative of the Hospital or Medical Staff shall be liable to any Practitioner in any administrative or judicial proceeding 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 and without malice and in the reasonable belief that the action, statement or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

F. ACTIVITIES AND INFORMATION COVERED

1. Activities: The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:
   a. Applications for appointment, Clinical Privileges or specified services.
   b. Periodic reappraisals for reappointment, Clinical Privileges, or specified services.
   c. Corrective action.
d. Hearings and appellate reviews.

e. Patient care quality maintenance activities.

f. Utilization reviews.

g. Other Hospital, department, service or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

h. Reports made to the Maryland Board of Physicians or other licensing boards.

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 which might directly or indirectly affect patient care.

G. RELEASES

Each Practitioner shall, upon request of the Hospital, 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 this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

H. CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XVI - GENERAL PROVISIONS

A. STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles found within these Bylaws. These shall 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 in the Hospital. Rules and Regulations and policies may be approved by the MEC and the Board and presented to the Medical Staff at its semi-annual meeting.

B. DEPARTMENTAL AND SUBSECTION RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee, each department and subsection shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations of the Medical Staff, or other policies of the Hospital. All amendments to the Department Rules and Regulations shall be approved by the Department, Medical Executive Committee and Board of the Hospital. Subsection Rules and Regulations shall
be approved by the Subsection and Department prior to approval by the Medical Executive Committee and Hospital Board.

As part of its rules and regulations, the department or subsection may establish dues as a condition of membership in the department. The department or subsection shall have the power to set the amount of annual dues for each category of Medical Staff membership and to determine the manner of expenditure of funds received. Dues shall be payable on or before the date specified in the statement of dues payable sent to each department member. Failure, unless excused by the Department Chair or Subsection Chair in consultation with the Department Chair for just cause, to render payment by said date may be grounds, after special notice of the delinquency, constitutes a voluntary resignation from the Medical Staff.

C. MEDICAL STAFF DUES AND FUNDS

The Medical Executive Committee shall have the power to set the amount of annual dues for each category of Medical Staff membership and to determine the manner of expenditure of funds received. Dues shall be payable on or before the date specified in the Statement of Dues Payable sent to each Practitioner. Failure, unless excused by the Medical Executive Committee for just cause, to render payment by said date, after special notice of the delinquency, constitutes a voluntary resignation from the Medical Staff. If the member pays his/her dues prior to the next meeting of the Board of Directors, it will be the sole discretion of the Board of Directors whether to reinstate the member. In this circumstance, a practitioner may reapply and there will be no waiting period. In the event of dissolution of the Medical Staff, any remaining funds shall be distributed to the Congregation of the Sisters of the Holy Cross, which is tax exempt under the provisions of Section 501(c)(3) of the Internal Revenue Code.

D. CONSTRUCTION OF TERMS AND HEADINGS

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

E. TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the President of the Hospital.

ARTICLE XVII - ADOPTION AND AMENDMENT OF BYLAWS

A. MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend to the Board, Medical Staff Bylaws, Rules, Regulations and Policies and amendments thereto, which shall be effective when approved by the Board. The Medical Executive Committee and the Board shall approve amendments to the Rules, Regulations and Policies, and are responsible for presenting them to the Medical Staff at the semi-annual meeting. The Medical Staff's responsibilities and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of
professionally recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Board, the Hospital and with the community. Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff governing documents. If Medical Staff approval is required, it may be obtained electronically provided notice requirements are complied with.

If a conflict on issues (including, but not limited to, proposals to adopt a rule, regulation, policy, or an amendment thereto) between the Medical Staff and MEC becomes apparent, any members of the Medical Staff may, within a reasonable amount of time, meet to frame a recommendation and present that directly to the Board. If disagreement persists, the Board’s actions prevail.

The foregoing Medical Staff Bylaws were approved and adopted by resolution of the Board of Directors after considering the Medical Staff’s recommendation. The overall responsibility for the management and control of the Hospital rests with the Board of the Hospital. Therefore, to the extent that these bylaws differ from or are inconsistent with the charter, bylaws or any rule or regulation of the Hospital's Board, the Board’s charter, bylaws or rules or regulations shall take precedence and prevail.

B. METHODOLOGY

1. Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

   a. Medical Staff: The affirmative vote of a two-thirds majority of the Practitioners eligible to vote and who are present at a meeting at which a quorum is present, provided at least fourteen days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action; and

   b. Board: Approval by the Board.

2. Notwithstanding the preceding section B., the initial Medical Staff Bylaws shall be adopted as follows:

   Approved by Medical Staff:

   [Signature]

   [Date]

   President

   Approved by Holy Cross Health, Inc. Board of Directors:

   [Signature]

   [Date]