# UNION HOSPITAL

# MEDICAL STAFF BYLAWS

# ARTICLE 1: NAME


ARTICLE 1: NAME ........ 1

ARTICLE 2: DEFINITIONS ........ 1

ARTICLE 3: PURPOSE AND RESPONSIBILITIES ........ 1

3.1 Establishment. ........ 1

3.2 Responsibility ........ 1

ARTICLE 4: MEDICAL STAFF MEMBERSHIP ........ 2

4.1 QUALIFICATIONS FOR MEMBERSHIP. ........ 2

4.2 Basic Responsibilities of Medical Staff Membership and Clinical Privileges. ........ 4

4.3 Special Responsibilities. ........ 5

4.3.1 Emergency and Service Care Assignments. ........ 5

4.3.2 Physician Availability. ........ 6

4.3.3 Obligation to Report Adverse Events. ........ 6

4.3.4 Participation in Quality Assurance, Performance Improvement, Utilization Review and Management, Risk Management, Peer Review, and Credentialing Activities. ........ 6

4.3.5 Malpractice Insurance Purchase ........ 7

4.4 CONDITION AND DURATION OF APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF ........ 7

4.5 PROCEDURE FOR INITIAL APPOINTMENT ........ 8

4.5.1 Application Process ........ 8

4.5.2 Submission of Application ........ 8

4.5.3 Department Chairperson Procedure ........ 8

4.5.4 Credentials Committee Procedure ........ 9

4.5.5 Credentials Committee Report ........ 10

4.5.6 Medical Executive Committee Procedure ........ 10

4.5.7 Board of Directors Procedure ........ 10

4.6 APPOINTMENT TO THE MEDICAL STAFF ........ 11

4.6.1 Initial Appointment. ........ 11

4.7 OBSERVATION OF MEMBERS ON PROVISIONAL STATUS ........ 12

4.8 TERM OF PROVISIONAL STATUS MEMBERSHIP ........ 12

4.9 ACTION AT CONCLUSION OF PROVISIONAL STATUS ........ 12

4.10 PROCEDURE FOR REAPPOINTMENT ........ 12

4.10.1 Application ........ 12

4.10.2 Department Chairperson Review ........ 13

4.10.3 Credentials Committee Procedure ........ 14

4.10.4 Medical Executive Committee Procedure ........ 15

4.10.5 Board of Directors Procedure ........ 15

4.11 LEAVE OF ABSENCE ..... 15

4.11.1 Leave Status. ..... 15

4.11.2 Termination of Leave. ..... 16

4.11.3 Failure to Request Reinstatement. ..... 16

4.12 NONDISCRIMINATION ..... 16

4.13 EFFECT OF OTHER AFFILIATIONS ..... 16

ARTICLE 5: CATEGORIES OF THE MEDICAL STAFF ..... 16

5.1 CATEGORIES ..... 16

5.2 Union Hospital's Active, Associate and Consulting Staff shall consist of members who: ..... 16

5.3 ACTIVE STAFF ..... 16

5.3.1 Qualifications ..... 16

5.4 ASSOCIATE STAFF ..... 17

5.4.1 Qualifications ..... 17

5.5 COMMUNITY AFFILIATE STAFF ..... 17

5.5.1 Qualifications ..... 17

5.6 HONORARY STAFF ..... 18

5.6.1 Qualifications ..... 18

5.7 ALLIED HEALTH PROFESSIONALS ..... 19

5.7.1 Independent Allied Health Professionals Qualifications for Membership 19

5.7.2 Dependent Allied Health Professionals ..... 19

ARTICLE 6: DELINEATION OF CLINICAL PRIVILEGES ..... 20

6.1 GENERAL INFORMATION ..... 20

6.2 DELINEATION OF CLINICAL PRIVILEGES ..... 20

6.2.1 Mechanism ..... 20

6.2.2 Criteria for the Delineation of Clinical Privileges ..... 21

6.2.3 Establishment of Privileges for New Procedures or Expanded Scope of Care 21

6.2.4 Multi-Service Procedures ..... 21

6.3 PROVISIONS OF CARE IN EMERGENCY SITUATIONS ..... 22

6.3.1 Circumstances ..... 22

6.4 TEMPORARY PRIVILEGES ..... 22

6.4.1 General Information ..... 22

6.4.2 Circumstances for Requesting Temporary Privileges. ..... 22

ARTICLE 7: ORGANIZATION OF THE MEDICAL STAFF ..... 23

7.1 PARTICIPATION IN MEDICAL STAFF ACTIVITIES ..... 23

7.2 OFFICERS OF THE MEDICAL STAFF ..... 23

7.2.1 Leadership Positions ..... 23

7.3 QUALIFICATIONS ........ 23
7.4 NOMINATIONS ........ 23
7.5 ELECTION ........ 24
7.6 TERM OF ELECTED OFFICE ........ 24
7.7 RECALL OF OFFICERS ........ 24
7.8 VACANCIES IN ELECTED OFFICE ........ 24
7.9 DUTIES OF OFFICERS ........ 24
7.9.1 President of the Medical Staff ........ 24
7.9.2 The President of the Medical Staff shall serve as the Chief Officer of the Medical Staff. The duties of the President of the Medical Staff shall include, but not be limited to: ........ 24
7.9.3 Vice President of the Medical Staff ........ 25
7.9.4 Secretary/Treasurer. The Secretary-Treasurer shall be a member of the Medical Executive Committee. His duties shall include, but not be limited to: 25
7.10 CHAIRPERSON OF THE DEPARTMENT ........ 25
7.10.1 General Information ........ 25
7.10.2 Duties of the Chairperson of the Department ........ 26
7.10.3 Duties of Vice Chairperson ........ 27
7.10.4 Qualifications for Appointment as Chairperson and Vice-Chairperson of a Department ........ 27
7.10.5 Selection ........ 27
7.10.6 Term of Office ........ 28
7.10.7 Removal
7.11 CONTRACTED SERVICES AND APPOINTMENTS ........ 28
7.11.1 CONTRACTED SERVICES ........ 28
7.11.2 CONTRACTUAL APPOINTMENT ........ 28
7.11.3 MEDICAL DIRECTOR ........ 28
7.12 Term of Office ........ 28
ARTICLE 8: CLINICAL DEPARTMENTS ........ 28
8.1 GENERAL ........ 28
8.2 DESIGNATION OF DEPARTMENT AND SECTIONS ........ 29
8.3 ASSIGNMENT TO DEPARTMENT ........ 30
8.4 FUNCTIONS OF DEPARTMENTS ........ 30
ARTICLE 9: COMMITTEES OF THE MEDICAL STAFF ........ 30
9.1 GENERAL ........ 30
9.2 MEDICAL EXECUTIVE COMMITTEE ........ 31
9.2.1 Composition ........ 31
9.2.2 Meetings ........ 31
9.2.3 Duties ........ 31

9.2.4 Quorum .......... 32
9.3 STANDING COMMITTEES .......... 32
9.3.2 Terms of Committee Members .......... 32
9.3.3 Removal .......... 32
9.3.4 Vacancy .......... 33
9.3.5 Voting 33
9.4 MEDICAL STAFF MEETINGS .......... 33
9.4.1 Time of Meetings .......... 33
9.4.2 Notice of Meetings .......... 33
9.4.3 Quorum .......... 33
9.4.4 Minutes 33
9.4.5 Attendance Requirements .......... 33
9.5 COMMITTEE AND DEPARTMENT MEETINGS .......... 33
9.5.1 Time of Meetings .......... 33
9.5.2 Notice of Meetings .......... 34
9.5.3 Quorum .......... 34
9.5.4 Manner of Action .......... 34
9.5.5 Minutes 34
9.5.6 Attendance Requirements .......... 34
ARTICLE 10: QUESTIONS OF CLINICAL COMPETENCY AND CONDUCT .......... 34
10.1 CRITERIA FOR INITIATION .......... 34
10.2 INITIATION OF EVALUATION OF CLINICAL COMPETENCY AND CONDUCT 34
10.3 INVESTIGATION .......... 35
10.4 DETERMINING WHETHER ADEQUATE GROUNDS FOR EVALUATION EXIST 35
10.5 INITIATION OF INVESTIGATION BY BOARD OF DIRECTORS .......... 35
10.6 MEDICAL EXECUTIVE COMMITTEE ACTION .......... 35
10.7 AUTOMATIC AND SUMMARY SUSPENSION .......... 36
10.7.1 Criteria for Initiation .......... 36
10.7.2 Written Notice of Precautionary Suspension .......... 36
10.7.3 Medical Executive Committee Action .......... 36
10.8 VOLUNTARY RELINQUISHMENT .......... 36
ARTICLE 11: HEARINGS AND APPELLATE REVIEWS .......... 37
11.1 GROUNDS FOR A HEARING .......... 37
11.1.1 Notice of Right to Hearing .......... 38
11.1.2 Notice of Hearing .......... 38
11.1.3 Hearing Committee .......... 38

11.1.4 Failure to Appear or Proceed ... 39
11.2 HEARING PROCEDURE ... 39
11.2.1 Pre-Hearing Conference ... 39
11.2.2 Record of the Hearing ... 39
11.2.3 Representation by an Attorney ... 39
11.2.4 Presentation of Evidence and Right to Cross Examination ... 39
11.3 HEARING COMMITTEE RECOMMENDATIONS ... 39
11.3.1 Deliberations and Adjournment ... 39
11.3.2 Recommendation ... 40
11.3.3 Notice and Further Action ... 40
11.4 INITIATION AND SCOPE OF APPELLATE REVIEW ... 40
11.5 PROCEDURE FOR APPELLATE REVIEW ... 40
11.5.1 Statements ... 40
11.5.2 Final Decision ... 40
ARTICLE 12: CONFIDENTIALITY OF INFORMATION ... 40
12.1 GENERAL ... 40
12.2 BREACH OF CONFIDENTIALITY ... 41
12.3 IMMUNITY OF LIABILITY ... 41
12.3.1 For Action Taken ... 41
12.3.2 For Providing Information ... 41
12.4 ACTIVITIES AND INFORMATION COVERED ... 41
12.4.1 Activities ... 41
12.4.2 Releases ... 41
ARTICLE 13: GENERAL PROVISIONS ... 42
13.1 RULES AND REGULATIONS ... 42
13.2 DUES OR ASSESSMENTS ... 42
13.3 CONSTRUCTION OF TERMS AND HEADINGS ... 42
13.4 AUTHORITY TO ACT ... 42
13.5 NOTICES ... 42
13.6 DISCLOSURE OF INTEREST ... 42
13.7 CONFIDENTIALITY ... 43
13.8 MEMBERS' OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE ... 43
ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS ... 44
14.1 PROCEDURE ... 44
14.2 ACTION ON BYLAW CHANGE ... 44
14.3 APPROVAL ... 44
14.4 EXCLUSIVITY ... 44

14.5 SUCCESSOR IN INTEREST ........................................................................ 44

## PREAMBLE

WHEREAS, the Union Hospital is organized under the laws of the State of Maryland;

WHEREAS, the Hospital's purpose is to serve as a general hospital providing quality patient care;

WHEREAS, the Medical Staff of the Hospital is responsible and accountable to the Board of Directors for the provision of quality medical care, treatment and services provided to patients in the Hospital by practitioners with clinical privileges. The Medical Staff is organized in a manner approved by the Board of Directors;

WHEREAS, the Medical Staff, through its departments, committees and officers must accept and discharge its responsibilities to monitor the medical care in the Hospital subject to the ultimate authority of the Board of Directors and in accordance with applicable law and Joint Commission on the Accreditation of Health Care Organizations Standards; and

WHEREAS, the cooperative efforts of the Medical Staff, the President, and the Board of Directors are necessary to fulfill the Hospital's obligation to its patients;

NOW, THEREFORE, the physicians, dentists and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff and shall function and act in accordance with these Bylaws. The Hospital management shall cooperate with and assist the appointees to the medical staff in the accomplishment of this responsibility to the hospital pursuant to these bylaws.

# ARTICLE 1: NAME

The name of this organization to which these Bylaws apply shall be the Union Hospital Medical Staff.

# ARTICLE 2: DEFINITIONS

“Board Certification” or “Board Certified” means holding a certificate issued by the American Board of Medical Specialties or American Osteopathic Association as determined by the Credentials Committee.

“Board of Directors”, “Board” or “Governing Body” means the Board of Directors of Union Hospital.

Bylaws shall mean these Medical Staff Bylaws, as well as Medical Staff rules and regulations that are adopted by the Medical Staff and approved by the Board of Directors.

“Hospital” means the acute care facility operated by Union Hospital of Cecil County.

“Medical Staff” – means all physicians (M.D.’s and D.O.’s) and Independent Allied Health Professionals (dentists, podiatrists, psychologists, and nurse practitioners) who are granted privileges to treat patients of the Hospital.

# ARTICLE 3: PURPOSE AND RESPONSIBILITIES

3.1 Establishment.

(a) There shall be established within the Hospital a medical staff, which shall consist of those Practitioners who have been granted the right to exercise clinical privileges within the Hospital. No Practitioner, including those employed by or contracted to the Hospital, may admit patients or provide medical services to any patient in the Hospital, unless he/she has been granted appropriate Clinical Privileges through the Medical Staff Credentialing Process set forth in these Bylaws.

3.2 Responsibility

It is the responsibility of the Medical Staff to ensure:

(a) that quality medical care is provided to patients and the community served by Union Hospital

(b) that clinical leadership within Union Hospital addresses issues that allow for continual improvements in care and services;

(c) self-governance of activities inherent to the provision of proper care in accordance with the Medical Staff Bylaws

(d) Specific activities that are the responsibility of the Medical Staff are:

(1) the delineation of clinical privileges and qualifications for staff membership;

(2) the assessment of the quality of care, and utilization of clinical resources;

(3) the ongoing surveillance of practitioner performance;

(4) the performance of corrective action to improve practitioner performance; The initiation, development, and approval of medical staff bylaws and rules and regulations;

(5) The approval or disapproval of amendments to the medical staff bylaws and rules and regulations;

(6) The selection and removal of medical staff officers;

(7) The determination of the mechanism for establishing and enforcing criteria and standards for medical staff membership;

(8) The determination of the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;

(9) The determination of the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges;

(10) Participation in the Hospital's quality improvement and assessment, utilization review and resource management programs;

(11) A mechanism to ensure a uniform standard of quality patient care, treatment and services.

## ARTICLE 4: MEDICAL STAFF MEMBERSHIP

4.1 QUALIFICATIONS FOR MEMBERSHIP.

Staff membership will consist of physicians (M.D., D.O.), and such other Independent Allied Health Professionals(dentists, podiatrists, psychologists, and nurse practitioners) licensed by the state of Maryland who practice independently within the scope of services approved by the Medical Staff and the Board of Directors. Individuals will be considered for appointment or reappointment to the Medical Staff or for the delineation of clinical privileges only if they meet the following minimum requirements:

(a) has a current unsuspended, unrevoked and unrestricted professional licensure from the State of Maryland;

(b) is able to document education background, relevant experience and training, demonstrate current competence and evidence of ability to perform the privileges requested. Adequate experience and training will be determined by the Medical Staff and Board of Directors. Independent Allied Health Professionals must be in compliance with Maryland State licensure and training requirements.

(c) current Drug Enforcement Administration (DEA) and State of Maryland (CDS) controlled dangerous substances registrations as appropriate;

(d) professional liability insurance issued by an insurer acceptable to the Board and in an amount of not less than $1,000,000/$3,000,000. If any Practitioner changes insurance carriers for any reason, changes from occurrence to claims – made coverage, or has his/her insurance coverage terminated or limited for any reason, Practitioner shall immediately notify the Medical Staff Officer, in writing.

(e) compliance with specific requirements for membership as adopted by the Medical Staff and approved by the Board of Directors;

(f) maintenance of a professional practice and residence close enough to the hospital to provide timely and continuous care to patients;

(g) adherence to the ethics of their respective professions, ability to work cooperatively with other professionals and Hospital Personnel, interact appropriately with such persons, as well as with patients and the general public. Behave in a manner that does not adversely affect patient care and to keep as confidential, as required by law, all information or records received as part of the physician patient relationship, and willingness to participate in and properly discharge those responsibilities required by the Medical Staff and/or their Bylaws;

(h) agreement to comply with the Bylaws, Rules and Regulations of the Medical Staff, Department Rules and Regulations, and participation in the medical staff and Hospital quality assurance, risk management and performance improvement activities;

(i) assume all the functions and responsibilities of appointment, including, when appropriate, care for unassigned patients, emergency service care, and consultations.

(j) Initial appointments to the Medical Staff will not be made unless the applicant is board certified or can provide proof that applicant is qualified for certification by a board that is approved and recognized by the American Board of Medical Specialties and/or the American Osteopathic Association in the area in which privileges are requested.

Board Certification is required for Medical Staff Membership within five (5) years of initial appointment date. Proof of active eligibility for Board Certification is required at the time of initial application. Applicant's who have not achieved Board Certification within five (5) years of initial appointment will not be eligible for reappointment.

Physician members of the medical staff whose initial appointment to the medical staff occurred prior to September of 1995, have complied with the criteria in effect at the time of their initial appointment and shall have demonstrated proficiency in the execution of clinical privileges equivalent to that of board certification for a period of not less than 5 years are exempted (9/95).

Active candidates who are unable to become board certified within five (5) years from the date of their initial appointment, will be deemed to have voluntarily relinquished Medical Staff Appointment and Clinical Privileges and their Medical Staff membership and clinical privileges will not be renewed at the expiration of its then-current term of appointment. Members are required to maintain board certification by an appropriate board of the specialty or subspecialty in which the provider is seeking clinical privileges and maintenance of certification or recertification status of the specialty, or subspecialty in which the provider is seeking clinical privileges. Upon written request by an Applicant, the Medical Executive Committee, subject to the prior approval of the Board, and upon the demonstration of extenuating circumstances by the Applicant may, in its sole discretion, grant an extension of time for an Applicant to achieve Board Certification. The burden of proof of demonstrating extenuating circumstances shall be upon the Applicant and the denial of such an extension by the Medical Executive Committee or the Board shall not constitute grounds for a hearing as set forth in § 11.1 et. Seq. of these Bylaws.
Allied Health Practitioners must be certified or achieve certification within 3 years of their initial appointment by a professional specialty board appropriate to their professional discipline. If certification has not been obtained within 3 years of their initial appointment, the Credentials Committee, in conjunction with the

Department Chairperson, may recommend no more than 2 one-year extensions of a member's appointment and privileges requested to allow satisfaction of the board certification requirement. Failure to obtain certification within the time limits set forth above shall result in non-renewal of clinical privileges.

(k) Consent to the inspection of records/documents on licensure, training, experience, current competence, and ability to perform privileges including cooperation in any review of a practitioner’s credentials, qualifications, or compliance with these bylaws and document their conformity with rules, regulations and policies at other hospitals, healthcare facilities, managed care networks with which they have been affiliated as requested by the Department Chair, Credentials Committee, Medical Executive Committee, or Board of Directors and if requested appear for an interview.

(l) Payment of medical staff dues in an amount determined by the Medical Executive Committee.

(m) Practitioners are deemed to have consented, as a condition of submitting an application for appointment or reappointment, to mental or physical examination or immediate testing of blood and/or urine for controlled dangerous substances and/or alcohol, in circumstances where probable cause is found to exist, upon request of both its President of the Medical Staff and the Chief Executive Officer (or their designees). Probable cause may include but not be limited to, erratic behavior, apparent inability to perform work duties, odor of alcohol or controlled dangerous substances, for any other behavior that reasonably gives rise to concern for patient, Medical Staff or employee safety, and that reasonably appears to result from consumption or use of controlled substances or alcohol.

(n) For any practitioners request for appointment or reappointment to be deemed complete and sufficient to initiate review, such practitioner shall execute a hold harmless and release agreement in a form approved by the CEO or the Board.

(o) The time periods set forth in these Bylaws are intended to be guidelines for the routine processing of applications, requests for appointment of reappointment, requests for corrective action or appeals there from. Deviations from the time periods set forth herein shall not be grounds for invalidating the actions taken.

4.2 Basic Responsibilities of Medical Staff Membership and Clinical Privileges.

(a) All Practitioners who apply for and/or are granted Privileges are subject to the particular obligations and limitations of the Medical Staff category to which they are approved and the Privileges which are granted. All such Practitioners have a continuing obligation to ensure that material information provided in their application for initial appointment and reappointment remains current and shall immediately notify the Medical Staff Office of any changes in such information. Qualifications for Medical Staff Members are continuing and must be fulfilled continuously during the time the Practitioner has Privileges. Failure to continuously comply with these obligations is sufficient cause for suspension of Privileges. If a Practitioner is not in compliance, he/she shall be provided 30 days’ notice by the Chief Executive Officer, or his designee, of his/her noncompliance. Failure to cure such noncompliance within the 30 day period shall be reported to the Medical Executive Committee for appropriate action, including suspension of Privileges.

(b) Each Member of the Medical Staff and Practitioner granted Privileges shall:

(1) provide patients with care at the generally recognized professional level of quality and efficiency;

(2) abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, Hospital Bylaws, Rules and Regulations, policies, procedures and standards;

(3) complete such reasonable responsibilities and assignments imposed upon the Practitioner by virtue of Medical Staff membership and/or Clinical Privileges, including committee assignments;

(4) prepare and complete in timely fashion medical records for all patients to whom the Practitioner provides care in the Hospital (Failure to comply with the time requirements set forth in the Medical Records Rules and Regulations shall be reported to the Medical Executive Committee, or their designee, for appropriate action);

(5) make appropriate arrangements with another Practitioner who possesses substantially comparable Privileges within his/her specialty/subspecialty for coverage for his/her patients in the Practitioner's absence;

(6) participate in continuing education programs, as determined by the Medical Staff;

(7) participate in such emergency and charitable service coverage or consultation as may be required by the Medical Staff, Administration and Board of Directors;

(8) discharge such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff;

(9) abide by the ethical principals of his/her profession, including but not limited to any ethical prohibitions on fee-splitting or other inducements regarding patient referrals;

(10) maintain confidentiality of patient care;

(11) accept Emergency Department and inpatient call as requested by his/her department chair for unassigned patients;

(12) see and write a progress note every day for each of his/her hospitalized patients;

(13) agrees to take into account the recommendations of Hospital Committees concerning resource utilization;

(14) appropriately contact the consultant when requesting a consultation. The consultant is also required to follow up with the referring physician;

(15) explain all treatments, procedures, and tests to patients, to include risks, benefits, and alternatives, in a language the patient can understand (and, if the patient is pregnant, to include the risks, benefits, and alternatives with regard to the fetus); and

(16) Discuss advance directives with each appropriate patient.

4.3 Special Responsibilities.

4.3.1 Emergency and Service Care Assignments.

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

A Physician on call in the Emergency Department must see in his/her office for follow-up care, within a time frame appropriate to the nature of the diagnosis, any patient referred to him/her by the Emergency Department.

4.3.2 Physician Availability.

Each Medical Staff Member shall be responsible for 24-hour coverage of his/her patients and on-call obligations. In order to comply with this requirement, each Medical Staff Member must have an answering service, a 24-hour paging device or a cell phone available on a 24 Hour basis. In his/her absence, a Physician must sign-out to another Physician with appropriate Clinical Privileges at the Hospital and must notify his/her answering service of such coverage arrangements. In the case of a Physician's failure to make adequate coverage arrangements, the applicable department chair shall have authority to call any Members of the Medical Staff should he/she consider it appropriate. In case of mass disaster, department chairs (or their designees) shall have authority to require all Practitioners with Clinical Privileges to perform designated services as appropriate to deal with the mass disaster.

4.3.3 Obligation to Report Adverse Events.

Any of the following events shall be promptly reported by an Applicant or Member to the Medical Staff Office, which will be transmitted it to the appropriate Department Chair or Vice President of Medical Affairs:

(1) any medical malpractice action in which the Applicant or Member is named as a defendant;

(2) any charges brought before any state licensing or other registration board (including but not limited to the U.S. Drug Enforcement Administration and/or the Maryland Division of Drug Control);

(3) any previous or currently pending challenges, or any voluntary or involuntary relinquishment, of such licensure or registration;

(4) any limitations, reduction or termination, whether voluntary or involuntary, of medical staff membership or clinical privileges at another hospital or surgery center;

(5) any indictment or formal criminal charge, excluding minor traffic violations;

(6) any notice of proposed or actual suspensions, exclusions, or debarment from participation in any federally-funded healthcare program, including but not limited to Medicare and/or Medicaid.

4.3.4 Participation in Quality Assurance, Performance Improvement, Utilization Review and Management, Risk Management, Peer Review, and Credentialing Activities.

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

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

(1) in a reasonable belief that the action was in furtherance of quality care;

(2) after reasonable effort to obtain the facts of the matter;

(3) after adequate notice and hearing procedures are afforded to the Practitioner involved or after such other procedures are fair to the Practitioner under the circumstances; and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts.

4.3.5 Malpractice Insurance Purchase

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

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

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

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

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

4.4 CONDITION AND DURATION OF APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

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

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

(c) All initial appointments to the Medical Staff shall be subject to a provisional period as set forth in Section 4.6 Initial appointment to the Medical Staff shall be for a period of two years, inclusive of any provisional period. Reappointments shall likewise be for two-year periods. The duration of the appointment may be shortened to a period of less than two years if done so as part of the approval of the application for appointment or reappointment.

(d) Applicants shall be assigned to a specific department.

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

(f) In connection with all applications for appointment, reappointment, advancement or transfer, the Applicant shall have the burden of producing information for an adequate evaluation of the Applicant’s qualifications

and suitability for the Clinical Privileges and Medical Staff category requested, or resolving any doubts about these matters, and of satisfying requests for information including external evaluations. The Applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychiatric examination, at the Applicant's expense, if deemed appropriate by the Chair of the department or the Medical Executive Committee which may select the examining physician.

4.5 PROCEDURE FOR INITIAL APPOINTMENT

4.5.1 Application Process

(a) An individual requesting an application for appointment shall be sent a letter that outlines the threshold criteria for appointment and clinical privileges, describes the categories of medical staff membership, explains the review process and copy of the medical staff bylaws and rules and regulations. Prior to receiving the complete application materials, the individual shall acknowledge in writing that he/she meets the threshold criteria for appointment to the Medical Staff.

(b) The appointment process will be initiated for those individuals who meet the threshold criteria. Individuals who fail to meet the threshold criteria will not have their application processed further and shall be so notified.

4.5.2 Submission of Application

(a) The application for Medical Staff appointment shall be submitted by the applicant to the Medical Staff Office , or other designee of the President of the hospital. It must be accompanied by payment of such processing fees as shall be determined from time to time and a current picture hospital ID card or a valid picture ID issued by a state or federal agency, such as a driver's license or passport for identification of the applicant. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chairperson.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. The application review process shall be suspended if the need arises for new, additional or clarifying information anytime during the evaluation. Any application that continues to be suspended for more then sixty (60) days after the applicant has been notified of the need for additional information shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

(c) The Applicant has the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, background, training, demonstrated ability and physical and mental status and resolving any doubt about these or any other qualifications for approval. The applicant shall have the obligation to continuously update his or her application with the most current information available. Failure to so update shall constitute grounds for denial of the application.

4.5.3 Department Chairperson Procedure

(a) The chairperson of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with a written report concerning the applicant's qualifications for the requested clinical privileges. This report shall be appended to the Credentials Committee's report. As part of the process of making this report, the department chairperson has the authority to require the applicant to meet to discuss any aspect of his application, qualifications and requested clinical privileges.

(b) The department chairperson, or the individual within the department to whom the chairperson has assigned this responsibility, shall evaluate the applicant's education, training, experience, conduct, and ability to perform the privileges requested and make inquiries with respect to the same to the applicant's past or current

department chief(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The Department Chairperson will also recommend to the Credentials Committee the nature and scope of proctoring appropriate to the applicant during the provisional period.

(c) The department chairperson shall be available to the Credentials Committee to answer any questions that may be raised with respect to that chairperson's report and findings.

4.5.4 Credentials Committee Procedure

(a) The Credentials Committee Chairperson, or his/her designee, shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

The Credentials Committee shall determine if the completed application is eligible for credentialing approval and advise the Medical Executive Committee of this determination. Applicants will not be considered for credentialing approval or shall be subject to further review under the following conditions:

(1) A reference provides adverse information regarding competency or conduct;

(2) Discrepancies in information are found in the application or references

(3) The applicant has been the subject of professional disciplinary actions or has been sanctioned by legal or professional bodies

(4) The applicant requests clinical privileges outside of the ordinary scope of practice for his/her clinical specialty or training

(5) The applicant has been excluded, suspended or otherwise restricted from participation in Medicare, Medicaid or other third party payor or insurance program

(6) The applicant has had a criminal conviction

(7) The applicant's medical staff membership or clinical privileges have been involuntarily terminated, limited or reduced at another healthcare organization

(8) The number and nature of professional liability actions, judgments or settlements involving the applicant are atypical or excessive

(9) The Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.

(10) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(11) If, after considering the report of the department chairperson, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional appointment and provisional department assignment. All recommendations to appoint must specifically recommend the clinical privileges to be granted, which may be qualified by a probationary or other conditions or restrictions as deemed appropriate by the committee. The Credentials Committee may make this recommendation during their monthly meeting or , in lieu of a meeting, two members of the Credentials Committee may review the

file and make this recommendation to the Medical Executive Committee. Documentation of this recommendation will be in written format signed by both members of the Credentials Committee.

(12) If the recommendation of the Credentials Committee is delayed longer than ninety (90) days from receipt of a completed application, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and, the President of the hospital explaining the reasons for the delay.

4.5.5 Credentials Committee Report

(a) The Credentials Committee shall send its recommendation and written findings to the Medical Executive Committee.

(b) The Chairperson of the Credentials Committee and the completed application and all supporting documentation shall be available to the Medical Executive Committee (and to the Board) to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

4.5.6 Medical Executive Committee Procedure

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee and forward to the Professional Affairs Committee of the Board, applications eligible for credentialing approval; or

(2) Adopt the findings and recommendations of the Credentials Committee for applications not eligible for credentialing approval or who otherwise have limitations placed on their appointment and forward recommendations to the Board of Directors for consideration at the next regularly scheduled meeting; or

(3) Refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(4) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the department chairperson's report and the Credentials Committee's findings and recommendation, through the President of the Medical Staff to the Board. The Board of Directors makes final decision to grant appointment/reappointment and clinical privileges to the applicants.

4.5.7 Board of Directors Procedure

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, Medical Executive Committee, and the Professional Affairs Committee of the Board, the Board of Directors shall:

(1) adopt the findings and recommendation of the Medical Executive Committee and Professional Affairs Committee or

(2) refer the matter back to the Medical Executive Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or,

(3) deny privileges and membership to applicant; or

(b) If the decision of the Board of Directors entitles the applicant to request a hearing pursuant to these bylaws, the President of the hospital shall promptly notify the applicant in writing certified mail, return receipt

requested of the applicant's right to a hearing, the time limit within which a hearing request must be made and where such request shall be delivered.

4.6 APPOINTMENT TO THE MEDICAL STAFF

4.6.1 Initial Appointment.

Initial appointments to any category of the Medical Staff, with the exception of Honorary Staff and Community Affiliate Staff, are provisional and will be for a period of at least one (1) year. A proctor shall be assigned to each member of the Medical Staff on provisional status by the Chairperson of the Department. Prior to the end of this one-year period, the Chairperson of the Department will formally evaluate the clinical performance of the individual based on:

(a) scope of practice;

(b) medical/clinical knowledge

(c) interpersonal skills

(d) communication skills;

(e) professionalism;

(f) the results of quality assessment and improvement activities related to the individual's performance;

(g) utilization of the hospital's resources;

(h) participation in Department and Medical Staff activities;

(i) ethical conduct;

(j) demonstrated compliance with Bylaws, Rules and Regulations;

(k) continuing professional education;

(l) involvement in any professional liability actions, and at a minimum, final judgments or settlements involving the individual;

(m) any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;

(n) current competence and evidence of ability to perform clinical privileges requested;

(o) proctoring reports, if any;

(p) previously successful or currently pending challenges to any professional licensure or registration, or the voluntary relinquishment of such licensure or registration;

(q) voluntary or involuntary relinquishment of any license or registration;

(r) voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital;

(s) documentation as to the applicant's health status;

(t) information provided by a peer of the applicant;

(u) professional performance, judgment, and clinical or technical skills;

(v) behavior and interaction with other physicians, patients and their families, and staff;

(w) relevant practitioner-specific data as compared to aggregate data, when available; and

(x) morbidity and mortality data, when available..

Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

4.7 OBSERVATION OF MEMBERS ON PROVISIONAL STATUS

Provisional members shall undergo a period of observation by a designated proctor as described. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional members shall include but not be limited to, concurrent or retrospective chart review, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the Department Chairperson to the Credentials Committee.

4.8 TERM OF PROVISIONAL STATUS MEMBERSHIP

A member shall remain in the provisional staff for a period of at least 1 year. Provisional status may be extended by the Medical Executive Committee for an additional period of up to 6 months upon a determination of good cause.

4.9 ACTION AT CONCLUSION OF PROVISIONAL STATUS

(a) Upon completion of the term of provisional status, the appropriate Department Chairperson shall advise the Credentials Committee which shall make its report to the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Directors regarding a modification or termination of clinical privileges or staff status.

(b) If the provisional member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for full membership in their staff category, upon recommendation of the Medical Executive Committee and approval by the Board of Directors.

(c) If, after review of the recommendation of the Department Chair and the provisional member's clinical performance, the Credentials Committee recommends modification or termination of clinical privileges or staff membership, the Credentials Committee will make a recommendation to the Medical Executive Committee. In all other cases, the appropriate Department Chair shall advise the Credentials Committee which shall make its report to the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Directors regarding a modification or termination of clinical privileges or termination of medical staff membership.

4.10 PROCEDURE FOR REAPPOINTMENT

All terms, conditions and procedures relating to initial appointment, except for provisional status, shall apply to continued appointment and clinical privileges and to reappointment.

4.10.1 Application

(a) At least 90 days prior to the expiration of a member’s current appointment, the Medical Staff Office shall mail to the member an application for reappointment. Each staff member who is eligible to be reappointed to

the Medical Staff shall be responsible for completing the reappointment application form. The reappointment application shall be submitted to the Medical Staff Office, or other designee of the President of the hospital, at least two (2) months prior to the expiration of the member's current appointment period.

(b) Reappointment, if granted by the Board, shall be for a period of not more than two (2) years, with reappointments staggered in a manner established by the Medical Staff Office.

4.10.2 Department Chairperson Review

(a) The Department Chairperson will assess the following criteria in preparing a recommendation to the Credentials Committee regarding the reappointment of a medical staff member.

(1) current professional licensure from state of Maryland;

(2) hospital activity during the previous appointment term;

(3) ethical behavior, clinical competence and clinical judgment in the treatment of patients, professional performance, technical skill, and documented experience in categories of treatment areas or procedures and results of treatment;

(4) attendance at Medical Staff, department and committee meetings, and participation in staff duties;

(5) compliance with the bylaws, policies and rules and regulations of the Medical Staff and the hospital;

(6) results of performance reviews obtained through the hospital's PI/QA activities;

(7) behavior at the hospital, including cooperation with Medical Staff and hospital personnel as it relates to patient care, the orderly operation of this hospital, interpersonal and communication skills, professionalism, and general attitude toward patients, the hospital and its personnel;

(8) use of the hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;

(9) current physical, mental and emotional health status and evidence of ability to perform clinical privileges requested;

(10) capacity to satisfactorily treat patients as indicated by the results of the hospital's quality assessment activities, organizational PI activities, or other reasonable indicators of continuing qualifications;

(11) satisfactory completion of such continuing education requirements as may be imposed by law, this hospital or applicable accreditation agencies;

(12) current professional liability insurance status and any involvement in a professional liability action,;, and at a minimum, final judgments or settlements involving the individual;

(13) any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;

(14) previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

(15) voluntary or involuntary relinquishment of any license or registration

(16) voluntary or involuntary termination or resignation of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

;

(17) documentation as to the applicant’s health status;

(18) relevant practitioner-specific data as compared to aggregate data, when available; and

(19) morbidity and mortality data, when available..

(20) other reasonable indicators of continuing qualifications;

(21) relevant training or experience, current competence, and ability to perform privileges requested;

(22) information provided by a peer of the applicant,

(23) satisfaction of board certification requirements; and maintenance of certification status (i.e. recertification) of the specialty in which the provider is seeking clinical privileges within 3 years of the expiration date of their certification/recertification.

(b) To be eligible to apply for renewal of clinical privileges an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the department chairperson to assess the applicant's clinical competence. At the request of the Credentials Committee, Medical Executive Committee, department Chairperson, or Chief Executive Officer, the applicant is required to submit any reasonable evidence of current ability to perform privileges that may be requested.

(1) The Medical Staff Office shall submit for review to the Department Chairpersons the completed reappointment applications along with supporting documentation for all staff members with clinical privileges in that department who are being reappointed.

(2) The department chairperson shall provide the Credentials Committee with a written report concerning each individual seeking reappointment. The chairperson shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment. The chairperson of the department concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to the report.

4.10.3 Credentials Committee Procedure

(a) The Credentials Committee, after receiving the reports from each department chairperson, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(b) As part of the process of making its recommendation, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or at anytime during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(c) The Credentials Committee shall have the right to require the individual to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(d) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the individual's qualifications for reappointment.

(e) If, after considering the report of the clinical department chairperson concerned, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by a probationary or other conditions or restrictions, as deemed appropriate by the committee.

4.10.4 Medical Executive Committee Procedure

(a) The Credentials Committee shall forward written findings and recommendations, including the report of the department chairperson, to the Medical Executive Committee. The completed application and all supporting documentation shall accompany the Credentials Committee's findings and recommendation. If the Committee’s recommendation is adverse to the applicant, the reasons for such adverse decision shall be documented in writing and included in the report. The Chairperson of the Credentials Committee and the completed application and all supporting documentation shall be available to the Medical Executive Committee (and to the Board) to answer any questions that may be raised with respect to the recommendation.

(b) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt findings and recommendation of the Credentials Committee and forward to the Professional Affairs Committee of the Board, applications for reappointment, advancement of staff category or change in clinical privileges eligible for expedited credentialing approval;

(2) adopt the findings and recommendations of the Credentials Committee and forward to the Board of Directors its recommendations for reappointment, advancement of staff category or change in clinical privileges for applicants eligible for expedited credentialing approval;

(3) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(4) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation and the report of the department chairperson, through the President of the hospital to the Board.

4.10.5 Board of Directors Procedure

(a) Any recommendation by the Medical Executive Committee that would entitle the applicant for initial appointment, reappointment or clinical privileges to a hearing pursuant to these bylaws shall be forwarded to the President of the hospital who shall promptly notify the affected individual by certified mail, return receipt requested. Adverse decisions on reappointment applications may be subject to fair hearing and appeals process.

(b) In the event the Board determines to modify an action of the Medical Executive Committee and such modification would entitle the individual to a hearing in accordance with these bylaws, it shall notify the affected individual, through the President of the hospital, and shall take no final action until the individual has exercised or has waived the right to a hearing.

4.11 LEAVE OF ABSENCE

4.11.1 Leave Status.

At the discretion of the Medical Executive Committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the

approximate period of leave desired, which may not exceed one year. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive.

4.11.2 Termination of Leave.

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the normal procedure regarding appointment and reappointment will be followed.

4.11.3 Failure to Request Reinstatement.

Failure, without good cause, to request reinstatement in accordance with § 4.9.2 shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. 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.

4.12 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

4.13 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this state or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party which contracts with this hospital.

## ARTICLE 5: CATEGORIES OF THE MEDICAL STAFF

5.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Associate, Community Affiliate, Honorary, Independent Allied Health Professionals and Dependent Allied Health Professionals. At the time of appointment or reappointment, the member's staff category shall be determined.

5.2 Union Hospital's Active, Associate and Community Affiliate Staff shall consist of members who meet the qualifications set forth in Section 4.1.

5.3 ACTIVE STAFF

5.3.1 Qualifications

The Active Category shall consist of physicians of demonstrated competence who are actively engaged in the provision of comprehensive patient care within their specialty.

Members of the Active Staff will serve as proctors for Provisional members of the Medical Staff. Members of the Active Staff will provide emergency department coverage as required in the medical staff rules and regulations.

The prerogatives of a member of the Active Staff shall be to:

(a) Admit patients and exercise such clinical privileges as have been granted; Members of the Active Staff must admit at least 10 patients per year or demonstrate an appropriate level of clinical activity consistent with their specialty;

(b) Attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member;

(c) Hold staff and departmental office;

(d) Provide health care services in an efficient and cost effective manner;

(e) Abide by the Medical Staff Bylaws and Rules and Regulations of the Department to which appointed, and the Rules and Regulations of Union Hospital of Cecil County.

5.4 ASSOCIATE STAFF

5.4.1 Qualifications

The Associate Category shall consist of physicians of demonstrated competence who wish to provide specialized services and/or coverage for a member of the Medical Staff or physicians who have demonstrated little activity at Union Hospital because of duties and responsibilities in another hospital, involvement in public health, occupational medicine, or with a managed care or recognized professional review organization. The Chairperson of a Department, in conjunction with the Credentials Committee, may recommend membership to the Associate Staff for those members of his/her department, with active status, who are unable to exercise the prerogatives of that category during the current appointment year.

Members of the Associate Staff may provide emergency department coverage as required in the rules of their respective department.

The prerogatives of a member of the Associate Staff shall be to:

(a) admit not more than 10 patients per year (20 patients in the 2-year reappointment cycle) nor perform more than 10 procedures or provide more than 10 consultations and/or demonstrate an appropriate level of clinical activity consistent with their specialty as determined by the department chair.

(b) attend staff and department meetings, members of the Associate staff may not vote and may not hold office. Members of the Associate Staff have no committee responsibilities but may serve at the request of the committee chairperson without voting rights.

(c) Provide health care services in an efficient and cost-effective manner.

(d) Abide by the Medical Staff Bylaws and Rules and Regulations of the Department to which appointed, and Rules and Regulations of Union Hospital of Cecil County.

5.5 COMMUNITY AFFILIATE STAFF

5.5.1 Qualifications

The Community Affiliate Staff shall consist of those providers who have an active practice in the community served by Union Hospital and who wish to be members of the medical staff and refer patients to Active members of the Staff but who do not wish to admit or treat patients within the Hospital.

Community Affiliate Staff are expected to meet all of the basic criteria for appointment to the medical staff and are appointed and reappointed in the same manner as other practitioners on the medical staff with the exception of clinical privileges.

The prerogatives of a member of the Community Affiliate Staff:

(a) May not:

(1) admit,

(2) give orders for inpatient care,

(3) make entries in the medical record (except for pre-procedure histories and physicals),

(4) perform surgical or invasive procedures or otherwise treat patients in the Hospital, and

(5) shall not have delineated clinical privileges,

(b) May not hold a Medical Staff or Department Leadership position,

(c) May:

(1) visit and examine patients in the Hospital,

(2) review patient's medical records;

(3) and receive information concerning patients' medical condition and treatment, May perform pre-procedure histories and physical examinations for patients receiving treatment as in-patients or out-patients in the hospital,

(d) May serve on but not chair committees and may not vote,

(e) May attend Medical Staff and Department meetings, but not required to do so and may not vote,

(f) Shall not be required to meet any activity requirements,

(g) Shall be required to pay such dues or fees as may be assessed by the Hospital

(h) Shall not be required to assume care for unassigned patients, or accept emergency call.

Any provider on the Community Affiliate Staff who wishes to apply for Active or Associate Staff membership and clinical privileges, will be required to provide sufficient documentation of hospital activity and a reference who can attest to clinical competence. Providers will be placed on the Provisional Staff as outlined in the Medical Staff Bylaws.

5.6 HONORARY STAFF

5.6.1 Qualifications

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the hospital but are deemed deserving of recognition by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

A staff member may submit a letter of notification of their retirement and request appointment to the Honorary Staff.

Honorary Staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees without

vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and education programs.

5.7 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are patient care providers who are authorized by the Board of Directors to provide patient care services. Allied Health Professionals shall be classified as either independent or dependent professionals. The Board of Directors shall, with the advice of the Medical Staff, determine the specific Allied Health Professional disciplines necessary to meet the needs of the hospital.

An independent Allied Health Professional can, under authority of Maryland State Law and the Board of Directors, provide patient care services independently in the hospital. Independent Allied Health Professions are eligible for membership in the Allied Health Professional Category of the Medical Staff. Dependent Allied Health Professionals are not eligible for membership in the Medical Staff but may be granted clinical privileges to provide services as outlined in the Dependent Allied Health Practitioners Policy.

5.7.1 Independent Allied Health Professionals Qualifications for Membership

The Independent Allied Health Professional Staff shall consist of members who:

(a) Practice in a professional discipline within the scope of services approved by the Board of Directors. (Dentists, Podiatrists, Psychologists, Nurse Practitioners, Nurse Midwives, Optometrists).

(b) Practice independently under authority of Maryland State Law.

(c) Meet the criteria for Medical Staff Membership and clinical privileges as determined by the Medical Staff and Board of Directors.

(d) Provide evidence of professional liability insurance in an amount of at least 1,000,000/3,000,000;

The prerogatives of an Independent Allied Health Professional shall be to:

(a) Retain responsibility within their area of professional competence for the continuous care and supervision of each patient admitted to the hospital for which they are providing services.

(b) Serve on Medical Staff and Hospital Committees. Independent Allied Health Professionals shall be assigned to the clinical department appropriate to their professional training and shall be subject in general to the same terms and conditions as specified for other categories of Medical Staff membership.

(c) Attend meetings of the Medical Staff and the clinical departments to which the Allied Health Professional is assigned.

(d) Exercise such other Prerogatives as shall be accorded, by resolution or written policy duly adopted by the Medical Staff or any of its clinical Departments or Committees and approved by the Medical Executive Committee and the Board, to Allied Health Professionals as a group or to any specified category thereof. Such Prerogatives may include, without limitation, the right to vote on specific matters, to hold defined office, or any other Prerogative for which the Allied Health Professional has the requisite medical education, training, and experience.

(e) Allied Health professionals may not admit patients to the Hospital.

5.7.2 Dependent Allied Health Professionals

The Dependent Allied Health Professional Staff shall consist of practitioners who:

(a) Practice in a professional discipline within the scope of services approved by the Board of Directors. (Scribes, Certified Registered Nurse Anesthetists, and Physician Assistants);

(b) work under the appropriate supervision of a physician with appropriate clinical privileges at Union Hospital;

(c) have a scope of practice approved by the sponsoring physician and the appropriate medical staff department chairperson and/or designee. The scope of practice must specify the duties and responsibilities of the position and requirements for education and training;

(d) Provide evidence of professional liability insurance in an amount of at least 1,000,000/3,000,000;

(e) Exercise such other Prerogatives as shall be accorded, by resolution or written policy duly adopted by the Medical Staff or any of its clinical Departments or Committees and approved by the Medical Executive Committee and the Board, to Allied Health Professionals as a group or to any specified category thereof.

(f) Abide by the Medical Staff Bylaws and Rules and Regulations of Union Hospital of Cecil County and Dependent Allied Health Practitioners Policy.

5.8 PRECEPTEE STAFF

Preceptee Staff are: residents and fellows training in medicine or another health care field that are appointed to the Medical Staff for no longer than six (6) months and work and study under the supervision of a preceptor who is a member of the active Medical Staff, as part of, and in conjunction with an ongoing, approved, training program.

Preceptee staff members may perform only such services as are permitted under the rules and regulations of the Medical Staff.

Preceptees who are participants in an educational program approved by the Maryland Board of Physicians are permitted to practice in Maryland without a Maryland License and are therefore excused from that requirement under these Bylaws so long as their practice is limited to those services as are permitted and approved by the supervising physician.

## ARTICLE 6: DELINEATION OF CLINICAL PRIVILEGES

6.1 GENERAL INFORMATION

Practitioners appointed to the Medical Staff may only practice within the defined clinical privileges granted to them by the Board of Directors. Chairpersons of Departments have the responsibility to recommend to the Medical Executive Committee and the Board of Directors the following:

(a) the scope of services to be provided by the Department;

(b) privilege delineation lists;

(c) criteria for the granting of clinical privileges, including certification specific training and experiences needed to be eligible for specific clinical procedures;

(d) for individual applicants for clinical privileges, departmental Chairpersons have the responsibility to monitor the performance of all practitioners granted defined clinical privileges in their Department and to develop mechanisms to ensure that all practitioners' practices are limited to the defined privileges granted by the Board of Directors.

6.2 DELINEATION OF CLINICAL PRIVILEGES

6.2.1 Mechanism

All medical staff members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital. Each application for appointment and reappointment to the Medical Staff

must be accompanied by a request for specific clinical privileges using a privilege delineation form approved by the Medical Staff. Members of the Medical Staff may request modifications (enhancements or reductions) or termination of privileges at any time in accordance with procedures in Article V.

The medical staff will recommend those clinical services that may be delivered via use of electronic communications (i.e., telemedicine) for the benefit of patient care services for approval through the appropriate process. Practitioners who provide telemedicine services will be required to apply and meet all of the requirements for credentialing and reappointment as outlined in these bylaws.

6.2.2 Criteria for the Delineation of Clinical Privileges

The following criteria shall be used in the delineation of clinical privileges:

(a) the scope of services permitted by Maryland State law and regulations, and by the Board of Directors;

(b) general criteria applied to all applicants, including:

(1) current licensure;

(2) education and training relative to privileges requested;

(3) current documented competence, professional performance, judgment, clinical or technical skills, documented experience in categories of treatment areas or procedures, and results of treatment;

(4) physical ability to perform privileges requested;

(5) current medical malpractice liability insurance coverage in the specialty for which privileges are requested in amounts of coverage as may be required from time to time by the Board of Directors;

(6) information provided by peers, faculty, and data from professional practice review by an organization that currently privileges the applicant;

(7) continuing medical education and related to the performance of requested clinical privileges; and

(8) conclusions drawn from organizational Performance Improvement, Quality Assurance and Risk Management activities.

(c) Departmental-specific criteria will be developed by the department Chairpersons for management of specific, highly complex diseases, performance of new or of technically sophisticated procedures, or the administration of experimental drugs or therapies.

(d) All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital must have delineated clinical privileges, whether or not they are members of the Medical Staff. A supervised clinical practitioner may have a job description and/or delineated clinical privileges as defined by their Delegation Agreement approved by the Maryland State Board.

(e) Each applicant is required to submit any reasonable evidence of current ability to perform privileges that may be requested.

6.2.3 Establishment of Privileges for New Procedures or Expanded Scope of Care

6.2.4 Multi-Service Procedures

All requests for new procedures and/or expanded scope of care and multi-service procedures shall be made in accordance with the Procedure for The Establishment of Privileges, New Procedures,

Expanded Scope of Care and Multi-Service Procedures outlined in the Credentialing Policy and Procedure Manual. (Available in the Medical Staff Office).

6.3 PROVISIONS OF CARE IN EMERGENCY SITUATIONS

6.3.1 Circumstances

For the well being of the patients and community served by the hospital, all categories of staff members may render services within the scope of their professional licenses in bona fide emergency situations.

6.4 TEMPORARY PRIVILEGES

6.4.1 General Information

Temporary privileges shall not be routinely granted to applicants and may be granted only by the Chief Executive Officer of the hospital and his designee upon the recommendation of the President of the Medical Staff or his authorized designee (the applicable clinical department chair).. Temporary privileges are limited to not longer than 120 days.

6.4.2 Circumstances for Requesting Temporary Privileges.

Requests for temporary privileges will only be considered in the following circumstances:

(a) In the case of a circumstance in which privileges are required to fulfill a patient care need, temporary privileges may be granted upon written consent of the practitioner. Types of patient care needs include the need for a practitioner who has a required skill, a required number of practitioners to adequately cover a service, and to provide coverage in the absence of a practitioner. The time limit for privileges will be considered on a case by case basis but will not exceed 60 days. Prior to granting of such privileges, documentation of the patient care need, verification of current licensure, current competency, and National Practitioner Data Bank will be obtained and evaluated.

(b) Upon receipt of a complete application (as defined by the medical staff) for medical staff appointment and a written requests for temporary privileges, temporary privileges may be granted for a period not to exceed 120 days while awaiting approval of the application. To be eligible for temporary privileges, there must be no evidence of current or previously successful challenges to licensure or registration; involuntary termination of medical staff membership at another organization; or involuntary limitation, reduction, denial, or loss of clinical privileges. Prior to granting temporary privileges, verification of the following must be obtained and evaluated:

(1) Current licensure

(2) Relevant training or experience

(3) Current competence

(4) Ability to perform the privileges requested

(5) NPDB query

In addition, the applicant must:

1) have no health concerns regarding the privileges requested

2) have appropriate alternate coverage

3) meet criteria for privileges

4) have adequate professional liability insurance (1/3 million)

5) meet CME requirements

(c) In the event that the hospital activates its Emergency Management Plan and the organization is unable to provide for its immediate patient needs, disaster privileges may be granted to providers as outlined in the policy for "Credentialing Physicians and Allied Health Professionals in a Disaster."

## ARTICLE 7: ORGANIZATION OF THE MEDICAL STAFF

### 7.1 PARTICIPATION IN MEDICAL STAFF ACTIVITIES

Every member of the Medical Staff is encouraged to actively participate in the Medical Staff activities described in this Article and to contribute to ongoing efforts aimed at continuously improving the quality of patient care and of the hospital.

There is a mutual commitment of the Board of Directors, Administration and the Medical Staff to support ongoing education and training to develop leadership abilities enhance skills and advance the scope, range and quality of services provided to the patients served by Union Hospital. In recognition of the time commitment by officers of the Medical Staff, the Medical Staff and Union Hospital will fund honoraria for the President, Vice President and Secretary/Treasurer. The amount of such honoraria shall be determined and approved by the Medical Executive Committee, Administration and Board of Directors.

### 7.2 OFFICERS OF THE MEDICAL STAFF

#### 7.2.1 Leadership Positions

The elected officers of the Medical Staff shall be the:

(a) President;

(b) Vice-President; and

(c) Secretary/Treasurer

### 7.3 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their term of office. Medical Staff Officers and Board Representatives of the medical staff may not serve as medical staff officers or board members of another hospital during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

### 7.4 NOMINATIONS

(a) The medical staff election year shall be on odd numbered medical staff years. A nominating committee consisting of four (4) members shall be appointed by the Medical Executive Committee not later than ninety (90) days prior to the scheduled election of officers or at least thirty (30) days prior to any special election. The President of the Medical Staff shall be the Chairman and shall submit to the Medical Staff Coordinator one or more qualified nominees for each office. The names of such nominees shall be reported to the Medical Executive Committee at least sixty (60) days prior to the election and shall be delivered or mailed to the voting members of the Medical Staff at least thirty (7) days prior to the election if possible. Nominations shall be accepted from the floor on the day of the scheduled election if the nominee is present and accepts.

The Nominating Committee shall, through written ballot, establish that a majority of members of the active staff qualified to vote approve of the assumption of the office of President of the Medical Staff by the Vice President consistent with Section 7.7. In the event that such approval is not obtained, the Vice President will no longer be the

President-Elect and the committee shall submit to the Medical Staff Director the names of one or more nominees for the office of President.

(b) If, before the election, any nominated persons shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit substitute nominees at the medical staff meeting and nominations shall be accepted from the floor if the nominee is present and consents.

7.5 ELECTION

Officers shall be elected in odd numbered years, and shall serve two-year terms commencing the January 1st next following their election. Only Staff members afforded the Prerogative to vote for general Staff officers shall be eligible to vote. Voting shall be by secret written ballot, 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 runoff election shall be held immediately between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

7.6 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the medical staff year following his or her election. Each officer shall serve in his office until the end of the two year term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. An officer is eligible to succeed himself in the same office but not for more than a total of two (2) consecutive terms. At the end of the initial term of the President of the Medical Staff, or the second term should he or she be nominated and then elected to a second term, the Vice-President will automatically assume the office of President for the next two-year term.

7.7 RECALL OF OFFICERS

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect, serious acts of moral turpitude, or misfeasance in office. Recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least 1/3 (one-third) of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a 2/3 (two-thirds) vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

7.8 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of president of the medical staff, the vice president shall serve the remainder of the unexpired term.

7.9 DUTIES OF OFFICERS

7.9.1 President of the Medical Staff.

7.9.2 The President of the Medical Staff shall serve as the Chief Officer of the Medical Staff. The duties of the President of the Medical Staff shall include, but not be limited to:

(a) enforcing the Medial Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance where corrective action has been initiated.

(b) calling, presiding at, and being responsible for the agenda for all meetings of the Medical Staff;

(c) serving as Chairperson of the Medical Executive Committee;

(d) serving as an ex-officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these bylaws;

(e) interacting with the Administrator and Board of Directors in all matters of mutual concern within the hospital;

(f) appointing committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise indicated, designating the Chairs of these committees;

(g) representing the views and policies of the Medical Staff to the Board of Directors and to the Administrator;

(h) serving as spokesperson for the Medical Staff in external professional and public relations;

(i) serving on liaison committees with the Board of Directors and Administration, as well as outside licensing or accreditation agencies;

(j) ensuring that the departmental Chairpersons carry out their duties in accordance with these Bylaws;

(k) presenting and explaining the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board of Directors, President, President of the hospital, and other officials of the Staff.

7.9.3 Vice President of the Medical Staff

The Vice President of the Medical Staff shall assume all duties and authority of the President of the Medical Staff in the absence of the president of the Medical Staff. The Vice President shall be a member of the Medical Executive Committee and shall perform such other duties as the President of the Medical Staff may assign or as may be delegated by these Bylaws, or the Medical Executive Committee. The Vice President will also be the President-elect.

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

(a) receiving and safeguarding all funds of the Medical Staff;

(b) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the President of the Medical Staff or Medical Executive Committee.

7.10 CHAIRPERSON OF THE DEPARTMENT

7.10.1 General Information

The exercise of clinical privileges within any Department is subject to the Rules and Regulations of the Department and to the authority of the Chairperson of the Department. The Chairperson serves several primary functions;

(a) The Chairperson shall be responsible for providing direction for current and future Clinical Services and for ensuring that patients are provided the proper care and service;

(b) The Chairperson shall report the needs of the Department to the Medical Executive Committee and serve as an advocate for his specialty;

(c) The Chairperson shall organize the activities of the Department to ensure compliance with the standards of the Joint Commission, the State of Maryland Department of Health and with these Bylaws of the Medical Staff.

7.10.2 Duties of the Chairperson of the Department

(a) Chairpersons of Departments are responsible for:

(1) all clinically related activities of the department;

(2) all professionally, clinically, and administratively related activities of the department, unless otherwise provided for by the hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who has delineated clinical privileges;

(4) recommending to the medical staff the professional criteria for clinical privileges that are relevant to the care provided in the department;

(5) recommending clinical privileges for each member of the department by evaluating and reviewing the criteria for clinical privileges;

(6) assessing and recommending to the relevant hospital authority off site sources for needed patient care, treatment, and services not provided by the department or the organization;

(7) the integration of the department or service into the primary functions of the organization;

(8) the coordination and integration of interdepartmental and intradepartmental services;

(9) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(10) the recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and service;

(11) the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) the continuous assessment and improvement of the quality of care, treatment, and services provided;

(13) the maintenance of quality control programs, as appropriate;

(14) the orientation and continuing education of all persons in the department or service;

(15) recommendations for space and other resources needed by the department or service;

(16) the development and implementation of programs, in cooperation with the President of the Medical Staff, for patient care quality review; credentials review and privileges delineation, medical education, and clinical resource management;

(17) the enforcement of the hospital and Medical Staff Bylaws, policies and Rules and Regulations in their Department, the initiation of actions to improve patient care, investigate clinical performance or support corrective actions directed at members of his Department.;

(18) the implementation within their Departments of actions taken by the Medical Executive Committee and the Board of Directors;

(19) the performance of such other duties of the office as may from time to time be reasonably requested by the President of the Medical Staff, the Medical Executive Committee, or the Board of Directors.

7.10.3 Duties of Vice Chairperson

Each Vice-Chairman

(1) assumes the responsibilities of the Chairperson in their absence;

(2) performs such duties as may be assigned by the Chairperson.

7.10.4 Qualifications for Appointment as Chairperson and Vice-Chairperson of a Department

(a) Qualifications for Appointment as Chairperson are:

(1) membership in good standing on the active medical staff of the hospital. This membership must be continuous during their term of office. Failure to maintain active medical staff membership will result in immediate termination of status as Department Chair;

(2) board certification by an appropriate board of the specialty in which the provider is seeking clinical privileges within five (5) years of initial appointment date and maintenance of certification status (i.e. recertification) of the specialty in which the provider is seeking clinical privileges within 3 years of the expiration date of their certification/recertification. Certification by an appropriate specialty board or affirmatively established comparable competence through the credentialing process.

(3) maintenance of an active clinical practice at the hospital;

(4) willingness to faithfully discharge the duties and responsibilities of the position;

(5) constructive past participation in medical staff affairs, including performance improvement and peer review activities;

(6) a Department Chair may not serve as a medical staff or corporate officer, department chair, credentials committee chair at another hospital during the term of his office.

(b) Qualifications for Appointment as Vice-Chairperson generally include:

(1) membership on the active Medical Staff.

(2) demonstrated commitment to the hospital and Medical Staff evidenced by consistent participation at Department meetings and other assigned committees and exemplary personal conduct.

7.10.5 Selection

Each Chairperson and Vice-Chairperson of each Department shall be elected for a two year term by ballot by Active and Provisional members with primary membership in the Department, subject to the approval of the Board of Directors. Election of Chairpersons and Vice-Chairpersons will be held no less than one month prior to the end of the current term. All ballots must be signed. In case of a tie, the President of the Medical Staff, in consultation with the Medical Executive Committee, will break the tie.

Voting by proxy for departmental officers will not be allowed unless such a policy is specifically adopted in departmental rules and regulations.

7.10.6 Term of Office

7.10.7 Each elected Chairperson and Vice-Chairperson shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that Department. After election, removal of Department Chairpersons and Vice-Chairperson from office may occur for cause by a 2/3 (two-thirds) votes of the Medical Executive Committee or a 2/3 (two-thirds) vote of the Department members eligible to vote on Departmental matters.

7.10.8 The Medical Staff shall be entitled to have two (2) of its members sit as directors on the Board of Directors of Union Hospital of Cecil County Health Systems, Inc. (the "Parent Board")

7.11 CONTRACTED SERVICES AND APPOINTMENTS

7.11.1 CONTRACTED SERVICES

When a physician or other individual eligible for delineated clinical privileges are engaged by the hospital to provide patient care services pursuant to a contract, their clinical privileges to admit or treat patients are as defined as provided through these Bylaws. The administrative duties or position of a medical-administrative person shall be governed by the contract, job description, or agreement between the hospital and any such person. Individual with administrative positions that desire membership and/or clinical privileges are subject to the same procedures as all other applicants.

7.11.2 CONTRACTUAL APPOINTMENT.

If the Board of Directors negotiates and executes a written contract with the chair of any clinical department, the terms of the written contract supersede the provisions of these Bylaws. Regardless of such written contract, the Medical Executive Committee reserves the right to ratify or refuse to ratify the chairmanship. If the Committee does not ratify the chairmanship, then the Board of Directors will take alternative action. Directors will take action to rectify the situation.

7.11.3 MEDICAL DIRECTOR

The Medical Director of a clinical department shall be responsible for the administrative responsibilities of the department as governed by his/her contract or agreement with the Hospital. The clinical privileges of a Medical Director shall be defined as provided through these Bylaws. The Medical Director shall be accountable to the President or his designee for the performance of his/her administrative duties.

7.12 Term of Office

The Medical Director of a clinical department shall serve for such term as is described in his contract or agreements with the Hospital, unless he shall resign, lose his medical staff membership or have his clinical privileges revoked in the department that he directs.

If the terms of any contract provide that the medical staff appointment and/or clinical privileges of any physician or other practitioner subject to the contract are incident to and/or coterminous with the contract or the individual's association with the group holding the contract, such contractual provisions shall control, notwithstanding the fact that such contractual provisions may be inconsistent with any provision of the medical staff bylaws.

## ARTICLE 8: CLINICAL DEPARTMENTS

8.1 GENERAL

The clinical activities of the Medical Staff shall be performed within specific Departments. Each Department shall have a Chairperson and Vice-Chairperson as outlined in Article VII.

A Department may be further divided, as appropriate, into sections which shall be directly responsible to the Department within which it functions, and which shall have a Section Chairperson selected to assist the Chairperson in the duties and responsibilities specified in Section VI. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification, or combination of Departments or sections.

## 8.2 DESIGNATION OF DEPARTMENT AND SECTIONS

Effective with the implementation of these Bylaws, the Clinical Departments and Sections are designated as follows:

- Department of Anesthesiology
- Department of Emergency Medicine
- Department of Family Practice
- Department of Hospitalists
- Department of Medicine
  - Allergy/Immunology Section
  - Cardiology Section
  - Dermatology Section
  - Endocrinology Section
  - Gastroenterology Section
  - Hematology/Oncology Section
  - Infectious Diseases Section
  - Internal Medicine Section
  - Nephrology Section
  - Neurology Section
  - Physiatry Section (Physical and Rehabilitative Medicine)
  - Psychiatry Section
  - Psychology Section
  - Pulmonary Medicine Section
  - Radiation Oncology Section
  - Rheumatology Section
- Department of OB/GYN
  - Endocrinology
  - Infertility/Reproductive Section
  - Maternal/Fetal Medicine Section
  - Perinatology Section
- Department of Pathology
- Department of Pediatrics
  - Allergy/Immunology Section
  - Cardiology Section
  - Endocrinology Section
  - General Pediatrics Section
  - Pediatric Hospitalists Section
  - Neonatology Section
  - Nephrology Section
- Department of Radiology
  - Teleradiology
- Department of Surgery
  - Dentistry Section
  - General Surgery Section
  - Hand Section
  - Neurosurgery Section
  - Ophthalmology Section
  - Oral/Maxillofacial Section
  - Orthopedics Section

Otolaryngology Section
Plastic and Reconstructive Section
Podiatry Section
Thoracic Section
Vascular Section
Urology Section

8.3 ASSIGNMENT TO DEPARTMENT

Each member of the Staff and each Independent Allied Health Professional shall have primary membership in one (1) department and may have secondary membership in another department and may be granted clinical privileges or the privilege to perform specified services in one (1) or more other Departments.

8.4 FUNCTIONS OF DEPARTMENTS

The general functions of each Department shall include:

(a) conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. The Department shall routinely collect information about important aspects of patient care, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the member whose work is subject to such review is a member of that Department;

(b) conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

(c) reviewing and evaluating department adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice;

(d) submitting written reports to the Medical Executive Committee concerning recommendations for maintaining and improving quality of care provided in the Department and the hospital;

(e) meeting at least quarterly or as required for review of patient care and performance improvement activities and the conduct of other department business;

(f) appointing such committees as may be necessary or appropriate to conduct Department functions; and

(g) formulating recommendations for Departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and Board of Directors.

## ARTICLE 9: COMMITTEES OF THE MEDICAL STAFF

9.1 GENERAL

The Medical Staff has established standing committees in order to augment the clinical Department's activities and to assist the officers of the Medical Staff in fulfilling the self-governance responsibilities of the Medical Staff. In addition to standing committees, the President of the Medical Staff acting with the consent of the Medical Executive Committee may establish ad hoc committees or task forces to address specific issues. Unless otherwise specified, the Chair and members of all committees shall be appointed by and may be removed by the President of the Medical Staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee.

## 9.2 MEDICAL EXECUTIVE COMMITTEE

### 9.2.1 Composition

The Medical Executive Committee shall consist of the elected officers of the Medical Staff, the Chairpersons of the Departments, the Chief Executive Officer of the hospital (or his designee), and VPMA. The President of the hospital and the VPMA are ex-officio without voting rights. All members of the Medical Executive Committee must be active members practicing in the hospital. All Active members are eligible regardless of professional discipline or specialty. The Medical Executive Committee includes physicians and may include other licensed independent practitioners. The majority of voting Medical Executive Committee members shall be fully licensed physicians actively practicing in the hospital. The Chair of the Committee has the authority to invite special guests to the Medical Executive Committee for specific issues without voting rights.

The structure and function of the Medical Executive Committee shall conform to the Medical Staff Bylaws. The Medical Executive Committee acts on behalf of the medical staff between Medical Staff meetings.

### 9.2.2 Meetings

The Medical Executive Committee shall meet monthly, and shall maintain a permanent record of its proceedings.

### 9.2.3 Duties

The Medical Executive Committee shall have the authority and empowerment, and shall be charged with the responsibility to:

(a) receive and act on reports and recommendations from the Medical Staff departments and subsections, Medical Staff and joint Medical Staff organization committees, Medical Staff officers, and other assigned activity groups;

(b) review and make recommendations on quality assurance activities of departments, subsections, and committees

(c) coordinate activities and policies of the Medical Staff, its departments, and committees;

(d) review all rules, regulations, or bylaws proposed by any Medical Staff department or committee and make recommendations to the Governing Board for their approval or disapproval;

(e) make recommendations directly to the Board of Directors on all matters relating to medical staff structure; medical staff membership; appointments; reappointments; staff categories; department and department requirements; delineation and review of clinical privileges; specified services; corrective action, including termination, suspension, or modification of the clinical privileges of any medical staff member; the mechanism used to review credentials and to delineate individual clinical privileges; and the mechanism for fair hearing procedures, and participation of the medical staff in organizational performance improvement activities;

(f) account to the Board for the overall quality, appropriateness, efficiency, and effectiveness of the clinical care rendered to patients in the organization by members of the Medical Staff;

(g) pursue corrective action in accordance with medical Staff Bylaws;

(h) resolve disputes between clinical department chairpersons or section chairperson, when necessary and possible;

(i) make recommendations to Administration and the Board on medico-administrative matters and hospital operations;

(j) participate in identifying community health needs and setting organizational goals, and in establishing plans and programs to meet those needs;

(k) assist the organization in maintaining its accreditation status, and inform the medical staff on issues regarding accreditation and requirements of local, state, and federal regulations; and

(l) represent and act on behalf of the Medical Staff subject to medical staff and organization bylaws;

(m) reviews and acts on reports of medical staff committees, departments, and other assigned activity groups;

(n) act for the Medical Staff as a whole in the intervals between the Medical Staff meetings.

9.2.4 Quorum

The presence of 1/3 of the voting members (4 members) constitutes a quorum.

9.3 STANDING COMMITTEES

The standing committees of the Medical Staff are:

(a) CME/Library Committee;

(b) Cancer Committee

(c) Critical Care Committee;

(d) Credentials/Bylaws Committee;

(e) Bio-Ethics/ Committee;

(f) Infection Control Committee;

(g) Medical Executive Committee;

(h) Performance Improvement Committee

(i) Medical Staff Quality Oversight Committee

(j) Pharmacy and Therapeutics Committee

9.3.2 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. Members may serve more than one term.

9.3.3 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the President of the Medical Staff subject to consultation and approval by the Medical Executive Committee. In the event that the President of the Medical Staff fails to take such action, a two-thirds vote of the Medical Executive Committee will be required.

### 9.3.4 Vacancy

A vacancy on a Medical Staff Committee is filled in the manner in which the original appointment was made.

### 9.3.5 Voting

All assigned members from the Medical Staff with voting privileges shall participate in committee decisions and votes. Administrative representatives shall not vote.

## 9.4 MEDICAL STAFF MEETINGS

### 9.4.1 Time of Meetings

Regular meetings of the Medical Staff are held monthly. The January Meeting is considered the Annual Meeting. The Medical Executive Committee may authorize additional Medical Staff meetings by resolution. The resolution authorizing any such additional meeting requires notice to all Medical Staff members specifying the place, date and time for the meeting, and specifying that the meeting can transact any business that may come before it. Special meetings of the Medical Staff for a specific purpose may be called at any time by the Board of Directors, the President of the Medical Staff, or not less than ten percent (10%) of the members of the Active Staff, and be held at the time and place designated in the meeting Notice. No business shall be transacted at any special meeting except for the business mentioned in the meeting notice.

### 9.4.2 Notice of Meetings

A written or printed notice stating the place, day and hour of any general staff meeting or any special meeting not held as the result of a resolution shall be distributed to each person entitled to be present thereat not less than seven ((5) days before the date of such meeting.

### 9.4.3 Quorum

The presence of one third (1/3) of the members of the Active Medical Staff at any regular or special meeting constitutes a quorum.

### 9.4.4 Minutes

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

### 9.4.5 Attendance Requirements

All members of the Medical Staff subject to provisions under Article III are encouraged to attend all general meetings of the Medical Staff. Active and Associate members should attend at least one-third (33%) of all general Medical Staff meetings duly convened according to these Bylaws. The Medical Staff attendance year is defined as January 1 through December 31.

## 9.5 COMMITTEE AND DEPARTMENT MEETINGS

### 9.5.1 Time of Meetings

The time for regular meetings may be decided upon by resolution in committee and department meetings, and no notice other than such resolution shall be required. A special meeting of any committee or department may be called by, or at the request of, the chairperson thereof, the Board of Directors, the President of the Medical Staff, or by one-third (1/3) of the group's current members. A written notice to all members of the group shall announce the meeting. No business shall be transacted at any special meeting except for the business mentioned in the meeting notice.

#### 9.5.2 Notice of Meetings

A written or printed notice stating the place, day and hour of any regular committee or department meeting not held as the result of a resolution shall be distributed to each person entitled to be present thereat not less than five (5) days before the date of such meeting.

#### 9.5.3 Quorum

A quorum shall consist of one-third (1/3) of the voting members of a committee or department.

#### 9.5.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference.

#### 9.5.5 Minutes

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

#### 9.5.6 Attendance Requirements

All members of the Medical Staff are strongly encouraged to attend committee and department meetings. Members of the Medical Executive Committee and Credentials Committee are required to attend at least 50% of meetings.

## ARTICLE 10: QUESTIONS OF CLINICAL COMPETENCY AND CONDUCT

The provisions of this Article 10 shall not apply to routine inquiries and informal peer review, such as departmental review and discussion of cases handled by departmental members, requests for further information from various departments. Rather, the provisions of this Article shall be used when a more serious question has been raised regarding a Practitioner’s conduct, performance or competence while at the Hospital.

This process is adjunctive to and not in conflict with the role of the Medical Staff Quality Oversight Committee as set forth on the Medical Staff Quality Oversight Committee Plan.

### 10.1 CRITERIA FOR INITIATION

Routine evaluation of clinical competency and conduct shall be taken against a staff member whenever his activities or professional conduct are considered to be lower than professional standards, detrimental to patient safety or to the delivery of efficient and quality patient care, not in compliance with staff bylaws or hospital policies, or disruptive to hospital or staff operations. The Medical Executive Committee requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.

### 10.2 INITIATION OF EVALUATION OF CLINICAL COMPETENCY AND CONDUCT

The prerogative to initiate evaluation of clinical competency and conduct is limited to the members of the Medical Executive Committee. Any person may provide information leading to an evaluation of a practitioner's clinical

competency and conduct. A request for an investigation must be in writing and supported by references to specific activities or conduct.

10.3 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted it shall direct an investigation to be undertaken. The affected Practitioner shall be notified by certified mail, return receipt requested of the Medical Executive Committee's determination that an investigation will be undertaken. The term investigation means the process specifically initiated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the medical staff. Commencement of an investigation shall be documented in the records and proceedings of the Medical Executive Committee. The Medical Executive Committee may conduct the investigation itself or assign the task to an appropriate medical staff officer or ad hoc committee of the medical staff. At its discretion, the Medical Executive Committee may appoint practitioners who are not members of the medical staff to such an ad hoc committee for the sole purpose of assisting in an investigation.

10.4 DETERMINING WHETHER ADEQUATE GROUNDS FOR EVALUATION EXIST

The investigating committee shall not be limited to the examination of any particular incident or event or to just incidents or events occurring within the hospital. The practitioner shall not be entitled to be present during the investigation or during interviews with any witnesses. The practitioner for whom investigation has been requested shall have an opportunity to appear before the investigating committee in the course of its investigation. At such appearance the practitioner shall be invited to provide information about any matters being considered by the investigating committee. The appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rights of review shall apply. The practitioner may not be accompanied by an attorney or other individual. The investigating committee shall conduct its proceeding in a timely manner and shall make its report to the Medical Executive Committee as soon as is practicable and minutes of the appearance of the affected practitioner prepared by the committee shall be included with its report.

Despite the status of any investigation, the Medical Executive Committee shall retain authority to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

10.5 INITIATION OF INVESTIGATION BY BOARD OF DIRECTORS

If the Medical Executive Committee fails to investigate or take action contrary to the weight of evidence, the Board of Directors may direct the Medical Executive Committee to initiate such an investigation or disciplinary action. Such board action shall be taken only after consultation with the medical executive committee. If the Medical Executive Committee fails to take action in response to the Board of Directors, the Board of Directors may initiate corrective action in compliance with these medical staff bylaws.

10.6 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practical, after the conclusion of the investigation, the Medical Executive Committee shall take action, which may include:

(a) Issuing letters of censure, reprimand or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the members credentials file.

(b) Recommending the imposition of terms of probation or special limitations upon continued medical staff membership or clinical privileges. Such measures may include without limitation, a requirement for mandatory consultation or the requirement for co-admission or monitoring by another member of the medical staff.

(c) Recommending reduction, modification, suspension, or revocation of clinical privileges.

(d) Recommending suspension, revocation, or probation of medical staff membership.

(e) Deferring action of a reasonable time where circumstances warrant.

(f) If the Medical Executive Committee determines there was no credible evidence for the complaint, no corrective action shall be taken, and any adverse information shall be removed from the members credentials file.

Recommendations by the Medical Executive Committee shall be transmitted to the Board of Directors.

10.7 SUMMARY SUSPENSION

10.7.1 Criteria for Initiation

Emergency corrective action may be imposed on a staff member effective immediately whenever failure to do so may result in imminent danger to the health or safety of any person, or to the orderly operation of the hospital. Any of the following individuals acting to further the peer review function of the hospital may impose emergency corrective action by suspending all or any portion of a practitioners clinical privileges.

(a) the President of the Medical Staff on behalf of the Medical Executive Committee;

(b) the Chairman of the practitioner's clinical department on behalf of the department;

(c) the Chief Executive Officer or Chairman of the Board of Directors on behalf of the Board of Directors.

Such summary restriction or suspension shall become effective immediately upon imposition. The person or body responsible for the summary suspension shall promptly give written notice to the President of the Medical Staff, the Chairperson of the Credentials Committee, and the Chief Executive Officer, admissions office and the surgical posting staff. The affected medical staff member shall be provided with a written notice of the action in compliance with the section below. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the member’s patients shall be assigned to another member by the appropriate departmental chairperson or by the President of the Medical Staff.

10.7.2 Written Notice of Suspension

Within one working day of imposition of a precautionary suspension, the affected staff member shall be provided with written notice of such suspension. This written notice shall include a statement of facts demonstrating the necessity of the immediate suspension or restriction of the practitioners' privileges. A summary of one or more particular incidents giving rise to the assessment of imminent danger shall be included in the statement of facts.

10.7.3 Medical Executive Committee Action

Within a reasonable period of time, after the imposition of a precautionary restriction or suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action. If such a meeting is delayed, the reasons for such delay shall be transmitted to the Board of Directors so that the Board may consider whether the suspension should be lifted. Upon request the affected staff member may attend and make a statement concerning the issues under investigation on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee constitute a hearing. The Medical Executive Committee may modify, continue, or terminate the precautionary restriction or suspension. It shall furnish the affected member with notice of its decision within 2 working days of the meeting. If the suspension will be in effect for more than fourteen days (14), the precautionary suspension action will be referred to the Board of Directors to determine if suspension should be lifted or continued.

It shall be the duty of all Medical Staff members to cooperate with the President of the Medical Staff, the department chairperson concerned, the Credentials and Medical Executive Committees and President of the hospital in enforcing all suspensions.

10.8 AUTOMATIC RELINQUISHMENT

Occurrence of any of the following events shall result in voluntary relinquishment of clinical privileges effective immediately as specified below.

(a) Loss of professional license. If a practitioner's professional license is revoked or suspended, the practitioners' clinical privileges and staff appointment are terminated. If a practitioner's professional license is limited or restricted, any clinical privileges within the scope of the limitation or restriction are similarly limited or restricted for the term of the license limitation.

(b) Loss of controlled substances registration. Whenever a practitioner's authority to prescribe controlled substances is revoked or limited for a period of time, his clinical privileges to prescribe control substances shall be similarly revoked or limited for the same period of time.

(c) Loss of professional liability insurance. Whenever a practitioner fails to maintain professional liability insurance as required by these bylaws, all clinical privileges shall be suspended immediately. If insurance is not reinstated within 30 days, staff appointment shall terminate.

(d) conviction of a felony will result in loss of appointment and cancellation of privileges.

(e) refusal to respond to a formal request by the Credentials or Medical Executive Committee for information regarding disciplinary or malpractice actions taken or pending against a practitioner will result in loss of appointment and cancellation of privileges.

(f) refusal to undergo a physical examination or drug screening when requested by the Medical Executive Committee for their evaluation of clinical competence or conduct of as part of its credentialing and peer review activities.

(g) revocation restriction or involuntary surrender of a physician's participation in Medicare, Medicaid or any other state or federal health care benefit programs.

A practitioner subject to automatic corrective action shall not be entitled to any procedural rights or review pursuant to these bylaws or otherwise.

## ARTICLE 11: HEARINGS AND APPELLATE REVIEWS

### 11.1 GROUNDS FOR A HEARING

Except as qualified below and provided no prior right to a hearing existed, only the following recommendations or actions taken by the Medical Executive Committee or the governing body are adverse and constitute grounds for a hearing.

(a) Denial of staff appointment or reappointment.

(b) Suspension or termination of staff appointment.

(c) Denial of requested staff category.

(d) Reduction in staff category.

(e) Failure to advance from provisional status.

(f) Denial of requested clinical privileges.

(g) Reduction, suspension, revision, or revocation of clinical privileges.

(h) Imposition of a consultation or concurrent supervision requirement except during a provisional period.

11.1.2 Recommended adverse actions described in this section shall become final only after the hearing process set forth in these bylaws have been exhausted or waived. The following recommendations or actions and any other specifically set forth in the bylaws shall not entitle a practitioner to any procedural rights of review:

(a) Failure to process an application because it is incomplete or because required information has not been provided.

(b) Expiration of appointment for failure to timely reapply or submit completed request for reappointment.

(c) Failure to be considered for advancement from provisional status because of insufficient use of the hospital.

(d) Termination of appointment or clinical privileges pursuant to a contractual agreement with the hospital.

(e) Voluntary relinquishment of clinical privileges.

(f) Imposition of any conditions on the exercise of temporary privileges.

(g) Termination of emergency privileges.

(h) Issuance of a warning or letter of reprimand.

(i) Precautionary suspension.

(j) Removal from elected staff office, section chairmanship, or committee appointment.

11.1.3Notice of Right to Hearing

Practitioner against whom an adverse recommendation has been issued shall be given special written notice in writing by the Chief Executive Officer within 15 days of the recommendation. Such notice shall:

(a) Advise the practitioner of the adverse recommendation, which shall include a statement of the reasons for the proposed action and a listing of any patient records in issue.

(b) Advise the practitioner of his right to a hearing and that a written request for such a hearing must be received by the Chief Executive Officer by certified mail within 30 days of receipt of the notice.

(c) State that failure to request a hearing within the specified time period shall constitute a waiver of any rights to a hearing, appellate review, or any other review of the matter.

(d) State that upon receipt of the practitioners request for a hearing in the manner specified, the Chief Executive Officer will notify the practitioner of the date, time and place of the hearing.

**11.1.4**Notice of Hearing

Within 30 days after receipt of a request for a hearing, the Chief Executive Officer shall schedule or arrange for such a hearing and shall notify the practitioner of the date, time and place of the hearing. Notice shall include a list of witnesses expected to testify in support of the adverse recommendation. The notice shall also advise the practitioner that at least 15 days before the hearing, the practitioner shall be required to forward to the Chief Executive Officer, a written list of witnesses the practitioner expects to present to testify against the adverse recommendation. The practitioner is responsible for arranging for the attendance of his witnesses. The practitioner shall be afforded access to relevant medical records and shall be given the opportunity to copy the records upon request. The chief executive officer shall rule on other requests for access to information by the practitioner.

11.1.5Hearing Committee

When a hearing is requested the Medical Executive Committee shall recommend a hearing panel to the Board of Directors for appointment. The Directors shall be deemed to approve the selection, unless it provides written notice to the Chief Executive Officer of its objection within 5 days. The hearing committee shall be composed of not less than 5 members of the active Medical Staff. Practitioners who have participated in the initiation of a complaint will not be eligible to sit on the hearing panel evaluating the complaint. If necessary, the President of the hospital may appoint members from other staff categories or non-staff practitioners to serve on the Hearing Committee. The Board of Directors upon recommendation of the CEO, shall appoint a hearing officer who may or may not be an attorney but must be experienced in conducting hearings. He or she shall act as the presiding officer, may participate in the deliberation, act as legal advisor but shall not be entitled to vote.

11.1.6
Failure to Appear or Proceed

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

## 11.2 HEARING PROCEDURE

The representative of the body issuing the adverse recommendation shall first present any evidence in support of the recommendation. The Hearing Committee and practitioner shall question the representatives and other witnesses. The practitioner or his representative shall then present any evidence against the recommendation and shall have the burden of proof to persuade the Hearing Committee that there is not sufficient evidence to support an adverse recommendation or that an adverse recommendation would be unreasonable, arbitrary, capricious, or discriminatory. The Hearing Committee and the body's representative may question the practitioner and any witnesses.

### 11.2.1 Pre-Hearing Conference

Counsel for the affected physician and counsel for the hearing committee must attend a pre-hearing conference to resolve all procedural issues in advance of the hearing. Both parties must present all documentary evidence to be submitted at the hearing and must resolve any objections to documents at this time. Evidence unrelated to the reasons for the adverse recommendation and any documentation not provided and agreed upon in advance of the hearing can be excluded by the presiding officer.

### 11.2.2 Record of the Hearing

A court reporter selected by the hospital shall make a record of the hearing. The cost of the attendance of the reporter will be born by the hospital but the cost of obtaining a cost of the transcript shall be born by the requesting party.

### 11.2.3 Representation by an Attorney

The practitioner shall be entitled to be accompanied by and represented at the hearing by an individual of the practitioner's choice. The practitioner must provide the President of the hospital with the name of his representative at least fifteen (15) days prior to the hearing. The body whose adverse recommendation initiated the hearing shall also be entitled to be represented by an attorney at the hearing.

### 11.2.4 Presentation of Evidence and Right to Cross Examination

The hearing or presiding officer shall provide participants in the hearing with a reasonable opportunity to present relevant oral and documentary evidence in an efficient and expeditious manner and shall maintain proper decorum. The hearing or presiding officer shall be entitled to determine the order in procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that arise during the hearing.

## 11.3 HEARING COMMITTEE RECOMMENDATIONS

### 11.3.1 Deliberations and Adjournment

The hearing committee shall at a convenient time conduct deliberations outside the presence of the parties and court reporter. The committee shall recommend rejection, affirmation, or modification of the adverse recommendation. The affirmative vote of a majority of members of the hearing committee is required for any recommendation. Upon conclusion of all deliberations, the hearing shall be declared adjourned.

11.3.2 Recommendation

Within 15 days after adjournment of a hearing, the hearing committee shall issue its written recommendation including a statement of its findings and the basis for its recommendation. All recommendations, together with the hearing record and all other documentation shall be forwarded to the President of the hospital.

11.3.3 Notice and Further Action

The President of the hospital shall notify the practitioner of the hearing committee's recommendation.

11.4 INITIATION AND SCOPE OF APPELLATE REVIEW

(a) An Appellate Review shall be limited in scope exclusively as to the following issues:

(1) Whether the procedures set forth in the Medical Staff Bylaws regarding the hearing and any subsequent review were substantially complied with; and

(2) Whether based on the evidence in the record, the adverse recommendation is unreasonable, arbitrary, capricious, discriminatory, or without basis.

(b) Requests for appellate review must be forwarded to the President of the hospital within 10 days of notification of the affected practitioner of the recommendation of the hearing panel. An appellate review committee shall be appointed by the Medical Executive Committee. The committee shall consist of three members of the active medical staff. Members of the Hearing Committee issuing the adverse recommendations under appeal shall not serve on the appellate review committee.

11.5 PROCEDURE FOR APPELLATE REVIEW

The proceedings shall be based upon the record of the hearing, the hearing committee's recommendation, any written statements submitted, and such other material that may be accepted by the appellate review committee. New or additional matters not raised during the original hearing shall only be introduced at the discretion of the appellate review committee.

11.5.1 Statements

The appellate review committee may allow the practitioner and a representative of the hearing committee that issued the adverse recommendation to personally appear and make brief oral statements. Parties appearing may not be accompanied by legal counsel.

11.5.2 Final Decision

The recommendation of the appellate review committee shall be forwarded to the Board of Directors. Within seven (7) days after receiving the appellate review committee's recommendation, the Board of Directors shall review the matter and issue a final written decision. The CEO shall send a copy of the Board of Director's final decision to the practitioner by certified mail.

## ARTICLE 12: CONFIDENTIALITY OF INFORMATION

12.1 GENERAL

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, or of the evaluation of the compliance or conduct of any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential.

## 12.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

## 12.3 IMMUNITY OF LIABILITY

### 12.3.1 For Action Taken

Each representative of the medical staff and hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

### 12.3.2 For Providing Information

Each representative of the medical staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

## 12.4 ACTIVITIES AND INFORMATION COVERED

### 12.4.1 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 hospital activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization review;

(e) other department, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) National Practitioner Data Bank queries and reports, peer review organizations, and similar reports.

### 12.4.2 Releases

Each applicant or member shall, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

# ARTICLE 13: GENERAL PROVISIONS

## 13.1 RULES AND REGULATIONS

The medical staff shall initiate and adopt such rules and regulations, as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules and regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the medical staff as a whole under such review or approval mechanism as the medical staff shall establish. Following adoption such rules and regulations shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably or automatically within 60 days if no action plan is taken by the Board of Directors. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations. Neither the Medical Staff nor Board of Directors may unilaterally amend the Medical Staff Rules and Regulations, or the medical staff bylaws.

## 13.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

## 13.3 CONSTRUCTION OF TERMS AND HEADINGS

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

## 13.4 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

## 13.5 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff, or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of department or committee
(c/o Medical Staff Office)
Union Hospital
106 Bow Street
Elkton, MD 21921

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

## 13.6 DISCLOSURE OF INTEREST

All nominees for election or appointment to the medical staff offices, department chairships, or the Medical Executive Committee shall, at least (20) days prior to the election or appointment, disclose in writing to the Medical

Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff or the hospital.

## 13.7 CONFIDENTIALITY

The following applies to records of the medical staff and its Committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and departmental chairpersons, Chief Executive Officer, Board of Directors, and committees of the medical staff for the sole purpose of discharging medical staff and hospital responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the Board of Directors of the hospital or its appointed representatives – in order that the Board of Directors may discharge its lawful obligations and responsibilities – shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the President of the medical staff or hospital, his written authorization, and notice to the member.

(e) A medical staff member shall be granted access to his/her own credentials file, subject to the following provisions:

(1) timely notice of such shall be made by the member to the President of the medical staff or his/her designee;

(2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information – including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the chairperson of the Credentials Committee, within a reasonable period of time. Such summary shall disclose the substance, but not the source, of the information summarized;

(3) the review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.

## 13.8 MEMBERS' OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his/her file as provided under Section (e) he/she may address to the president of the medical staff written request for correction or deletion of information in his/her credentials file. Such request shall include a statement of the basis for the action requested.

(b) The president of the medical staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

(d) In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

# ARTICLE 14: ADOPTION AND AMENDMENT OF BYLAWS

## 14.1 PROCEDURE

Upon the request of the president of the medical staff, the Medical Executive Committee, the credentials/bylaws committee, or upon timely written petition signed by at least (10%) of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws. Such action shall be taken at a regular or special meeting provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

## 14.2 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of (51%) of the members voting in person or by written ballot.

## 14.3 APPROVAL

Bylaw changes adopted by the medical staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably, or automatically within (60) days if no action is taken by the Board of Directors. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the president of the medical staff, the medical executive and bylaws committee.

Medical Staff Bylaws and Rules and Regulations are adopted by the Medical Staff and approved by the Board of Directors before becoming effective. The Board of Directors and Medical Staff enforce and comply with these Medical Staff Bylaws. Neither body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. An annual review of the Medical Staff Bylaws must be performed. Approved bylaws and rules and regulations are submitted and distributed to the Medical Staff annually.

## 14.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

## 14.5 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the Board of Directors of any successor in interest in this hospital, except where hospital medical staffs are being combined.

Revisions, review and approvals:
Revised 1/28/94
Reviewed 3/11/94 Credentials Committee
Reviewed 4/5/94 Medical Staff
Reviewed and approved 5/3/94 Medical Staff
Reviewed and approved 5/17/94 MEC
Reviewed and approved 5/25/94 Board of Directors
Reviewed and approved 5/12/95 Credentials Committee
Reviewed and approved 5/16/95 MEC
Reviewed and approved 7/11/95 Medical Staff
Reviewed and approved 7/18/94 MEC
Reviewed and approved 7/26/95 Board of Directors

Reviewed and approved 9/5/95 Medical Staff
Reviewed and approved 9/19/95 MEC
Reviewed and approved 9/28/95 Board of Directors
Reviewed and revised – (See Credentials Minutes for February, 1997) 2/14/97
Reviewed 3/4/97 Medical Staff (See Medical Staff Minutes)
Reviewed and approved 3/27/97 Board of Directors (See Board of Directors Minutes)
Reviewed and revised 6/97
Reviewed, revised, and approved – Credentials Committee 7/11/97
Reviewed and approved – Medical Executive Committee 7/11//97
Reviewed and approved – Board of Directors 7/24/97
Reviewed and approved – Medical Staff 8/5/97
Reviewed and approved – Board of Directors 09/1997
Reviewed and approved – Credentials Committee 4/10/98
Reviewed and approved – Credentials Committee 6/12/98
Reviewed and approved – Medical Staff 7/7/98
Reviewed and approved – Medical Executive Committee 7/21/98
Reviewed and approved – Board of Directors 8/4/98
Reviewed and approved – Medical Executive Committee 8/18/98
Reviewed and approved – Board of Directors 9/2/98
Reviewed, revised and approved – Credential Committee 6/15/99
Reviewed and approved – Medical Executive Committee 7/27/99
Reviewed and approved – Board of Directors 9/1/99
Reviewed and approved – Medical Staff 11/2/99
Reviewed and approved – Credentials Committee (Courtesy Staff) 9/21/01
Reviewed and approved – Medical Executive Committee 9/25/01
Reviewed and approved – Board of Directors 10/3/01
Reviewed and approved – Board of Directors 11/7/01 (Deletion of 3.2.2 Item (c))
Revised, reviewed and approved – Board of Directors: 11/06/02 (Temporary Privileges 5.4)
Revised, reviewed and approved – Board of Directors: 3/5/2003 (addition of Optometrists – 4.7.1a)
Revised, reviewed and approved – Credentials Committee 5/23/03
Reviewed and approved – Medical Executive Committee 5/27/03
Reviewed and approved – Board of Directors 6/4/03 (Recertification Requirements)
Revised Reviewed and Approved – Credentials Committee (08/2003 – PAC additions)
Reviewed and Approved – Medical Executive Committee (08/2003)
Reviewed and Approved – Board of Directors – 9/6/2003
Revised, Reviewed and Approved – Credentials Committee (10/24/03)
Revised, Reviewed and Approved – Medical Executive Committee (10/28/03)
Revised, Reviewed and Approved – Board of Directors (11/03/2003) – (Category changes)
Revised, Reviewed and Approved – CC – 1/16/04; MEC – 02/02/04; BOD – 02/04/04 – (Telemedicine Addition)
Addition – as approved by the Board – 3/2004 Nurse Midwives.
Revised, Reviewed and Approved – 04/07/2004 – 5.2.3/5.2.4
Reviewed and corrected for typographical errors on 6/28/2004 regarding sections and spelling.
**Revised – Categories 06/2005; Approved: 08/03/2005**
Monday, December 05, 2005
Friday, December 9, 2005 Review
Revised 1/12/06, 1/26/06, 2/15/06 Credentials/Bylaws Committee3/06, 4/06, 5/06, 6/06, 9/06, 10/06, 12/06,
Credentials Committee 2/07
Medical Executive Committee 2/07
Medical Staff 3/07

Monday, December 05, 2005
Friday, December 9, 2005 Review
Revised 1/12/06, 1/26/06, 2/15/06 Credentials/Bylaws Committee3/06, 4/06, 5/06, 6/06, 9/06, 10/06, 12/06, 1/07, 2/07, 3/07
Reviewed, revised and Approved – Credentials Committee - November 14, 2007 (Preceptee Staff, Initial, Reappointment, and Clinical Privileges)
Reviewed and Approved – Medical Executive Committee – November 27, 2007
Reviewed and approved – Medical Staff Meeting – December 4, 2007
Reviewed and approved – Board of Directors January 2008