**GREATER BALTIMORE MEDICAL CENTER**

**BYLAWS**

**OF THE**

**MEDICAL STAFF**

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| | 02/24/65 | Revised | 12/10/92 | Revised | 04/10/03 |
| Revised | 05/17/65 | Revised | 01/14/93 | Revised | 05/15/03 |
| Revised | 02/28/67 | Revised | 04/15/93 | Revised | 12/02/04 |
| Revised | 01/25/68 | Revised | 07/15/93 | Revised | 05/05/05 |
| Revised | 02/04/70 | Revised | 09/17/93 | Revised | 04/06/06 |
| Revised | 10/20/70 | Revised | 10/14/93 | Revised | 07/06/06 |
| Revised | 04/26/72 | Revised | 12/16/93 | Revised | 10/05/06 |
| Revised | 11/08/72 | Revised | 01/13/94 | Revised | 02/01/07 |
| Revised | 09/12/74 | Revised | 03/10/94 | Revised | 04/04/07 |
| Revised | 09/11/75 | Revised | 04/12/94 | Revised | 10/04/07 |
| Revised | 03/12/76 | Revised | 05/12/94 | Revised | 05/22/08 |
| Revised | 12/02/76 | Revised | 07/14/94 | Revised | 02/05/09 |
| Revised | 04/01/77 | Revised | 10/20/94 | Revised | 04/02/09 |
| Revised | 01/13/78 | Revised | 01/12/95 | Revised | 07/02/09 |
| Revised | 03/01/79 | Revised | 02/16/95 | Revised | 12/03/09 |
| Revised | 03/14/80 | Revised | 07/13/95 | Revised | 02/04/10 |
| Revised | 05/18/82 | Revised | 09/21/95 | Revised | 03/04/10 |
| Revised | 04/12/84 | Revised | 02/20/96 | Revised | 04/01/10 |
| Revised | 01/10/85 | Revised | 07/11/96 | Revised | 06/03/10 |
| Revised | 10/10/85 | Revised | 10/10/96 | Revised | 02/03/11 |
| Revised | 11/13/86 | Revised | 11/14/96 | Revised | 03/03/11 |
| Revised | 09/10/87 | Revised | 11/13/97 | Revised | 07/07/11 |
| Revised | 04/14/88 | Revised | 04/16/98 | Revised | 09/01/11 |
| Revised | 04/13/89 | Revised | 07/16/98 | Revised | 04/12/12 |
| Revised | 10/12/89 | Revised | 02/04/99 | Revised | 09/06/12 |
| Revised | 11/09/89 | Revised | 03/11/99 | Revised | 12/06/12 |
| Revised | 07/12/90 | Revised | 07/26/99 | Revised | 10/03/13 |
| Revised | 09/13/90 | Revised | 11/18/99 | Revised | 12/05/13 |
| Revised | 11/08/90 | Revised | 01/13/00 | Revised | 03/06/14 |
| Revised | 02/14/91 | Revised | 09/28/00 | Revised | 04/03/14 |
| Revised | 04/11/91 | Revised | 01/18/01 | Revised | 07/31/14 |
| Revised | 07/11/91 | Revised | 04/12/01 | Revised | 12/04/14 |
| Revised | 11/14/91 | Revised | 03/14/02 | Revised | 04/21/15 |
| Revised | 02/28/92 | Revised | 07/11/02 | Revised | 11/03/16 |
| Revised | 04/16/92 | Revised | 09/12/02 | | |
| Revised | 06/11/92 | Revised | 12/12/02 | | |
| Revised | 09/10/92 | Revised | 01/16/03 | | |

**BYLAWS OF THE MEDICAL STAFF**

C O N T E N T S

**GREATER BALTIMORE MEDICAL CENTER**
**MEDICAL STAFF BYLAWS**

## PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care in the Greater Baltimore Medical Center and must accept and assume this responsibility, subject to the ultimate authority of the Board of Directors, and also that the best interests of the patient are protected by concerted efforts, the physicians practicing in the Greater Baltimore Medical Center hereby organize themselves and agree to be governed in conformity with the Bylaws hereinafter stated. The masculine gender shall include the feminine gender and vice versa.

The administration and physical facilities of the Medical Center shall constitute a unified institution bearing the title of the "Greater Baltimore Medical Center". For the purpose of these Bylaws, the following definition of terms is to be observed: "Medical Center" shall mean the Greater Baltimore Medical Center; "President" shall mean the President and CEO of the Medical Center or, in his absence or disability, such person as designated by the President and CEO or Board of Directors; "Medical Staff" shall mean the Medical Staff of the Greater Baltimore Medical Center.

# GREATER BALTIMORE MEDICAL CENTER
# MEDICAL STAFF BYLAWS

## ARTICLE I
NAME

The name of this organization shall be THE MEDICAL STAFF OF THE GREATER BALTIMORE MEDICAL CENTER.

## ARTICLE II
PURPOSE

2.1. The Purpose of this Organization. The purpose of this organization shall be to assist in the establishment and maintenance of a hospital for the greater Baltimore community in which the medical needs of our patients will be fulfilled through the thoughtful and personal application of the arts and sciences of modern medicine. Its functions include the approval and amendment of the Medical Staff Bylaws and the provision of oversight for the quality of care, treatment and services provided by practitioners with privileges.

2.2. The Purpose of these Bylaws. The members of the Medical Staff of the Greater Baltimore Medical Center have agreed to these Bylaws, Rules and Regulations in order to:

2.2.1. Establish an instrument of self-government that will best insure optimal care of the individual patient as the dominant purpose of the Medical Center, which all other programs will serve.

2.2.2. Provide a means whereby problems relating both to medical care and administrative functions of the Medical Center can be discussed and resolved through the joint efforts of the Medical Staff, Chairmen of Departments, the President and the Board of Directors.

2.3. These Bylaws, together with the appended Rules and Regulations and any subsequent amendments, having been adopted at any regular or special meeting of the Active Staff by a two-thirds (2/3) vote of the eligible voting members present and approved by the governing body of the hospital, are equally binding on the governing body and the Medical Staff.

## ARTICLE III
MEMBERSHIP

3.1. Qualifications. The membership of the Medical Staff shall consist of physicians, dentists and podiatrists. Applications for membership on the Medical Staff shall be considered on a nondiscriminatory basis without regard to race, creed, color, sex, or national origin in compliance with the Civil Rights Act of 1964. All applicants and members of the Medical Staff shall be subject to the appointment, reappointment and corrective action procedures of Article IV.

3.1.1. Physician Staff.

3.1.1.1. The applicant shall have recognized capacity as determined by the Department in the field of medical practice for which he has made application and shall be legally licensed to practice in the State of Maryland.

3.1.1.2. The professional conduct of the Physician Staff shall be governed by the ethical and moral codes of the American Medical Association and the Medical and Chirurgical Faculty of Maryland.

3.1.2. Dental Staff.

3.1.2.1. Dentists shall be eligible for membership on the Medical Staff and shall enjoy the privileges granted them by these Bylaws. The applicant for membership on the Dental Staff shall be a graduate of an approved dental school, legally licensed to practice in the State of Maryland.

3.1.2.2. The Dental Staff shall be governed by the ethical and moral codes of the American Dental Association. The Dental Staff shall conform in general to the rules, regulations, and terms of appointment of the Medical Staff and to specific additional regulations pertaining to the Dental Staff.

3.1.3. Podiatry Staff.

3.1.3.1. Podiatrists shall be eligible for membership on the Medical Staff and shall enjoy the privileges granted them by these Bylaws. The applicant for membership on the Podiatry Staff shall be a graduate of an approved podiatry school, legally licensed to practice in the State of Maryland.

3.1.3.2. The Podiatry Staff shall be governed by the ethical and moral codes of the American Podiatric Medical Association. The Podiatry Staff shall conform in general to the rules, regulations, and terms of appointment of the Medical Staff and to specific regulations pertaining to the Podiatry Staff.

3.2. Conditions of Appointment.

3.2.1. Appointments shall be made by the Board of Directors of the Medical Center in accordance with the procedures prescribed in Article IV.

3.2.2. In no case shall the Board of Directors of the Medical Center take action on an application, refuse to renew an appointment or revoke, suspend or modify an appointment previously made except in accordance with the procedures prescribed in Article IV.

3.2.3. With the exception of Emergency Privileges, as provided for in Article V of these Bylaws, the granting of membership in the Medical Staff shall confer no particular clinical privileges. Clinical privileges shall be granted only in accordance with the criteria and procedures hereinafter set forth. Notwithstanding the foregoing, with the exception of the Affiliate, Emeritus and Distinguished Emeritus Staffs, as hereinafter defined, no one shall be a member of the Medical Staff who does not hold delineated clinical privileges in one or more of the Departments of the Medical Staff.

3.3. Term of Appointment.

3.3.1 Unless membership or delineated clinical privileges are suspended or revoked pursuant to Article IV of these Bylaws, the term of appointment and reappointment to the Medical Staff shall not exceed 24 months.

3.3.2. The Staff year will commence on the first day of November each year.

3.4. Professional Affiliates. Professional Affiliates shall include physicians, dentists, and podiatrists and, as set forth in the Rules and Regulations, doctoral candidates in those professions, present at GBMC as participants in educational or consultative activities in the clinical setting, but who do not admit, treat, or otherwise provide patient care services independently. They shall not be members of the Medical Staff of GBMC. The qualifications, status and process for appointment of Professional Affiliates are delineated in the Rules and Regulations.

3.5. Allied Health Professionals. Allied Health Professionals are individuals who, pursuant to Section 3.1 are not eligible for membership in the Medical Staff. They may be licensed or certified by the State of Maryland in a health care profession other than medicine, dentistry or podiatry, or otherwise designated by Medical Center policy and procedure. Allied Health Professionals shall not admit patients or practice independently in the Medical Center; They shall be eligible for clinical privileges and subject to such requirements for physician supervision as required by Medical Center policy and procedure. They may be eligible for appointment to committees of the Medical Staff, under these Bylaws. The Director, Advance Practitioners, may be appointed to the Medical Board as an ex-officio member, without vote. The qualifications, status, clinical duties, responsibilities of and procedures for appointment for Allied Health Professionals shall be as set forth in the Policies and Procedures of the Medical Center.

Allied Health Professionals shall be entitled to the due process and hearing procedures of Article IV of these Bylaws. The decision of the President of the Medical Center or his designee shall be final in all matters having to do with the approval, discipline, suspension and termination of all AHPs in accordance with Medical Center policy, except for those instances where the due process and hearing procedures of Article IV are invoked where the decision of the Board of Directors shall be final.

## ARTICLE IV
APPOINTMENTS, REAPPOINTMENTS, CLINICAL PRIVILEGES, CORRECTIVE ACTION, AND HEARING PROCEDURES

4.1. Procedure for Appointments and Reappointments.

4.1.1. Content of Application for Appointment. An applicant for appointment to the Medical Staff shall apply, in writing, on a form prescribed by the Medical Center and provided by the Medical Staff Office. Along with the application, he shall be sent a copy of the current Medical Staff Bylaws and Rules and Regulations, all forms for requesting delineated clinical privileges in the applicable Department(s), and all credentialing criteria of the applicable Department(s). This application shall request or include, but shall not be limited to, the following information:

4.1.1.1. Qualifications. A request for information bearing on the applicant's professional qualifications and competence for the particular Medical Staff privileges requested including, but not limited to, education, licensure, relevant training, experience, current competence, and ability to perform the privileges requested.

4.1.1.2. Request for Privileges. A delineation of specific Medical Staff privileges in the Department(s) in which the applicant requests privileges.

4.1.1.3. Other Affiliations. A request for the name and address of any other hospital or other health care institution or practice where the applicant currently has or in the past has been granted medical privileges.

4.1.1.4. References. A request for the names of two (2) or more persons, preferably members of the Medical Staff, to whom evaluation forms may be sent and who have worked with the applicant and observed his professional performance in the recent past and who can provide reliable information, based on significant personal experience, about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism and any other qualifications relevant to eligibility for Medical Staff membership under these Bylaws.

4.1.1.5. Professional Sanctions. A request for information about whether:

4.1.1.5.1. the applicant has ever been denied medical staff membership or clinical privileges or had his medical staff membership or clinical privileges, revoked, suspended, reduced or not renewed, limited, or placed on probation at the Medical Center or any other hospital or health care institution;

4.1.1.5.2. any of the following have ever been revoked, denied, suspended or placed on probation: (1) membership in any local, state or national

professional health care society, institution or organization, including managed care organizations, (2) license to practice any health care profession in any jurisdiction, or (3) Drug Enforcement Administration (DEA) registration or other drug registration;

4.1.1.5.3. the applicant is the subject of any pending or threatened investigation or proceeding which, if decided adversely to the applicant, could result in any action named in the foregoing Sections 4.1.1.5.1. and 4.1.1.5.2.

4.1.1.5.4. either of the following have ever been voluntarily relinquished: (1) license to practice any health care profession in any jurisdiction or (2) DEA registration or other drug registration;

4.1.1.5.5. the applicant has ever voluntarily or involuntarily relinquished or agreed to the limitation or reduction of a medical staff appointment or clinical privileges or withdrawn an application at any hospital, health care institution or managed care organization for quality of care reasons or unprofessional conduct;

4.1.1.5.6. the applicant has ever been reprimanded, censured or admonished or the subject of any adverse action or finding for quality of care reasons or for unprofessional conduct by any hospital, other health care organization, professional organization, government agency, or managed care organization;

4.1.1.5.7. the applicant had ever been excluded from, found liable, received any other sanction from, or entered into any settlement with any governmental agency, including, but not limited to, Medicare or Medicaid, regarding any aspect of his professional practice;

4.1.1.5.8. the applicant has or ever had any health problems, including, but not limited to, alcohol or drug abuse, which might impair his ability to properly care for patients at the Medical Center;

4.1.1.5.9. the applicant is engaged in the use of illegal drugs.

The applicant shall provide a detailed written explanation of any affirmative response to the above.

4.1.1.6. Professional Liability Insurance. A statement that the applicant carries professional liability insurance at least in the minimum amount and in the form of coverage as may be required by the Medical Center from time to time and a request for information regarding his malpractice claims history and experience, including a

consent to the release of information from his present, and any past, malpractice insurance carriers and a waiver of any privilege relating thereto.

Applicant is responsible for notifying the Medical Staff Office of any changes in insurance coverage. Immediate notification is required for any lapses in coverage, including cancellation or termination of coverage. Failure to do so will lead to automatic revocation of privileges. See Section 4.2.7.1.5.

4.1.1.7. Verification and Agreement. The applicant shall sign a statement that all information provided by him is true, correct and complete in all material respects to the best of his knowledge and that he has received and read the current Medical Staff Bylaws and Rules and Regulations and agrees to be bound by the terms thereof and any amendments thereto.

4.1.1.8 Identification. The applicant shall present the Medical Staff Office with a valid government-issued photo identification issued by a State or Federal agency or a current picture hospital identification card.

4.1.2. Content of Application for Reappointment.

4.1.2.1 There shall be a biennial review of all Medical Staff appointments. Consideration of the applications for reappointment of the members of the various Departments shall follow a staggered schedule to be determined by the Medical Staff Office.

4.1.2.2. The President shall provide each Medical Staff member whose appointment is expiring with an application for reappointment prescribed by the Medical Center prior to the effective renewal date, and, upon request, a copy of the current Medical Staff Bylaws and Rules and Regulations. Within thirty (30) days after mailing of the reappointment application, each Medical Staff member applying for reappointment shall send his completed and signed reappointment application to the President. If the reappointment application has not been returned to the President within fifteen (15) days of mailing to the Medical Staff member, a certified letter, return receipt requested, shall be sent to the Medical Staff member advising him that his completed reappointment form was not received and that failure to return the application within fifteen (15) days of his receipt of the certified mailing will result in the voluntary resignation of Medical Staff membership and clinical privileges at the expiration of the current appointment pursuant to the Medical Staff Bylaws, unless good cause is shown by the applicant as to why the application has not been returned. A Medical Staff member whose appointment has expired pursuant to the foregoing provision and who wishes to apply for a new appointment will be required to complete the appropriate application and pay the appropriate credentialing fee established by the Medical Board.

4.1.2.3 The reappointment application shall require each Medical Staff member to update the information requested in his initial application for membership and request for clinical privileges described in this Article and any prior reappointment application. The reappointment application shall request information about the following:

4.1.2.3.1. Continuing Education. Relevant continuing education, training and experience related to the privileges requested by the applicant;

4.1.2.3.2. Physical and Mental Health Status. The current physical and mental health status and emotional stability of the applicant;

4.1.2.3.3. Other Affiliations. The name and address of any other hospital or other health care organization or practice where the applicant has been granted privileges or under whose auspices the applicant for reappointment rendered professional services during the expiring term;

4.1.2.3.4. Professional Societies. Membership or honors awarded, granted, denied, revoked or suspended by any professional health care society, institution or organization during the expiring term;

4.1.2.3.5. Professional Sanctions.

4.1.2.3.5.1. Sanctions of any kind imposed by and health care organization, professional society, or licensing or drug control authority during the expiring term;

4.1.2.3.5.2. any pending or threatened investigation or proceeding which, if decided adversely to the applicant, could result in the imposition of sanctions as described in the foregoing section 4.1.2.3.5.1.: or

4.1.2.3.5.3. the voluntary relinquishment, reduction, limitation or loss of any medical staff membership, clinical privileges, professional license or Drug Enforcement Administration registration:

4.1.2.3.6. Malpractice Claims. Details about any malpractice claims experienced during the expiring term;

4.1.2.3.7 Professional Liability Insurance. Details about any changes in the amount or form of coverage during the expiring term. Maintaining coverage is a condition of membership on the Medical Staff.

4.1.2.3.8. Staff Privileges. A delineation of specific clinical privileges in the Department(s) in which privileges are requested, and, if applicable, the applicant's reasons for seeking a change in his present privileges.

4.1.2.3.9. Current Address. The reappointment applicant's current home and office addresses and telephone numbers;

4.1.2.3.10. Miscellaneous. Any other information bearing on the applicant's qualifications, professional ethics, competence, ability, and insurance coverage as the Medical Board or the Board of Directors may require; and

4.1.2.3.11. Verification. The applicant shall sign a statement that all information provided by him is true, correct and complete in all material respects to the best of his knowledge.

4.1.3. Effect of Application for Appointment or Reappointment. For the purposes of this Subsection, the term "Medical Center representative" includes any duly authorized person who is responsible for collecting information about the applicant or evaluating the applicant's professional qualifications. By applying for appointment or reappointment to the Medical Staff, the applicant:

4.1.3.1. Signifies his willingness to appear for any interviews regarding his application and, for good cause, upon the request of the Credentials Committee, the Medical Board or the Board of Directors, agrees to undergo a complete physical and mental health evaluation at the applicant's expense by physicians designated by the Credentials Committee and to make the report of the evaluation a part of the application.

4.1.3.2. Authorizes Medical Center representatives to consult with others who have been associated with him or who may have information bearing on his professional competence and qualifications, regardless of whether such other persons are listed as references by the applicant, and authorizes those persons consulted to provide information relevant to the evaluation of his application.

4.1.3.3. Consents to the inspection by Medical Center representatives of all records and documents, including those that may be kept or maintained by any governmental agency, that, in the reasonable opinion of any Medical Center representative, may be material to an evaluation of his professional qualifications, ability to perform the clinical privileges requested, professional ethics, physical and mental health and emotional stability.

4.1.3.4. Releases from any liability all Medical Center representatives and any other reviewers or persons contacted for any acts or statements performed or made in good faith in connection with the evaluation of his credentials.

4.1.3.5. Releases from any liability all individuals, corporations and organizations who provide information, including privileged or confidential information, in good faith to the Medical Center and its representatives concerning the applicant's professional competence, education, training, experience, professional ethics, character, physical and mental health, emotional stability and any other qualifications for the requested staff privileges.

4.1.3.6. Authorizes and consents to Medical Center representatives providing other hospitals, professional associations, government agencies and other organizations concerned with provider performance, medical discipline or the quality and efficiency of patient care with any information the Medical Center may have concerning him to the extent required or permitted by law and releases the Medical Center and its representatives from liability for so doing provided that such information is furnished in good faith.

4.1.3.7. Represents and warrants that all information provided by him to Medical Center representatives is true, correct and complete in all material respects to the best of his knowledge.

4.1.3.8. Consents to notify the President and Chief of Staff of any pending or final disciplinary proceedings or quality of care review, by any licensing agency, hospital, health care organization or payor.

4.1.4 The applicant shall be given written notice of the intention of any Medical Center representative to request or otherwise seek information about the applicant if such a request is not of a routine nature or if such information is not of a nature normally sought in connection with the review of applications for appointment or reappointment. Any Medical Center representative who intends to request such information shall give such written notice to the applicant at least twenty (20) days prior to seeking such information. If the applicant wishes to object to the Medical Center's representative's intended action, he shall give written notice to that effect to the Medical Center representative within ten (10) days of receipt of the representative's notice. Failure by the applicant to give such written notice shall be deemed his consent and authorization to the Medical Center representative to seek the information described in his notice to the applicant. An applicant's written notice of objection shall be deemed a withdrawal of the consent and authorization given by operation of Section 4.1.3, and shall be made a part of the Credentials Committee's file on the applicant. Any Medical Center representative who receives such written notice of objection from an applicant shall forward a copy thereof to the President and the Chief of Staff. An applicant may withdraw his objection at any time by giving written notice thereof to the Medical Center representative, who shall forward copies thereof to the President and the Chief of Staff. Whether or not the applicant withdraws his objection to the proposed request for information, the Medical Staff committees and Medical Board shall continue to process the application and report their findings and conclusions in accordance with the procedures prescribed in this Article. If

any committee or the Medical Board determines that it cannot adequately evaluate an applicant without the information sought to be obtained, then it shall be the applicant's burden to provide the required information pursuant to these Bylaws (Section 4.1.5.5.).

4.1.5. Processing the Application for Appointment or Reappointment.

4.1.5.1. Final action to be taken by Board of Directors. The final action on all applications for appointment and reappointment, and requests for delineated clinical privileges, shall be taken only by the Board of Directors in accordance with its governing bylaws. Any review, investigation, findings of fact, evaluation or conclusion concerning such applications which may be conducted or formulated by any other body, board, committee, subcommittee or individual shall be preliminary and advisory only, and shall not constitute an action or recommendation. Only the final action on all applications for appointment or reappointment constitutes a professional review action; such professional review action includes the right to an evidentiary hearing, in accordance with the procedures set forth in Section 4.4.

4.1.5.2. Queries to National Practitioner Data Bank. In compliance with the requirements of Title IV of Public Law, 99-660, the Health Care Quality Improvement Act of 1986, the Medical Center or its authorized representative shall query the National Practitioner Data Bank as follows:

4.1.5.2.1. At the time a physician, dentist, podiatrist or other health care practitioner applies for membership on the Medical Staff, initial clinical privileges, renewal of clinical privileges and new clinical privileges; and,

4.1.5.2.2. At any other time as deemed necessary by the Medical Center.

4.1.5.2.3. At any other time as deemed necessary by the Medical Center.

4.1.5.3. Criteria for Evaluation of Applicants.

4.1.5.3.1. All Medical Staff committees and boards responsible for evaluating applicants for appointment and reappointment, and for delineated clinical privileges, shall consider all available information and recommendations concerning the applicant bearing on his demonstrated current competence, clinical judgment, character, professional ethics, education, relevant training and experience, ability to work with others, and physical and mental health before concluding its deliberations, and they shall further consider the organization of the Medical Center and of each Department in which the applicant has or requests privileges.

4.1.5.3.2. In addition, all Medical Staff committees and boards responsible for evaluating applicants for reappointment shall consider the Medical Staff member's professional competence and clinical judgment in the treatment of

Medical Center patients, including his pattern of practice which may be based, at least in part, on the findings of ongoing performance improvement evaluations and quality assurance measures, such as medical audit, utilization review, infection control activities, tissue review, medical record review and pharmacy and therapeutics activities, physical and mental health status; continuing education; cooperation with Medical Center authorities and personnel and other members of the Medical Staff so as to assure that patients receive quality health care and that the department in which he has privileges operates effectively and efficiently; use of the Medical Center's facilities for patients; attendance at Medical Staff and Department meetings, participation on committees and in education training programs; timely and accurate completion of medical records; and compliance with the Medical Staff Bylaws and Rules and Regulations. In all cases, the guiding principle shall be the provision of quality health care to Medical Center patients.

4.1.5.3.3. In cases of reappointment, a recommendation to deny the application shall be made only if there is affirmative evidence that the applicant does not satisfy the criteria for reappointment.

4.1.5.3.4. In cases where the applicant for reappointment is the Chairman of a Department, all Medical Staff committees and boards responsible for evaluating the applicant shall consider, in addition to all of the above-noted considerations, the applicant's ability to fulfill his duties and responsibilities as Chairman, and shall make their findings and decisions concerning such applicant with reference to both the renewal of his Medical Staff privileges and the continuation of his appointment as Chairman of the Department.

4.1.5.4. Department Application of Criteria for Evaluation. Every Department Chairman, in consultation with his Advisory Committee, shall prepare a written Department credentialing report which shall contain a determination of the method by which it will apply the criteria referred to in Section 4.1.5.3 to delineate the clinical privileges of applicants for privileges in the Department. This Department report shall apply to applicants for appointment and shall include any specific criteria for which the Department recommends special consideration be given, such as, without limitation, Board certification, Board eligibility, academic or other honors, fellowships, publications, and residency training. The Department report shall be reviewed and revised as often as necessary by the Department Chairman in consultation with his Advisory Committee, and shall be submitted to the Credentials Committee, Medical Board, and for the approval of the Board of Directors. The applicable Departmental criteria shall be applied by all Medical Staff committees and representatives and the Board of Directors in reviewing requests for clinical privileges pursuant to this Article IV.

4.1.5.5. Applicant's Burden. The burden of producing adequate information to permit a full and complete evaluation of all criteria for Medical Staff membership

and delineated clinical privileges shall always be on the applicant. The applicant shall also have the burden of providing whatever additional information is necessary to resolve any doubts about his qualifications for membership and delineated clinical privileges. If the information required has not been received within thirty (30) days from the mailing of the request, the processing of the application shall be terminated unless good cause is shown by the applicant as to why the request has not been satisfied. Requests shall be sent certified mail, return receipt requested.

4.1.5.6. Verification of Application. The applicant shall send the completed application to the President of the Medical Center. The President promptly shall forward the completed application to the Chief of Staff, who shall undertake to verify the information submitted in a timely manner. The Chief of Staff shall also request and collect letters of reference from the persons designated by an applicant for appointment, and may also request information concerning the applicant's qualifications from persons other than the references designated by the applicant for appointment. The Chief of Staff promptly shall notify the applicant of any failure of any sources he contacts to respond to his inquiries. After such notice, the applicant shall be responsible for having these sources forward the necessary information to the Chief of Staff.

A Medical Staff (re)application must be complete before it can be processed. A completed application means all blanks on the (re)application form are filled in and all necessary additional explanations are provided. Verification of the information is complete; that is, all information necessary to properly evaluate the (re)applicant's qualifications has been received and is consistent with the information provided in the (re)application form. Letters of reference and information from past hospitals and other affiliations have been received, including letters from department chairs or other physicians who have worked with or observed the applicant. Appraisal for reappointment to the Medical Staff is based on ongoing monitoring of information concerning the individual's professional performance, judgment and clinical or technical skills. The (re)applicant is responsible for providing the information to satisfy the process.

4.1.5.7. Conflict of Interest in Review of Reappointment Applications. Medical Staff members on any committee or board responsible for reviewing or evaluating reappointment applications shall not participate in and shall be excused from those portions of any meeting at which their own application is being considered. Members of the same professional corporation, association, partnership, or other physician's group shall not participate in and shall be excused from those portions of any meeting at which the application of a fellow member of the professional group is being considered, except if the Department is composed primarily of members of the same physician's group, then no member of the Advisory Committee, nor the Department Chairman if he is also a member of the physician's group, shall be disqualified from participating in the review of an application.

4.1.6. Review by Department Chairmen and Advisory Committees.

4.1.6.1. When the application is verified and all the references are obtained, the Chief of Staff promptly shall transmit the application and all related materials to the Chairman of each Department in which the applicant has or requests delineated clinical privileges. Each Department Chairman shall review the application and request for delineated clinical privileges in conjunction with his Advisory Committee including any Department reports submitted pursuant thereto. If there is more than one (1) application for initial appointment within a Department, the Department shall, to the extent appropriate and feasible, rank such applications based on the criteria adopted. The Department may in its discretion request an interview with an applicant, and may, for good cause, request that the Credentials Committee require the applicant to undergo a health evaluation. The Department Chairman shall forward the Department's written comments and conclusions as to whether the application and request for privileges merits approval, approval with modification, deferral, or denial to the Chief of Staff within two (2) months for initial appointments and one (1) month for reappointments after he received the completed application from the Chief of Staff. The application for reappointment of a Department Chairman shall be handled in the same manner as any other reappointment application, except that the Chief of Staff shall transmit the applica- tion directly to the Department Chairman's Advisory Committee, which shall forward its written comments and conclusions without those of the Department Chairman.

4.1.6.2. Notwithstanding the foregoing, if an applicant for initial appointment applies for privileges in a Department that has been determined to be over-utilized, the Chief of Staff shall forward the application directly to the Credentials Committee, the Chief of Staff shall also promptly notify the Chairman of the over-utilized Department(s) in which the applicant requests privileges that the application has been transmitted to the Credentials Committee.

4.1.7. Review by Credentials Committee.

4.1.7.1. Once all of the Departments in which the applicant requests privileges have forwarded their conclusions to the Chief of Staff, the Credentials Committee shall have two (2) months in which to prepare and submit its report to the Medical Board. The Credentials Committee shall review and evaluate all of the information compiled on all of the criteria for Medical Staff membership and delineated clinical privileges to assure that the applicant will provide patients with quality health care. The Credentials Committee's report shall be in writing and shall present its conclusions regarding whether the application for appointment or reappointment, and request for delineated clinical privileges should be approved with or without modifications, deferred or denied and specify the reasons in support of its conclusions. The report shall include a detailed delineation of the clinical privileges to be granted. If the Credentials Committee finds evidence that an applicant should

not be appointed or reappointed to the Medical Staff because of his physical or mental health, it may require the applicant to undergo a complete physical and/or mental health evaluation at the applicant's expense by physicians designated by the Credentials Committee, with the results thereof to be provided to the Credentials Committee. The Credentials Committee shall defer its consideration pending receipt of such results.

4.1.7.2. If the Credentials Committee has concluded that the application should be deferred, the Credentials Committee, in its discretion, may refer the application back to the Department for reconsideration and/or additional explanation of the reasons for the Department's conclusion, in which event the Department Chairman and Advisory Committee shall have one (1) month in which to make their supplemental report to the Credentials Committee. The Credentials Committee shall defer making its report pending receipt of the Department's supplemental report.

4.1.8. Review by the Medical Board. Within two (2) months after the Credentials Committee submits its report, the Medical Board shall evaluate the Credentials Committee report and all accompanying materials and reach its conclusion regarding the approval, approval with modifications, deferral of consideration, or denial of the application and/or request for delineated clinical privileges.

4.1.8.1. Conclusion that Application Merits Approval with or without Modification. If the Medical Board concludes that an application and/or request for clinical privileges merits approval, with or without modifications in the requested privileges, the Medical Board's conclusion shall be reported to the Board of Directors pursuant to Section 4.1.9. The Medical Board shall specify the department, category, and clinical privileges to be granted to the applicant. If applicable, the Medical Board shall state in its report its reasons for concluding that modification of the requested privileges is appropriate.

4.1.8.2. Deferral of Application. Action on an application or request for privileges may be deferred by the Medical Board, and the application may be remanded to the Credentials Committee for the collection of additional information. If such a remand is ordered by the Medical Board, the Credentials Committee shall submit its amended report in time for final action at the next regularly scheduled Medical Board meeting, but in no event more than two (2) months from the date the application was remanded. If the Medical Board does not remand the deferred application to the Credentials Committee, it must reach a conclusion as to whether the application merits approval, approval with modifications or denial at its next regularly scheduled meeting, but in no event more than two (2) months from the date of the meeting at which action on the application was deferred. If the applica- tion or request for clinical privileges is deferred, a written statement specifying the reasons for such action shall be forwarded promptly by the Medical Board to the Board of Directors.

4.1.8.3. Conclusion that Application or Request for Privileges Merits Denial. If the Medical Board concludes that the application or request for clinical privileges merits denial, a written statement specifying the reasons for the conclusion shall be forwarded promptly by the Medical Board to the applicant and the Board of Directors. The applicant shall be entitled to an evidentiary hearing pursuant to Section 4.4.

4.1.9. Final Action by the Board of Directors on Applications for Appointment and Reappointment.

4.1.9.1. The Board of Directors shall take final action on all applications for appointment and reappointment and requests for delineated clinical privileges in accordance with its governing bylaws. The Medical Board and committees responsible under these Medical Staff Bylaws for reviewing and reporting on the applications shall make available all applications, information, reports, and other materials compiled by the Medical Board and such committees to the Board of Directors in accordance with these Bylaws and as the Board of Directors otherwise may request or provide in its governing bylaws.

4.1.9.2. If the Board of Directors defers consideration of an application or request for clinical privileges and remands it to the Medical Board, the Medical Board shall submit its amended report in time for consideration at the Board of Directors' next regularly scheduled meeting, but in no event more than two (2) months from the date the application was remanded.

4.1.9.3. The President shall notify the applicant, the appropriate Department Chairmen, the Credentials Committee, and the Medical Board, in writing, of the final decision by the Board of Directors on an application and/or request for clinical privileges within thirty (30) days. Anyone entitled to a hearing on the decision of the Board of Directors under these Bylaws or the Bylaws of the Board of Directors shall be so notified within thirty (30) days of that decision.

4.1.9.4. If the final decision of the Board of Directors is a denial of the request for Medical Staff membership, or if the applicant withdraws his application after a recommendation of denial for appointment to the Medical Staff by the Medical Board, the applicant may not reapply for two years.

4.1.10. Waiting List for Appointment Because of Over-Utilization of Medical Center Departments and Divisions.

4.1.10.1. Over-Utilization Policy.

4.1.10.1.1. The formulation of an over-utilization policy in a Department or a division shall be based on all appropriate criteria, such as but not limited to

or necessarily including the following: utilization rate of the beds or facilities available to the Department or the division; number of procedures performed; length of patient stays; allocation and use of equipment and personnel and the extent to which the facilities can accommodate the number of persons already granted privileges in the Department or the division; community needs; new medical techniques and resources; discharge planning; and whether the appointment of additional Medical Staff Members would interfere with medical supervision or the effective administration of the Department or the division or weaken the Department's educational program.

4.1.10.1.2. Each Department Chairman, in conjunction with his Advisory Committee, shall be responsible for making a determination of whether over-utilization in his Department exists. The Department Chairman and his Advisory Committee shall propose a written over-utilization policy for the department which shall include documentation of the criteria upon which they relied to make the initial determination that over-utilization exists and an explanation of why the admission of new Medical Staff members would be detrimental to the quality of patient care provided by the Department. This proposed policy shall be forwarded to the Medical Board for its review and written recommendations. The policy and all supporting materials shall then be sent to the Board of Directors for its final approval, disapproval, or modification.

4.1.10.2. Waiting List.

4.1.10.2.1. If over-utilization has been found by the Board of Directors to exist in a particular Department, applicants applying for privileges in that Department shall be notified in writing by the Credentials Committee that over-utilization exists and the basis for that determination shall be explained. The Credentials Committee shall also inform the applicant that his completed application will be retained by the Committee and that his name will be added to a waiting list maintained by the Credentials Committee once his application is complete, with the understanding that it will not be processed until the Board of Directors determines that over-utilization no longer exists. The placement of an applicant on the waiting list shall not constitute a denial of appointment nor be subject to the evidentiary hearing procedures set forth in this Article. Applicants may remain on the waiting list for a three (3) year period from the date their names were added to the list. After three (3) years, the names of those applicants whose applications have not been processed due to continued over-utilization shall be deleted from the waiting list. At least two (2) months prior to deleting an applicant's name from the waiting list, he shall be notified in writing of this impending action by the Credentials Committee and informed that if he is still

interested in obtaining privileges in the over-utilized Department, he may submit a new application.

4.1.10.2.2. As soon as over-utilization ceases to exist in a particular Department, the Credentials Committee may require the applicants on the waiting list for that Department to update their applications prior to evaluating them. Applying the evaluation criteria for applicants for appointment specified in this Section and in accordance with the departmental report under this Section, the Chairman of the Department, in conjunction with his Advisory Committee, shall, according to the needs of the Department, select applicants from the waiting list and review their applications pursuant to the appointment procedures specified in this Section. The number of applicants selected shall be limited to the number of persons required to fill the needs of the Department. The names of those applicants selected shall remain on the waiting list until deleted pursuant to the procedures specified in this Subsection. Applicants who are not selected and who remain on the waiting list may be reconsidered whenever additional vacancies arise. The failure of the Department Chairman to select an applicant from the waiting list shall not constitute a denial of appointment nor be subject to the hearing procedures set forth in this Article.

4.1.10.3. Appointment to an Over-Utilized Department. If, in the opinion of the Department Chairman, the departmental Advisory Committee, or the Credentials Committee, an applicant for privileges in an over-utilized Department has particular and desired expertise in a specialty or subspecialty identified in the Department or will contribute significantly to the educational program of that Department and to the overall quality of patient care at the Medical Center, the Department Chairman, departmental Advisory Committee, or Credentials Committee shall so notify the Board of Directors and request permission to process the application notwithstanding the over-utilization policy. The request shall be in writing, shall be accompanied by the Department report prepared pursuant to Subsection 4 of this Section, and shall fully document why it is believed that the applicant fulfills departmental needs identified in such Department report or will contribute significantly to the educational program of the Department and to the overall quality of patient care at the Medical Center. The Board of Directors in its discretion may review the applications of other physicians on the waiting list for the over-utilized department before acting on the request to process the particular application under consideration. If the Board of Directors grants permission, the application shall be processed pursuant to the procedures for initial appointment. All Medical Center committees and boards responsible for evaluating the application shall consider the application in light of the criteria and considerations identified in both the Department credentialing report and the over-utilization policy.

4.1.11. Delineation of Privileges.

4.1.11.1. Upon appointment and reappointment, the scope of the privileges granted in a Department shall be delineated with reference to the specific procedures or other care that the Staff member shall be entitled to perform, as described hereinabove. In the interim between appointment and reappointment, or between reappointments, the scope of privileges relating to such specific procedures or other care may, upon request by the Staff member, be increased for good cause provided, however, that any Staff member who is the subject of a pending corrective action proceeding, is the subject of intensified or focused quality review or other special investigation by the Medical Center, or who has been granted temporary privileges and whose application for reappointment has not yet been the subject of final action by the Board of Directors, shall not be eligible for the granting of additional privileges.

4.1.11.2. A Staff member desiring additional privileges shall request them in writing addressed to the Chairman of the applicable Department, and shall provide such documentation of the Staff Member's qualifications as may be required by the Department's Credentialing Criteria or other applicable criteria or guidelines, or as requested by the Chairman. The Chairman shall consider the request in consultation with the Advisory Committee of the Department and shall forward to the Credentials Committee the Department's written comments and conclusions as to whether the request should be approved or denied. The Credentials Committee shall consider the request and shall forward to the Medical Board its written comments and conclusions as to whether the request should be approved or denied. The Medical Board shall consider the request, and shall forward to the Board of Directors its written comments and conclusions as to whether the request should be approved or denied. The Board of Directors shall consider the report of the Medical Board in taking its final action. Notwithstanding the foregoing, a conclusion by the Chairman that an eligible request should be approved shall act as a temporary grant of the additional privileges, which the Staff member shall be entitled to exercise until such time as either the Credentials Committee, Medical Board or Board of Directors shall conclude that such additional privileges should be denied.

4.1.11.3. The granting or denial of additional privileges shall not otherwise affect the Staff member's category of Staff membership or the Department in which he has been granted privileges. The denial of a requested increase in privileges shall not entitle the Staff member to request an evidentiary hearing pursuant to these Bylaws, if the staff member is deemed ineligible for such privileges based on lack of meeting departmental criteria on education, training or demonstrated clinical competence, but an affected Staff member shall be entitled to request the Board of Directors to reconsider such action and submit additional information in support of his request. Written notification of any increase in the number or nature of the procedures which a Staff member is entitled to perform shall be given to the Chief

of Staff, the Medical Board, and the Board of Directors and shall also be placed in the Credentials Committee's files of the affected Staff member and considered as part of his reappointment application. Any reduction in the scope of a Staff member's privileges shall be made only in accordance with the reappointment procedures or the corrective action procedures prescribed in this Article.

4.2. Investigation and Corrective Action.

4.2.1. Criteria for Request for Investigation. Whenever the activities, professional conduct or status of any Medical Staff member may be detrimental to patient safety or to the delivery of quality patient care, violate the Bylaws or Rules and Regulations of the Medical Staff or policies of the Medical Center, or be disruptive to the operations of the Medical Center, an investigation of such a Medical Staff member may be requested by the Board of Directors, the Medical Board, the President, any Department Chairman, or any member of the Medical Staff.

4.2.1.1. All requests for an investigation shall be made in writing to the Chief of Staff and, unless the request concerns a Department Chairman, to the Chairman of the Department involved, shall specifically state the basis for the request against the Medical Staff member, and shall cite specific activities, conduct or circumstances which support the request. If the request for investigation is made because of a reasonable suspicion that the Medical Staff member is impaired, the steps outlined in Section 4.5 shall be followed.

4.2.1.2. The Chief of Staff, in consultation with the Chairman of the appropriate Department, and with the Chief Medical Officer or designated hospital representative, shall promptly determine whether or not to refer the request for investigation, either to the Department Chairman and his Advisory Committee or, if the Department Chairman is the subject of the request or if the Chief of Staff otherwise determines it to be appropriate, to an impartial Special Committee appointed by the Chief of Staff pursuant to Article IX. For purposes of this Section 4.2, the Advisory Committee or the Special Committee, as the case may be, shall be referred to as the "Investigating Committee." The person who filed the request for corrective action shall not be a member of the Investigating Committee.

4.2.1.3. The Chief of Staff promptly shall notify the President of the Medical Center, in writing, of all requests for investigation received and shall keep the President informed about any action taken in connection therewith.

4.2.1.4. No Medical Staff member shall be deemed to be under investigation until the request is referred for investigation by the Chief of Staff or by the Medical Board if called upon to act.

4.2.1.5. If the request for investigation is directed against the Chief of Staff, the Vice Chief of Staff shall undertake the duties of the Chief of Staff in this Section.

If the request for corrective action is directed against a Chairman of a Department, all Medical Center committees and boards responsible for evaluating such request shall consider whether any action, alone or in addition to any other appropriate action, should be taken with respect to such Chairman's appointment as Chairman.

4.2.1.6. Nothing in this section shall be construed as prohibiting a Chairman of a Department, or his designee, from performing those duties outlined in Section 7.4.4. of these Bylaws, and resolving any issues regarding quality and appropriateness of patient care either informally or by requesting an investigation in accordance within this section.

4.2.2. Investigation. Within ten (10) days after receipt of a request for investigation, the Investigating Committee promptly shall initiate an investigation. Based upon its preliminary review, if the Investigating Committee believes that the request for investigation may be justified, or that an interview with the affected Medical Staff member would assist in its deliberations, the investigation shall include an informal interview with the affected Medical Staff member. Prior to the interview, the Medical Staff member shall be informed of the specific request for investigation against him and told that he shall be given an opportunity to discuss, explain or refute the request for investigation during the interview. The affected Medical Staff member has the duty to respond to the request for investigation and the duty to cooperate in the investigation. Failure to cooperate with the Investigating Committee shall be grounds for further corrective action, including automatic revocation of Medical Staff privileges pursuant to Section 4.2.7.1.4. The interview shall not constitute an evidentiary hearing but shall be preliminary and informal in nature and for the purpose of fact-finding only. None of the evidentiary hearing procedures specified in Section 4.4 shall apply to the interview. Notes of the interview shall be maintained by the Investigating Committee. Upon completion of its investigation, the Committee shall confer to evaluate the request for investigation. Reappointment during the time of an investigation for corrective action shall not be unreasonably withheld.

4.2.2.1. If the Investigating Committee concludes that the request for investigation warrants no further action, the person who filed the request for investigation, the affected Medical Staff member, the Medical Board, and the Board of Directors shall be so notified in writing within ninety (90) days after the Committee initiated its investigation of the matter, and the Committee's findings of fact, conclusions and recommendations shall be specified.

4.2.2.2. If it concludes that corrective action is warranted, the Committee shall submit a written report to the Medical Board and Board of Directors within ninety (90) days after the Investigating Committee initiated its investigation. The report shall include a record of any interview with the affected Medical Staff member; a detailed summary of the Investigating Committee's findings of fact, and recommendations regarding appropriate corrective action; and, copies of all documents considered in reaching its conclusion. The time limits stated herein may

be reasonably extended upon the approval of either the Chief of Staff or the Medical Board.

4.2.3. Medical Board Review and Conclusions.

4.2.3.1. At the next scheduled meeting after receipt of the Investigating Committee's report, the Medical Board shall initiate its review and evaluation of the request for investigation, the Investigating Committee's findings of fact, supporting evidence and recommendations; and, any request for an opportunity to be heard that may have been filed. The Medical Board, at its discretion, may permit the affected Medical Staff member to appear before it for an informal interview. Neither an interview with the affected Medical Staff member nor a presentation by the person requesting the investigation shall constitute an evidentiary hearing, nor shall the procedures specified in Section 4.4 apply. Within sixty (60) days after receipt of the Investigating Committee's report, the Medical Board shall prepare its findings of fact and conclusions.

4.2.3.2. The Medical Board's conclusions may include, without limitation, findings that the request for investigation or corrective action merits:

4.2.3.2.1. Rejection of the request for investigation or corrective action;

4.2.3.2.2. Issuance of a letter of admonition or reprimand;

4.2.3.2.3. Imposition of terms of probation with requirements of education, consultation or supervision; or,

4.2.3.2.4. Revocation, suspension or modification of clinical privileges, or termination or suspension of an appointment as Chairman of a Department, with such terms, conditions, or requirements as may be deemed appropriate.

4.2.3.3. The affected Medical Staff member, the person requesting the investigation, and the Board of Directors shall be informed by the Medical Board, in writing, of the Medical Board's findings of fact and conclusions, and reasons therefore. If the conclusion is as stated in Section 4.2.3.2.2., above, the affected Medical Staff member shall have the opportunity to submit a letter of protest to the Medical Board for inclusion in the permanent record of this action, but shall not be entitled to request an evidentiary hearing under Section 4.4. If the conclusion is as stated in Section 4.2.3.2.3. or Section 4.2.3.2.4., or any other decision that, if implemented, would affect a Medical Staff member's privileges, the affected Medical Staff member shall be promptly notified of his right to request an evidentiary hearing in accordance with Section 4.4. The Medical Board promptly shall notify the Board of Directors in writing of all requests for investigation received by the Medical Board and shall keep the Board of Directors fully informed of any action taken in connection therewith.

4.2.3.4. If the person requesting the investigation believes that the action taken by the Chief of Staff, Chairman of the Department, Investigating Committee, or the Medical Board is improper, he/she may, within fifteen (15) days after learning of such action, request an opportunity to be heard by the Medical Board.

4.2.4. Final Action by the Board of Directors on Requests for Investigation or Corrective Action.

4.2.4.1. Final Action by the Board of Directors. The final action regarding all requests for investigation or corrective action which may be conducted or formulated by any other body, board, committee, subcommittee, or individual shall be preliminary and advisory only, and shall not constitute an action or recommendation. Only the final action taken by the Board of Directors concerning a request for investigation or corrective action constitutes a professional review action; such professional review action includes the right to an evidentiary hearing in accordance with the procedures set forth on Section 4.4.

4.2.4.2. The Medical Board and committees responsible under these Medical Staff Bylaws for investigating, reviewing, and evaluating requests for investigation or corrective action shall forward all information, reports, records, and other materials compiled by the Medical Board and such committees to the Board of Directors in accordance with these Bylaws and as the Board of Directors otherwise may request or provide in its governing bylaws.

4.2.4.3. If the Board of Directors defers consideration of the request and remands it to the Medical Board, the Medical Board shall submit its amended report in time for consideration at the Board of Directors' next regularly scheduled meeting, but in no event more than two (2) months from the date the request was remanded.

4.2.4.4. The President shall notify in writing the affected Staff member, the person requesting the investigation, and the Medical Board of the decision of the Board of Directors. Anyone entitled to a hearing on the decision of the Board of Directors under these Bylaws or the Bylaws of the Board of Directors shall be so notified.

4.2.5. Credentials Committee's File. A copy of all requests for investigation, corrective action, complaints, reports, documents, notes, records, findings and conclusions made pursuant to this Section, including any evaluation regarding issues of quality and appropriateness of patient care performed under Section 7.4.4, shall be placed in the Credentials Committee's file of the affected Medical Staff member and shall be considered as part of his reappointment application.

4.2.6. Suspension.

4.2.6.1. Criteria and Initiation for Summary Suspension. Whenever a Medical Staff member's conduct constitutes a clear and present danger that requires prompt action to protect the life of any patient or to reduce the substantial likelihood of injury to the health or safety of any patient, employee or other person at the Medical Center, or whenever there are reasonable grounds to believe that such a circumstance has arisen, the Board of Directors, President of the Medical Center, Medical Board, Chief of Staff, or any Department Chairman shall have the authority to suspend immediately any or all of the Medical Staff member's privileges. Such summary suspension shall become effective immediately upon imposition.

4.2.6.2 Notice of Summary Suspension. The Chief of Staff shall give the affected Medical Staff member prompt written notice of any summary suspension of privileges, explaining the basis for the decision and the duration of the suspension period, and informing him of his right to request a hearing pursuant to Section 4.4. A copy of this notice shall be forwarded to the Medical Board and the Board of Directors. The terms of any summary suspension shall remain in effect pending final action by the Board of Directors.

4.2.6.3. Alternative Medical Staff Coverage. Immediately following a suspension, whether summary or otherwise, the Department Chairman or the Chief of Staff shall make arrangements for alternative staff coverage for the suspended Medical Staff member's patients who remain at the Medical Center during the suspension period.

4.2.6.4. Temporary Waiver of Suspension. Within ten (10) days after receipt of notice under Section 4.2.6.2., a Medical Staff member whose privileges have been summarily suspended may apply in writing to the Chief of Staff for a temporary waiver of the suspension pending the outcome of hearing requested pursuant to Section 4.4. To be entitled to apply for such a temporary waiver, the affected Staff member must simultaneously request a hearing on the suspension under Section 4.4. Within five (5) days after receipt of the Staff member's application for a temporary waiver, the Chief of Staff shall appoint a committee consisting of five (5) members of the Medical Board, which shall meet within five (5) days of its appointment to consider the suspension and the circumstances surrounding it. The committee may require whoever authorized the suspension to attend the meeting. The affected Staff member shall have the opportunity to speak at the meeting and to be represented by an attorney. The committee meeting shall not constitute an evidentiary hearing, nor shall the procedures under Section 4.4 apply. The committee may grant a temporary waiver of the suspension only if an affirmative finding is made by a majority of the committee (1) that the charges against the Staff member are frivolous, or (2) that the charges, which for the purposes of this Section 4.2.6.4. shall be assumed to be true, do not involve conduct that constitutes or

constituted a clear and present danger that requires or required prompt action to protect the life of any patient or to reduce the substantial likelihood of injury to the health or safety of any patient, employee, or other person at the Medical Center. The committee shall make its decision on the application for a temporary waiver at this meeting. The affected Staff member shall not be entitled to request a hearing on the committee's decision, and his hearing pursuant to Section 4.4 shall not be stayed or delayed pending the decision of the committee. The committee shall report its decision in writing to the Medical Board and Board of Directors.

4.2.6.5. Reinstatement and Expiration of Privileges.

4.2.6.5.1. Definite Period. Whether summary or otherwise, suspension may be for a definite period. When suspension is for a definite period, the affected Medical Staff member's privileges shall be reinstated automatically upon the expiration of the suspension period if the suspension period expires before the biennial reappointment review date of the Staff member's department. The affected Staff member shall not be entitled to apply for reinstatement of his privileges before the expiration of the suspension period. If the suspension period extends beyond the biennial reappointment review date, the Medical Staff member shall be entitled to submit a timely application for reappointment, and his application shall be handled in accordance with the usual procedures for review of reappointment applications. If his reappointment application is approved by the Board of Directors under this Article, the affected physician's privileges shall be automatically reinstated upon the expiration of the suspension period.

4.2.6.5.2. Indefinite Period. Whether summary or otherwise, suspension may be for an indefinite period, and such terms, conditions, and requirements as may be deemed appropriate may be placed upon any such indefinite suspension. If no such terms, conditions, or requirements have been placed upon the suspension, the affected Staff member's privileges shall automatically expire upon the biennial reappointment review date for the Medical Staff member's Department. In extraordinary circumstances, the Chief of Staff may recommend that the Staff member's privileges be reinstated before the biennial reappointment review date, in which event he shall obtain a written application for reinstatement from the Staff member, and such application shall be treated and processed as an application for reappointment. If any terms, conditions, or requirements have been placed on the suspension, the affected Staff member's privileges may be reinstated before the biennial reappointment review date only if he has complied with and fully satisfied all such terms, conditions, and requirements. The determination of whether there has been such compliance and approval of the reinstatement of privileges shall be made by the Medical Board or President of the Medical Center upon submission of written evidence of such compliance. If the Staff member has not satisfied the terms,

conditions, and requirements of his suspension by the biennial reappointment review date, his privileges shall automatically expire on that day until he has satisfied such terms, conditions, or requirements, nor shall he be entitled to an evidentiary hearing under Section 4.4 upon such automatic expiration. His application for reinstatement after his privileges have expired shall be treated and processed as an application for initial appointment.

4.2.6.6. Summary Suspension of a Chairman of a Department.

4.2.6.6.1. Authority. Whenever a Chairman of a Department fails to fulfill his duties as Chairman or whenever his conduct otherwise necessitates the immediate suspension of his appointment as Chairman of the Department, the Board of Directors, Medical Board, or Chief of Staff after consultation with the Medical Board, shall have the authority to suspend immediately such Chairman's appointment as Chairman and to relieve such Chairman of his duties and responsibilities as Chairman. Upon such suspension, the Chief of Staff shall appoint an Acting Chairman of the Department.

4.2.6.6.2. Effect of Suspension of Privileges. Whenever the privileges of a Chairman have been summarily suspended pursuant to this Section, his appointment as Chairman shall be deemed automatically and simultaneously to have been suspended.

4.2.6.6.3. Notice. The Chief of Staff shall give the affected Department Chairman prompt written notice of any summary suspension of his appointment as Chairman, explaining the basis for the decision and informing him of his right to request a hearing pursuant to Section 4.4. A copy of this notice shall be forwarded to the Medical Board and the Board of Directors.

4.2.6.6.4. Request for Hearing. The affected Chairman shall be entitled to request a hearing on a summary suspension of his appointment as Chairman pursuant to Section 4.4. If a Chairman's privileges also have been suspended, he shall be entitled to only one (1) hearing. If the affected Chairman fails to request a hearing on a summary suspension of his appointment as Chairman, he shall be deemed to have resigned such appointment.

4.2.6.6.5. Reinstatement. Following a summary suspension of his appointment as Chairman, a Chairman shall not be entitled to be reinstated as Chairman or to resume his duties and responsibilities as Chairman until the Board of Directors shall have decided to permit such reinstatement or resumption of duties as Chairman after a hearing on the suspension. No

reinstatement shall be permitted after resignation of an appointment as Chairman.

4.2.7. Automatic Revocation of Medical Staff Membership and Clinical Privileges.

4.2.7.1. Automatic revocation of Medical Staff membership and clinical privileges for any one or more of the following events shall not constitute a professional review action. The Medical Staff membership and clinical privileges of a Medical Staff member shall be deemed automatically revoked (i.e., no formal action by the Medical Board, Board of Directors, or officers of the Medical Center is required) if any one or more of the following events occur:

4.2.7.1.1. The member's license to practice medicine, dentistry or podiatry is revoked, suspended, voluntarily surrendered, or otherwise rendered inactive;

4.2.7.1.2. The member is convicted of or pleads guilty to a felony or other crime of moral turpitude;

4.2.7.1.3. The member has been requested to appear before, or cooperate with, any Medical Staff committee investigating an application for reappointment or a request for corrective action and fails to do so after reasonable notice has been given in writing from that committee;

4.2.7.1.4. The member fails to complete medical records in a timely manner pursuant to the Medical Staff Bylaws and Rules and Regulations after being warned of his delinquent status by certified mail, return receipt requested;

4.2.7.1.5. The member fails to maintain appropriate liability insurance as required by the Medical Center. Immediate notification is required for any lapses in coverage, including cancellation or termination of coverage.

4.2.7.1.6. The member fails to pay his annual dues and assessments after being warned of his delinquent status by certified mail, return receipt requested; or,

4.2.7.1.7. The member fails to comply with Section 4.7.13.

4.2.7.2. Medical Staff members must notify the President and the Chief of Staff immediately if any of the above events giving rise to automatic revocation occurs. Any Medical Staff member placed on probation by his licensing authority shall automatically assume a probationary status with regard to all Medical Staff privileges, i.e., all of the affected Medical Staff member's activities at the Medical Center shall be kept under continuous scrutiny and supervision by his Department Chairman (or if such member is a Chairman, then by the Chief of Staff) for the term of that probation. If a Medical Staff member's membership and clinical

privileges are revoked pursuant to Section 4.2.7.1.1. or 4.2.7.1.2., he shall not be entitled to an evidentiary hearing under Section 4.4 and he must comply with the procedure regarding appointments in this Article before his membership and clinical privileges may be reinstated. An application for reinstatement after Medical Staff membership and clinical privileges were automatically revoked per Section 4.2.7.1.3. or 4.2.7.1.4. is required. Medical Staff membership and clinical privileges shall be restored to any Medical Staff member whose membership and privileges were revoked pursuant to Sections 4.2.7.1.5. - 4.2.7.1.6. after satisfactory proof of compliance is submitted to and approved by the Chief of Staff or his designee. Any Medical Staff member whose membership and clinical privileges were revoked pursuant to Section 4.2.7.1.7. must reapply to the Medical Staff.

4.3. Reporting of Adverse Professional Review Actions.

4.3.1. National Practitioner Data Bank Reporting Requirements.

4.3.1.1. In compliance with the requirements of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, the Medical Center is required to report to the National Practitioner Data Bank, either directly or indirectly, through the Maryland Board of Physicians or other Board designated by the State for the purpose of licensing, monitoring and disciplining physicians, dentists, or podiatrists, certain clinical privilege actions and medical malpractice information regarding physicians, dentists, or podiatrists and in some cases other health care practitioners. Required reports shall be prepared and submitted as follows:

4.3.1.1.1. All required reports concerning adverse clinical privilege actions shall be submitted on the prescribed Adverse Action Report form to the appropriate Maryland licensing board responsible for the affected health care practitioner within fifteen (15) days of the final professional review action being taken.

4.3.1.1.2. All required reports concerning medical malpractice payments shall be submitted on the prescribed Medical Malpractice Payment Report form to (a) the appropriate Maryland licensing board responsible for licensing the affected health care practitioner; and, (b) directly to the National Practitioner Data Bank.

4.3.1.1.3. The Director, Medical Staff Services shall be responsible for assuring compliance with the National Practitioner Data Bank requirements, including timely submission, or verifying the accuracy of submitted reports.

4.3.2. Reports to State Authorities. The following professional review actions will be reported to the Maryland Board of Physicians, Dental Board, or Podiatric Board:

4.3.2.1. A professional review action that adversely affects the clinical privileges of a physician dentist or podiatrist for a period longer than thirty (30) days, when that action is based on the competence or professional conduct of an individual physician, dentist or podiatrist, which affects or could affect adversely the health or welfare of a patient or patients.

4.3.2.2. Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician, dentist or podiatrist (a) while the physician, dentist or podiatrist is under investigation by the Medical Center relating to possible incompetence or improper professional conduct; or, (b) in return for not conducting such an investigation or proceeding.

4.3.2.3. Privileging or credentialing decisions that are not based on competence or professional conduct of a physician, dentist or podiatrist are not reportable to the Maryland Board of Physicians, Board of Dental Examiners, or Board of Podiatric Medical Examiners for submission to the Data Bank.

4.3.3. Malpractice Payments. Malpractice payment reports must be filed by the Medical Center when the Medical Center makes a payment under an insurance policy, self insurance, or otherwise for the benefit of a physician, dentist, podiatrist, or other health care practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such physician, dentist, podiatrist, or other health care practitioner for medical malpractice.

4.4. Hearing Procedures.

4.4.1. Right to an Evidentiary Hearing.

4.4.1.1. The right of any applicant for appointment, reappointment, or privileges, or the right of a Medical Staff member, or a person requesting corrective action, or the Medical Board, on the behalf of the Medical Staff, to an evidentiary hearing shall be governed by these Bylaws and the bylaws of the Board of Directors. An "affected person" for the purposes of this Section shall mean anyone who is entitled to an evidentiary hearing.

4.4.1.2. The following actions pursuant to these Bylaws do not give rise to a right to an evidentiary hearing:

4.4.1.2.1. Reduction or termination of membership and/or privileges because of inactivity or failure to meet required levels of activity;

4.4.1.2.2. Automatic revocations of privileges arising from those events specified in Sections 4.2.7.1.1.- 4.2.7.1.7;

4.4.1.2.3. Minor adverse actions that do not affect Medical Staff privileges such as issuance of a letter of admonition or a letter of reprimand;

4.4.1.2.4. Denial of interim or temporary Staff privileges pursuant to Article V;

4.4.1.2.5. Adverse action against a Medical Staff member during the processing of his application for reappointment and until final action is taken on such application;

4.4.1.2.6. Placement of an applicant for appointment on a waiting list for an over-utilized Department; and,

4.4.1.2.7. Any other matter, unless these Bylaws or the bylaws of the Board of Directors expressly provide for a hearing or the Board of Directors agrees to grant an evidentiary hearing.

4.4.1.3. An evidentiary hearing may be requested by notifying the President of the Medical Center in writing within thirty (30) days after the date of the notice of an adverse action or adverse finding and conclusion entitling the affected person to an evidentiary hearing. Failure to make such a written request within the time limit provided shall be deemed a waiver of the affected person's right to an evidentiary hearing. The President shall promptly notify the Chief of Staff and the Chairman of the Board of Directors of all timely requests for an evidentiary hearing.

4.4.2. Notice of Right to Evidentiary Hearing.

4.4.2.1. Whenever a person is entitled to an evidentiary hearing pursuant to this Section either in accordance with these Bylaws or in accordance with the bylaws of the Board of Directors, he shall be so notified in writing. The notice shall advise him in writing that:

4.4.2.1.1. He has a right to an evidentiary hearing as described in the Medical Staff Bylaws;

4.4.2.1.2. He must give written notice to the President of the Medical Center of his request for an evidentiary hearing within thirty (30) days after the date of the notice or his right to an evidentiary hearing shall be forfeited; and;

4.4.2.1.3. Any adverse action or adverse finding or conclusion entitling the affected person to an evidentiary hearing shall be effective upon notice to the affected person and shall not be suspended by a request for an evidentiary hearing.

4.4.2.2. The notice shall be accompanied by a current copy of these Bylaws, or the President promptly shall provide a copy on request. Any adverse action or adverse finding or conclusion entitling the affected person to an evidentiary hearing shall be effective upon notice to the affected person and shall not be suspended by a request for an evidentiary hearing.

4.4.3. Appointment of Hearing Committee. Any person who makes a timely request for an evidentiary hearing shall have a right to a hearing as described in this Section before a Hearing Committee which shall be appointed within forty-five (45) days from the date the request for an evidentiary hearing was received. The Hearing Committee shall consist of four (4) members of the Medical Staff appointed by the Chief of Staff, who are Active or Associate members of the Medical Staff and are preferably providers in a similar specialty or training, as the affected person, and three (3) members of the Board of Trustees appointed by the Chairman of the Board of Directors, one of whom shall be selected to act as chairperson of the committee. If the affected person is an Allied Health Professional, i.e., NP, PA, etc., at least one (1) member of the committee shall be an Allied Health Professional. The position of the chairperson shall be alternated between physician and Board Members for successive hearings. To avoid prejudice, no one appointed to the Hearing Committee shall have participated in the investigation of the pending application for appointment or reappointment or the pending request for corrective action or have taken any action under this Article that resulted in the pending request for corrective action. If the affected person believes that any member of the Hearing Committee cannot reach a fair and impartial decision, he must assert his claim of prejudice and disqualification promptly after knowledge of the alleged disqualification. The Chairman of the Board of Directors and the Chief of Staff shall consider the reasons stated for the request and determine whether the member shall remain on the Hearing Committee or be replaced. If the challenged member of the Hearing Committee is not replaced, the basis for the decision shall be documented in writing and a copy of the determination shall be made available to the parties. The determination made by the Chairman of the Board of Directors and the Chief of Staff shall be final and binding on all the parties.

4.4.4. Notice of Evidentiary Hearing. The President, in cooperation with the Chairman of the Hearing Committee, shall schedule a hearing date. The hearing date shall not be scheduled less than thirty (30) days from the date the notice of hearing is issued. The Chief of Staff shall prepare the notice of hearing in cooperation with the person who will investigate, organize and present the evidence to the Hearing Committee on behalf of the Medical Staff. This person shall be designated by the Medical Board, with the approval of the President, and shall be provided with legal counsel at the Medical Center's expense. The President shall send the notice of hearing to the affected person, the Medical Board, and the Board of Directors within ten (10) days after the Hearing Committee is appointed. The notice, a copy of which also shall be sent to each member of the Hearing Committee and the Medical Center attorney, shall contain the following information:

4.4.4.1. The date, time and place of the hearing;

4.4.4.2. A concise statement specifying the reasons for the adverse finding or conclusion or adverse action as the case may be, and a description of the evidence considered by the person or body responsible for making such recommendation or taking such action.

4.4.4.3. That the affected person may be represented by an attorney if he wishes, that he may offer evidence from any relevant source or testimony by any person he wishes to attend the hearing, and that the Chief of Staff and the President will assist him in arranging for any member of the Medical Staff or any Medical Center employee to be present at the hearing, if he so requests;

4.4.4.4. That the presence of the affected person is required at the hearing and that his failure to attend in person, unless a request for a postponement is granted by the Chairman of the Hearing Committee, shall be deemed a waiver of his right to an evidentiary hearing; and

4.4.4.5. That if the affected person believes that any member of the Hearing Committee cannot reach a fair and impartial decision, he should immediately advise the President of the Board of Directors or the Chief of Staff in writing, stating the basis for that belief.

4.4.5. Preliminary Arrangements for the Evidentiary Hearing. After the President has scheduled the hearing and sent the required notice and necessary adjustments to the Hearing Committee membership have been made, the conduct of the evidentiary hearing shall be the responsibility of the Chairman of the Hearing Committee. The Chairman shall receive and rule on any requests for postponement of the hearing provided the request is in writing and specifies the reasons for seeking a postponement. Any preliminary questions regarding the hearing procedure shall be addressed, in writing, to the Chairman, and his response shall also be in writing. The Medical Center attorney shall assist the Chairman of the Hearing Committee in preparing for the hearing and implementing the procedures specified in this Section. The Medical Center attorney shall arrange for a stenographer to be present to make a verbatim recording of the hearing. The Chairman of the Hearing Committee shall take whatever measures necessary to insure that the hearing is conducted in a confidential manner. For example, he may require that persons who are to testify remain outside the hearing room except during their appearance.

4.4.6. Conduct of the Evidentiary Hearing.

4.4.6.1. Hearings before the Hearing Committee shall be informal. The legal rules of evidence shall not apply, and the Chairman of the Hearing Committee may admit the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. The witnesses shall not be required to testify under oath. A rigid order of proof need not be followed, but the Chairman should generally require that the case supporting the challenged adverse recommendation or adverse action be presented first. The hearing shall be conducted by the

Chairman of the Hearing Committee. The Medical Center attorney may be present at the hearing and may participate to the extent requested by the Chairman of the Hearing Committee, but may not vote.

4.4.6.2. At least four (4) members of the Hearing Committee, including at least two (2) members of the Board of Directors and at least two (2) members of the Medical Staff, must be present to conduct the hearing, and no member of the Hearing Committee may act by proxy.

4.4.6.3. The affected person, his attorney or representative, as the case may be, and the Medical Board representative or his legal counsel may question any person who testifies at the hearing. In all cases, the Chairman of the Hearing Committee shall give the person requesting the hearing an opportunity to make a statement as to why he believes that the adverse action or adverse recommendation was improper. If the parties wish, they may submit written statements to the Hearing Committee at least five (5) days prior to the hearing date. At the time of filing, copies of these statements shall also be sent to the opposing party and the Medical Center attorney.

4.4.6.4. During the course of the hearing, any member of the Hearing Committee may interrupt at any time to ask a question or request the presentation of additional evidence. The Chairman of the Hearing Committee shall take any measures necessary to keep the proceeding moving, to cut off repetitive or irrelevant inquiries, and to prevent time-consuming and extraneous debate and argument.

4.4.6.5. A stenographer shall be present to make a verbatim transcript of the proceedings. The Chairman of the Hearing Committee shall appoint one (1) member of the Hearing Committee to act as Secretary to make notes of the hearing, and the Committee shall not be required to wait for a transcription of the stenographic records before reaching its decision.

4.4.6.6. Any requests for a recess or temporary suspension of the hearing may be granted if the Chairman of the Hearing Committee, at his discretion, determines that it is appropriate.

4.4.6.7. At the conclusion of the hearing, the Hearing Committee shall not render an oral opinion on any issue but shall reduce its findings of fact, conclusions and recommendations to writing.

4.4.7. Decision of the Hearing Committee. Within fifteen (15) days after the adjournment of the evidentiary hearing, the Hearing Committee shall deliberate and reach a decision. Its findings of fact and conclusions shall be based only on the information presented at the hearing or matters of common knowledge, regardless of whether they are subject to judicial notice, so long as the Hearing Committee refers to them with appropriate specificity in its decision. Each member of the Hearing Committee shall be entitled to a single vote; however, the Chairman of the Hearing Committee shall not cast his vote unless there is a

tie. If a Hearing Committee member misses the hearing, he may not vote on the decision. The opinion of the majority of those present at the hearing shall control the decision. The Hearing Committee's written decision shall be transmitted to the affected person, the Board of Directors, the Medical Board, the Chief of Staff and the appropriate Department Chairmen before the end of the fifteen (15) day time limit. Those members of the Hearing Committee who wish to file dissenting opinions or other separate opinions with the Board of Directors must do so within that fifteen (15) day period. All notices, preliminary correspondence, memoranda, exhibits, notes, Hearing Committee Secretary's minutes, medical records or other evidentiary materials presented during the hearing and the stenographic transcript of the proceeding shall accompany the Hearing Committee's decision when it is forwarded to the Board of Directors.

4.4.8. Final Action by the Board of Directors Following an Evidentiary Hearing. The Board of Directors shall review the decision of the Hearing Committee and review the record of the proceedings for the purpose of determining whether the adverse finding or decision against the affected person was supported by substantial evidence. At its discretion, the Board of Directors may remand the matter to the Hearing Committee for the consideration of new evidence and the preparation of additional findings of fact and conclusions. The Hearing Committee shall respond to the Board's request promptly but in no event more than thirty (30) days from the date of the Board's remand. The ultimate decision of the Board of Directors is final and not subject to appeal.

4.5. Chief of Staff; Department Chairman.

4.5.1. Unless otherwise explicitly provided to the contrary, whenever the privileges, activities, conduct, or status of the Chief of Staff shall be under review pursuant to the reappointment or investigation and corrective action provisions of this Article, the Vice-Chief of Staff shall assume all the obligations, responsibilities, and authority with respect to such review as the Chief of Staff otherwise has under this Article with respect to the review of all other Staff members' privileges, activities, conduct, or status.

4.5.2. Whenever the privileges, activities, conduct, or status of a Chairman of a Department shall be under review pursuant to the reappointment or investigation and corrective action provisions of this Article, the departmental Advisory Committee shall assume all the obligations, responsibilities, and authority with respect to such review as the Department Chairman otherwise would have had under this Article. An Acting Chairman of a Department shall have the same rights, duties, powers, and authority as a Chairman of a Department under this Article.

4.6. Medical Review Committees. For the purposes of this Article IV, the Board of Directors, the Medical Board, and every Committee operating pursuant to this Article, including but not limited to the Credentials Committee, the Department Chairmen's Advisory Committees, Departmental Quality Assurance and Utilization Review Committees, any Investigating Committee, any Hearing Committee, and any standing or special committee or subcommittee formed by either the Board of Directors or the Medical Board, shall be a "medical review committee" within the meaning of

Maryland Annotated Code, and any successor legislation, and as such may be amended from time to time. The foregoing notwithstanding, no body or Board other than the Board of Directors, and no committee, subcommittee or individual may take or authorize a professional review action affecting appointment, reappointment, the clinical privileges of a Staff member, or concerning a corrective action against a Staff member, except in the case of a summary suspension.

4.7 Impaired Medical Staff Members.

4.7.1. For purposes of these Bylaws, "impaired" shall mean that a Medical Staff member is unable to practice his or her profession in accordance with the criteria set forth in the Medical Staff Bylaws or practices in a manner which may be detrimental to patient safety or to the delivery of quality patient care because of physical or mental illness, including, but not limited to, substance abuse or addiction.

4.7.2. The Medical Staff shall provide periodic education for its members concerning the maintenance of health and the recognition and prevention of physical, psychological, emotional and addictive disorders.

4.7.3. Any person who has reason to believe that a Medical Staff member may be impaired through substance abuse or drug addiction may make a report to the Chief of Staff, preferably in writing. Self-referral shall be encouraged. All information concerning such an individual shall be held in strict confidence to the fullest extent consistent with the assessment, development and implementation of a rehabilitation plan. The report shall include a description of the incident(s) that led to the belief that the Medical Staff member may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment, but must state the facts leading to the suspicions. A sufficient index of suspicion ethically dictates reporting (while maintaining confidentiality to the fullest extent possible) when patient safety is perceived to be threatened.

The Medical Staff encourages self-referral to the Chief of Staff or to the physician rehabilitation program endorsed by the State Medical Society if a Medical Staff member believes himself to be impaired.

4.7.4. If, after discussing the incident(s) with the individual who filed the report, the Chief of Staff believes there is enough information to warrant further study, the Chief of Staff shall, after consultation with the Chief Medical Officer or other designee of the President (hereinafter referred to as "the Hospital representative"), direct that a report be rendered based on the available facts at hand.

The Chief of Staff and the Hospital representative will decide the following:

4.7.4.1. The information presented to date does not warrant further action or investigation. If the evaluation reveals that there is no merit to the report, the report shall be destroyed. Throughout this process, all parties shall avoid speculation, conclusions and gossip.

4.7.4.2. Information presented to date warrants additional mandatory evaluation of the suspected individual or information available warrants immediate referral to an approved rehabilitation program for immediate intervention for a suspected substance abuse or drug addiction problem.

4.7.5. If, upon investigation, it is found that sufficient evidence exists that the Medical Staff member may be impaired, the Chief of Staff shall, together with the Hospital representative, meet personally with that Medical Staff member. The Medical Staff member shall be told that the results to date indicate that the Medical Staff member may suffer from an impairment that may affect his or her practice. There is no obligation to inform the Medical Staff member as to who filed the initial report.

The Chief of Staff or the Hospital representative may request the Staff member's urine or blood testing if a substance abuse or drug addiction problem is suspected. The practitioner involved is required to comply. Refusal of this testing constitutes a positive drug test. If such testing is positive for illicit drug use, the Hospital representative and the Chief of Staff shall request immediate intervention by the Staff member's approved rehabilitation program. Recommendations and a plan of action will be guided through their assistance. Even in the absence of positive testing for illicit drug use, the Chief of Staff and the Hospital representative may request evaluation by the Staff member's approved rehabilitation program. A written response to the practitioner concerning his or her acknowledgment of the evaluation to date, the recommendations, and the practitioner's intentions concerning the recommendations will be necessary. Complete documentation of all steps will be maintained by the Chief of Staff. Recommendations of treatment, advocacy and follow-up will be carried out with the assistance of the Staff member's approved rehabilitation program.

4.7.5.1. Significant patterns of a physician providing unsafe treatment to patients shall be reported to the Medical Board for its review and comment.

4.7.6. Depending upon the degree of severity of impairment, restrictions on the Medical Staff member's practice may be implemented and could include immediate withdrawal from Medical Center-related patient activities or practice under the supervision of another Medical Staff member.

The involved Medical Staff member may request a medical leave of absence from Medical Staff membership that would not require National Practitioner Data Bank reporting. Following completion of the rehabilitation program if required, there is no obligation on the part of the Medical Center that it reinstate the physician or remove any restrictions. Reinstatement or removal of restrictions, if any, shall be at the discretion of the Board of Directors upon advice from the Chief of Staff, the Hospital representative, the Medical Board and the Staff member's approved rehabilitation program. Confidentiality shall be maintained in these meetings. The specific practitioner's name (but not the substantive facts) should be withheld in discussions.

Reinstatement from medical leave of absence will not ensue prior to the Medical Staff member's successful enrollment in a suitable rehabilitation program if required, for at least three (3) months and only with the recommendation of the director of the program. The guiding principle of the Medical Center shall be physician advocacy in retaining or regaining optimal physician function so long as patient care is protected. The Medical Staff member will remain under surveillance if recommended by this State or other State's Physician Health Program. Recommendations of such a Committee should include to what extent the Medical Staff member is capable of providing continuous competent medical care to his patients. Alternatively, the involved Medical Staff member may continue to practice at the Medical Center if recommended by the Staff member's approved rehabilitation program, the Medical Board and approved by the Board of Directors. Such practice may be restricted or monitored to ensure compliance with the rehabilitation program and to ensure patient safety.

The Medical Staff member is responsible for locating a suitable rehabilitation program, if appropriate, and shall inform the Chief of Staff and the Hospital representative as to the program selected. Following completion of a program, there is no obligation on the part of the Medical Center that it reinstate the physician or remove any restrictions. Reinstatement or removal or restrictions, if any, will be in accordance with the sole discretion of the Hospital, after consultation with the President, the Chief of Staff, the Chief Medical Officer, the hospital representative and any other appropriate persons, and would require, at a minimum, that the Medical Staff member has successfully completed a suitable and appropriate program and that the member meet all other applicable criteria set forth in the Bylaws.

4.7.7. If the matter cannot be resolved successfully as above, including the failure of the Medical Staff member to complete the rehabilitation program if required, the Chief of Staff and the Hospital representative may request an investigation or call for summary suspension if patient safety is deemed to be at ongoing risk.

4.7.8. The original report and a description of the actions taken by the Chief of Staff shall be included in the Medical Staff member's credentials file. The Chief of Staff shall inform the individual who filed the report that follow-up action was taken. If the investigation reveals that there is no merit to the report, the report shall be destroyed. Throughout this process, all parties shall avoid speculation, conclusions and gossip.

4.7.9 If there has been resolution in accordance with Section 4.7.5., and upon sufficient proof that a Medical Staff member who has been found to be suffering an impairment has successfully completed a rehabilitation program if required, the Chief of Staff and the Hospital representative, may, in their discretion, and, if appropriate, consider the removal of any practice restrictions or other requirements adopted as part of the resolution. In any such consideration, patient care interests will be paramount.

4.7.9.1. In considering the removal of practice restrictions or other requirements, it will be the responsibility of the Medical Staff member to provide, or to facilitate providing to the Chief of Staff and Hospital representative, a written report from the rehabilitation program(s) in which the Medical Staff member participated if any, including:

4.7.9.1.1. Confirmation of the Medical Staff member's compliance with the terms of the program(s);

4.7.9.1.2. Confirmation of attendance at AA or similar programs (if appropriate);

4.7.9.1.3. A description of the extent to which the Medical Staff member's behavior and conduct have been and are monitored;

4.7.9.1.4. Whether, in the opinion of those supervising, the Medical Staff member has been rehabilitated;

4.7.9.1.5. Whether an after-care program has been recommended to Medical Staff member, and, if so, a description of the after-care program; and,

4.7.9.1.6. An opinion as to whether the Medical Staff member is capable of resuming medical practice and providing continuous, competent care to patients.

Notwithstanding the Medical Staff member's full cooperation in making the above- described reports available, there shall be no obligation on the part of the Chief of Staff and the Hospital representative to consider the removal of restrictions or other requirements, or to reinstate the Medical Staff member.

4.7.9.2. The Medical Staff member must also inform the Chief of Staff and the Hospital representative of the name and address of his or her primary care physician and will authorize that physician to provide information regarding his or her condition and treatment, including, whether in the primary care physician's opinion, the Medical Staff member has been rehabilitated and is capable of resuming medical practice. The Chief of Staff and the Hospital representative have the right to require an opinion from other consultants of their choice. For impaired Medical Staff members where the impairment is not a substance abuse or drug addiction situation, such statements from the Medical Staff member’s primary care physician and other consultants, if requested, may suffice if deemed satisfactory by the Chief of Staff, the Chief Medical Officer or designated hospital representative and the Chairman of the appropriate Department for removal of practice restrictions or other imposed requirements.

4.7.10 In the event that the Chief of Staff, the Hospital representative, Medical Board and Board of Directors choose to remove practice restrictions or other requirements adopted as part of the rehabilitation process, such action may be contingent upon further conditions reasonably applied for the maintenance of patient safety, including, but not limited to:

4.7.10.1. Requiring the Medical Staff member to identify other Medical Staff members who are willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability, or identify acceptable Medical Staff members who are willing to monitor the care provided by the Medical Staff member in accordance with such written terms and conditions as may be deemed appropriate by the Chief of Staff and the Hospital representative;

4.7.10.2. Requiring further reports from the Medical Staff member's primary care physician or other health care providers;

4.7.10.3. Requiring submission to random or behavior-based drug or alcohol testing for a substance abuse or drug addiction problem;

4.7.10.4. Intensified quality monitoring as deemed appropriate by the Chief of Staff and Hospital representative.

4.7.11. Medical Staff members formally known by the Medical Staff Office to be actively engaged in a drug or alcohol rehabilitation program, including an aftercare program, will allow the Medical Staff Office to obtain quarterly updates of their progress and results of any urine test performed. Such individuals shall allow the Medical Staff Office the option of performing random urine tests at the physician's expense to maintain Medical Staff membership. Positive urine tests or unfavorable reports will be directed immediately to the Chief of Staff and the Hospital representative. Immediate action ranging from increased surveillance to immediate suspension may be taken depending upon the severity of the circumstance, with the guiding principles continuing to be physician rehabilitation while maintaining patient safety.

4.7.12. Individuals currently in or previously in rehabilitation programs must report their status if their ability to properly care for patients at the Medical Center may be impaired.

4.7.13. Individuals known to the Medical Staff Office as having completed a rehabilitation program for a substance abuse or drug addiction problem may be subject to random drug or alcohol testing. Refusal will result in the automatic revocation of Medical Staff membership and clinical privileges.

## 4.8 Leave of Absence

### 4.8.1 Request for Leave of Absence

Leave of absence and reinstatement are matters of courtesy, not of right. A Medical Staff member may request a voluntary leave of absence from the Medical Staff by

submitting written notice to the Chief of Staff, stating the exact period of time of the leave, which may not exceed one (1) year, and the reason for the request. Approval of a leave of absence may be granted by the Chief of Staff. During the period of time of the leave, the Medical Staff member's clinical privileges, prerogatives and responsibilities shall be suspended. If the staff member's reappointment is due to expire during the leave of absence period, the member will be required to submit an application for reappointment of membership.

4.8.1.1 Maintenance of malpractice insurance is required during the leave of absence.

4.8.2 Termination of Leave of Absence

Prior to the conclusion of the leave of absence, the individual may request reinstatement of clinical privileges and prerogatives by submitting a written request to the Chief of Staff for review, and final approval by the Board of Directors. The staff member shall submit any changes in privileges, health status, proof of medical malpractice insurance coverage in the terms and amount specified in the Medical Staff Bylaws, or other conditions of appointment. The institution will verify proof of current medical licensure and other required State and Federal regulatory agency verifications in effect.

4.8.2.1 If leave of absence is for health reasons, the Medical Staff member must inform the Chief of Staff of the name and address of his or her primary care or attending physician and will authorize that physician to provide information regarding his or her condition and treatment, including whether in the physician's opinion, the Medical Staff member is capable of resuming medical practice. If the leave of absence was initiated under the Medical Staff Bylaws, Section 4.7 Impaired Medical Staff Members, request for reinstatement must be in accordance with said section.

4.8.3 The Board of Directors shall consider the recommendations of the Chief of Staff and may approve reinstatement to either the same or a different staff category and may limit or modify the clinical privileges to be extended to the individual upon reinstatement or impose conditions for the individual's practice deemed reasonably necessary for patient safety or the effective operation of the hospital. In the event that the Board of Directors recommends denial of reinstatement or modifications or conditions which would require a report to the NPDB, the individual shall be given written notice of his right to a hearing in accordance with Article IV, Section 4.2 Investigation and Corrective Action.

## ARTICLE V
PRIVILEGES

5.1. Method of Granting Privileges. Every person appointed to the Medical Staff shall be entitled to only such medical, surgical, or dental privileges as may be granted to him by the Board of Directors in accordance with Article IV. In addition, any member of the Medical Staff who is the attending physician for a patient at the Medical Center shall be entitled to request Advisory Consultant status in accordance with the Medical Staff Rules and Regulations for a physician, dentist or podiatrist who is not a member of the Staff, provided that all responsibility for managing and directing the care of the patient remains with the attending physician and that such action is not otherwise in conflict with the Bylaws, Rules and Regulations of the Medical Center.

5.2. Interim and Temporary Privileges.

5.2.1. Interim Privileges. After consultation with the Chairman of the Department concerned and with the Chief of Staff, the President or his designee may grant interim privileges for a limited time period not exceeding one hundred twenty (120) days to an applicant for membership on the Medical Staff or to an applicant on a waiting list in an over-utilized Department. Such privileges shall be granted only after the Medical Staff Office has completed the verification of all information required in connection with the application and all necessary references and evaluations required by these Bylaws and by the Credentialing Criteria of the applicable Department have been received; provided, there are no unfavorable reports and/or no reports missing on the following:

- Current licensure;
- Relevant training and experience;
- Current competence;
- Ability to perform the procedures for which privileges are requested;
- A query and evaluation of the National Practitioner Data Bank information;
- A complete application;
- No current or previously successful challenge to licensure or registration;
- No subjection to involuntary termination of medical staff membership at another organization;
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

The President or his designee shall inform the applicant in writing of the privileges granted and the expiration date thereof. The granting of such privileges shall be reported to the Medical Board at its next meeting. The Medical Board shall consider the action and make its determination as to approval or disapproval of such action at its next meeting. The recommendation of the Medical Board shall be forwarded to the Board of Directors.

5.2.2. Temporary Privileges.

5.2.2.1. Temporary privileges may be granted to provide subspecialty services urgently required for the care of a current Medical Center inpatient and not reasonably available from a member of the Medical Staff, and in departments when additional medical personnel are required to cover extraordinary department workloads. The Medical Staff Office shall verify current licensure and current competence. Such temporary privileges shall be limited in duration to the briefest period reasonably necessary to meet the urgent situation, but in no event longer than one hundred twenty (120) days. These privileges shall be granted by the President or his designee on the recommendation of the Chairman of Service and the Chief of Staff. The Medical Board shall consider the action and reach a conclusion regarding approval or disapproval of such action at its next meeting. The Medical Board shall report its conclusion to the Board of Directors.

5.2.2.2. Physicians granted temporary privileges under these circumstances will be required to complete an appointment application pursuant to Section 4.1 whenever the privileges granted are for the treatment of more than one patient.

5.2.3. All persons granted temporary or interim privileges shall meet the requirements of Section 3.1. Temporary or interim privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested. The clinical privileges granted the applicant shall be determined according to the same departmental credentialing criteria and delineated in the same fashion as they would were they being granted regularly. Temporary or interim privileges may be granted for a stated period or for a period spanning the specialized care of a specific patient, but in no event longer than one hundred twenty (120) days.

5.2.4. After consultation with the Chairman of the Department concerned and with the Chief of Staff, the President may terminate temporary or interim privileges for any reason or no reason, effective immediately upon written notice to the applicant. No applicant shall be entitled to appeal or to be granted an evidentiary hearing under Article IV upon a denial or termination of temporary or interim privileges unless such denial or termination is based on concerns regarding clinical competence or professional conduct.

5.3. Emergency Privileges. In the case of emergency, any member of the Medical Staff, to the degree permitted by his license and regardless of service or Staff status, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. If necessary, when an emergency situation no longer exists, such Medical Staff member must request the privileges necessary to continue to treat the patient. If the patient's needs are beyond the competence of the Medical Staff member involved, he will refer the patient to an appropriate physician as soon as practical. For the purpose of this Section, an "emergency" is defined as a condition in which

serious, permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.4. Disaster Privileges. During disaster(s) in which the Medical Center's Disaster Plan has been activated and the immediate needs of patient's cannot be met, the President or his designee may grant disaster privileges at his discretion on a case-by-case basis to volunteers eligible to be licensed independent practitioners who are not members of the Medical Staff and who do not possess Medical Staff privileges on the recommendation of the Chairman of the Department concerned and the Chief of Staff or their designee(s). Such privileges shall be granted prior to providing patient care on obtaining for each volunteer practitioner, at a minimum, a valid government-issued photo identification issued by a State or Federal agency and at least one of the following:

- A current picture hospital identification card that clearly identifies professional designation;
- A current license to practice;
- Primary source verification of the license;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC (Medical Reserve Corps), ESAR-VHP (Emergency System for Advance Registration of Volunteer Health Professionals), or other recognized State or Federal organizations or groups;
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a Federal, State or municipal entity);
- Identification by current Medical Center or Medical Staff member (s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

The practitioner will be provided with appropriate identification and should be paired with a currently-credentialed Medical Staff member and act only under the direct supervision of a Medical Staff member. Such practitioners will be granted core privileges in their specialty on an emergency basis.

The Medical Staff Office will begin the primary source verification of licensure as soon as the immediate situation is under control. This should be completed within 72 hours from the time the volunteer practitioner presents to the Medical Center. In the extraordinary circumstance that primary source verification of licensure cannot be completed within that time frame (e.g., no means of communication or a lack of resources), the reason shall be documented, along with evidence of a demonstrated ability to continue to provide adequate care, treatment and services, and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment and services under the disaster privileges. Based on the information obtained regarding the professional practice of the volunteer, the President or his designee shall make a decision within 72 hours related to the continuation of the disaster privileges initially granted. When the emergency situation no longer exists, these temporary disaster privileges terminate.

## ARTICLE VI
ORGANIZATION OF THE MEDICAL STAFF

6.1. Subdivision of the Medical Staff.

6.1.1. The Medical Staff shall be divided into Active, Associate, Contractual, Affiliate, Emeritus and Distinguished Emeritus categories.

6.1.1.1. With the exception of appointees recruited as Department Chairmen or Division Heads or as members of the Departments of Pathology, Anesthesiology, Diagnostic Radiology, Radiation Oncology and Emergency Medicine, who shall be initially appointed to the Active or Contractual Staff as provided in Section 6.1.4, all initial appointments with admitting privileges shall be made to the Associate Staff category in accordance with the procedures for initial appointment as prescribed in Article IV. All initial appointees shall be evaluated through a Focused Professional Practice Evaluation by the Department in which they have been appointed in accordance with the procedures and standards established by that Department and approved by the Board of Directors.

6.1.2. The Active Staff. The Active Staff shall consist of those members of the Medical Staff who desire to participate in the administration and governance of the Medical Staff by fulfilling the requirement of meeting attendance as outlined in the Rules and Regulations and also, when called upon, to serve in committee assignments. In addition, members of the Active Staff must admit or consult on at least ten (10) different patients or personally perform diagnostic or therapeutic procedures at the Medical Center on at least ten (10) different patients each year and/or devote commensurate time on committee or teaching assignments as designated by the Department in which their privileges are granted. Each Department will define what constitutes an appropriate procedure to be counted and so inform the Credentials Committee. This activity level is the minimum level to be met for this category. Each individual Department may require a higher level of activity to be met. Should a given member of the Active Staff be unable to participate during the current year, the reviewing Department Chairman, in conjunction with his Advisory Committee, may recommend his membership on the Associate Staff at the next renewal date of appointments and so notify said member at the time the review is made.

Active Staff members may vote on all matters which may come before the Medical Staff, departments/sections and committees to which the member is assigned. Only Active Staff members may be officers of the Medical Staff, Chairmen of Standing Committees and/or members of the Nominating Committee for officers of the staff.

6.1.3. The Associate Staff. The Associate Staff shall consist of those members of the medical profession eligible for Staff membership as herein provided who, although not members of the Active Staff, are given privileges in the area of their professional expertise. At the time of reappointment, the Associate Staff members may request to remain in the same category or they may request appointment to another category.

Each Department may require a minimum activity level to be met. Should a given member of the Associate Staff be unable to meet any required activity level, the reviewing Department Chairman, in conjunction with his Advisory Committee, may deem the Associate Staff member not eligible for reappointment at the expiration of the current appointment.

Associate Staff members may not vote on matters before the entire Medical Staff or be an officer of the Medical Staff. They may serve on Medical Staff committees and may vote on matters that come before such committees.

6.1.4. The Affiliate Staff. The Affiliate Staff shall consist of those members of the Medical Staff who do not wish to admit, consult, order or perform therapeutic interventions on patients utilizing the Medical Center's services. Affiliate Staff may attend Medical Staff and Department meetings, participate in continuing medical education functions and may be granted electronic access to laboratory and other diagnostic data relevant to their patients. They shall not hold clinical privileges. Each Department may specify additional requirements for Affiliate Staff membership.

At the time of reappointment, Affiliate Staff members may request to remain in the same category or request appointment to another category.

Affiliate Staff members may not vote on matters before the entire Medical Staff or be an officer of the Medical Staff. They may serve on Medical Staff committees and may vote on matters that come before such committees.

6.1.5. The Contractual Staff. The Contractual Staff shall consist of those members of the medical profession who do not have other staff privileges and who are eligible for staff membership as herein provided and who are given privileges limited to attending patients and/or performing services under conditions specified by a written contract with the Medical Center. The limitations of the contract related to the attending of patients or the services to be rendered shall be defined by the Chairman of the Department and the Departmental Advisory Committee initiating the appointment in conjunction with the Administration. Confirmation of such appointments, with specifications of the limitations of privileges for attending patients and services rendered, shall be in accordance with the procedures for initial appointment outlined in Article IV. Such appointments shall terminate when the contract expires unless sooner terminated for failure to perform the conditions of the contract. Contracts may be renewed or Contractual Staff may be promoted to another Staff category in accordance to the procedure outlined in Article IV.

Contractual Staff may not vote on matters before the entire Medical Staff or be an officer of the Medical Staff. They may serve on Medical Staff committees and may vote on matters that come before such committees.

6.1.6. The Emeritus Staff. The Emeritus Staff shall consist of professionals who have completely retired from active practice. Members of this category shall not hold clinical privileges and shall not be required to pay dues, carry malpractice insurance, or maintain current Maryland licensure.

Emeritus Staff may not vote on matters before the entire Medical Staff or be an officer of the Medical Staff. They may serve on Medical Staff Committees, and may vote on matters that come before such Committees.

6.1.7. The Distinguished Emeritus Staff. The Distinguished Emeritus Staff shall consist of those professionals who have completely retired from active practice at the Medical Center and who are of outstanding reputation and have served with distinction on the Active Medical Staff. Election of this category shall be recommended by the Chairman of the Department involved and consultation with his Advisory Committee and Attending Staff. Members of this category shall not hold clinical privileges and shall not be required to pay dues, carry malpractice insurance, or maintain current medical licensure.

Distinguished Emeritus Staff may not vote on matters before the entire Medical Staff or be an officer of the Medical Staff. They may serve on Medical Staff Committees, and may vote on matters that come before such Committees.

6.2. Privileges and Duties of the Staff.

6.2.1. Dues and Assessments. All members of the Medical Staff shall pay dues and assessments as determined by the Medical Board and stipulated in the Rules and Regulations except the Emeritus and Distinguished Emeritus Staffs.

6.2.2. Attendance at Meetings. Members of the Active Staff shall attend Medical Staff and departmental meetings as required by the Rules and Regulations and their individual Departments. Members of all other Staff categories shall be encouraged to attend meetings but shall not be required to do so unless otherwise specified by the Department in which their privileges are granted.

6.2.3. Teaching Programs. GBMC is an accredited teaching hospital and has certain formal and informal educational functions to perform in addition to and coincidental with its service responsibilities to the Community. The education of medical students, physicians, nurses, and allied health professionals at both the undergraduate and post- graduate levels is actively supported and encouraged. All members of the Medical Staff shall be encouraged to participate in these educational functions if requested.

6.2.4. Admission of Private Patients. Members of the Active and Associate Staff may admit patients to available beds without limitations in the area of their professional expertise as may be recommended by the Chairman of the Department concerned with his Advisory Committee and the Medical Board and granted by the Board of Directors. Members of the Departments of Radiation Oncology and Diagnostic Radiology shall be

allowed to participate in dual admissions as primary admitters only for those patients requiring diagnostic or therapeutic radiologic procedures. All members of the Division of Dentistry shall be allowed to participate in dual admission of patients solely for dental treatment with the concurrence of and in conjunction with a physician or surgeon on the Medical Staff. Podiatrists and those oral and maxillofacial surgeons, who are qualified by their training and appropriate certification by their delineation of privileges, may admit primarily subject to the requirements of the Rules and Regulations. A member of the Medical Staff with admitting privileges pledges to provide for the continuous care of his patients admitted to the Medical Center.

6.2.5. History and Physical Examination.

6.2.5.1. Pre-Surgical History and Physical Examination. There must be a complete history and physical examination in the chart of every patient prior to surgery, except in emergencies.

A history and physical performed within thirty (30) days prior to the surgery will meet this requirement if there is a subsequent assessment by the surgeon, including a physical examination, to update any components of the patient's medical status that may have changed since the prior history and physical; and a statement that the necessity for this procedure still exists.

This updated note must be done at the time of admission prior to any procedure whether or not there have been any changes to the patient's status. The operating surgeon may delegate all or part of the history and physical examination to other Medical Staff members, resident staff or to a credentialed nurse practitioner or physician assistant, but the surgeon must sign for and assume full responsibility for these activities.

6.2.5.2. Admission History and Physical. In those admissions without a planned surgical procedure, a complete history and physical examination shall, in all cases, be written within twenty-four (24) hours of the admission of the patient. The attending physician may delegate the history and physical to other Medical Staff members, resident staff or to a credentialed nurse practitioner or physician assistant. The attending physician is responsible for the admission note. The attending admission note should indicate: (1) reason for patient admission; (2) planned investigation; (3) intended plan of treatment.

6.2.5.2.1. For patients admitted under dental or podiatric services, the dentist or podiatrist shall be responsible for the dental or podiatric history and related physical examination. The medical history and physical examination shall be performed by a physician member of the Medical Staff. The dentist or podiatrist shall be responsible for obtaining consultation from a physician member of the Medical Staff for concurrent medical disorders that may affect the clinical outcome of the admission. Qualified oral and

maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examination on those patients if they have such privileges, and may assess the medical risks of the proposed surgical and/or other invasive procedures. For their patients admitted with medical problems, oral and maxillofacial surgeons shall follow the history and physical and consultation requirements set forth above for dentists and podiatrists.

6.2.5.2.2. The attending physician shall approve the physical examination, summary, and final diagnosis on all patients.

6.2.5.2.3. When such history and physical examination are not recorded before the time stated for operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would be detrimental to the patient. Patients from one service undergoing a major surgical procedure on another service are automatically transferred to the care of the surgeon unless otherwise specified by the person writing the post-operative orders.

6.2.5.3. History and Physical Examinations for Outpatient Procedures. History and physical examinations for outpatient procedures or services will be in accordance with the following:

6.2.5.3.1. A history and physical examination is not required for procedures and Outpatient services requiring only local or no anesthesia; provided, however, that any department may require a history and physical for an outpatient service or procedure in the interest of patient safety.

6.2.5.4. Minimal Requirements for All History and Physical Examinations. These include:

- Documentation of recent and past medical history;
- Indication for surgery or procedure;
- Current medications;
- Known allergies;
- Vital signs;
- Physical exam appropriate to the patient's condition.

6.2.5.4.1. The extent of the history and physical examination varies according to the type of anesthesia used. Additional requirements are found in organizational policies , e.g., Anesthesia Protocol, Sedation for Diagnostic Operative Invasive Procedures, etc.

6.2.5.4.2. Supplemental information may be obtained by other health care providers immediately prior to the procedure.

6.2.5.5. History and Physical Time Limits. All history and physical examinations must be performed within the time limits outlined in Sections 6.2.5.1. and 6.2.5.2.above.

6.2.6. Consultation Privileges. All members of the various staff categories may act as consultants in the area of their professional expertise. Distinguished and active specialists who are not members of the Medical Staff may act only as consultants on individual patients after approval of the Chairman of the Department concerned and the President of the Medical Center in accordance with Section 5.2.

6.2.7. Ambulatory Care Privileges. Members of the Medical Staff may exercise their privilege to care for patients in ambulatory care areas to the extent of their delineated privileges.

6.2.8. Contracts. A practitioner who is employed by the Medical Center with clinical responsibilities or privileges, and who may also serve in an administrative capacity, must have achieved and maintained Medical Staff membership through the procedures provided in these Bylaws and those of the Board of Directors, and his clinical privileges shall be delineated in accordance with these Bylaws.

6.2.9. Medical Review Committees. Members of the Medical Staff must cooperate with and respond in a timely manner to requests from Medical Review Committees, as defined in these Bylaws or the Rules and Regulations. Failure to comply may be construed as a violation of these Bylaws and may result in a request for corrective action.

6.2.10. Additional Responsibilities. The members of the Active Staff shall have the responsibility to formulate, review and recommend to the Board of Directors any Medical Staff Bylaws, Rules, Regulations, policies, procedures and amendments as needed. Amendments to the Bylaws and Rules and Regulations shall be effective when approved by the Board of Directors. Such responsibilities shall be exercised in good faith and in a reasonable and timely manner.

6.2.12. Behavior at the Medical Center. All members of the Medical Staff shall cooperate with the Medical Center authorities and personnel and other members of the Medical Staff so as to assure that patients receive quality health care and that the Medical Center operates effectively and efficiently. Abusive, harassing, intimidating or disruptive behavior that adversely affects patient care or the function of the Medical Center shall not be condoned or tolerated. Written complaints from Medical Center personnel or the Medical Staff regarding a Medical Staff member's behavior may be made to the Chief Medical Officer, the Medical Staff Office or the Staff member's Department Chairman. Retaliation or retribution towards the complainant will not be condoned or tolerated. Once a complaint is received regarding behavior at the Medical Center, the Chief of Staff and the Department Chairman shall review it, discuss the complaint with the Medical Staff member and determine what response is indicated. If the complaint is against a Departmental Chairman, the Chief of Staff and the Chief Medical Officer shall review the complaint. If the complaint is against

the Chief of Staff, the Vice Chief of Staff and the Chief Medical Officer will review the complaint. The complaint and Departmental Advisory Committee review, if performed, will become part of the Staff member's file and will be reviewed as part of the reappointment process. If the individual Staff member elects to respond in writing to the complaint, this response will also become part of the Staff member's file. Nothing contained in this subsection shall limit the right of any person as described in Article IV to request investigation or corrective action nor affect the manner in which such requests shall be processed.

6.3. Conflict Resolution.

Conflicts between the Medical Staff and the Medical Board will be resolved using the following process:

Each Active Staff member may challenge any rule, regulation, policy or procedure established by the Medical Board by submitting in writing to the Chief of Staff the challenge and the basis of the challenge including any recommended changes to the rule or policy.

After such notification, the Medical Board shall discuss the challenge at its next meeting and determine if any changes will be made to the rule or policy. If changes are proposed, they will be communicated to the Medical Staff and, at such time, any Active Staff member may submit in writing to the Chief of Staff any further challenge(s) to the rule or policy.

In response to the written challenge, the Medical Board may appoint an ad hoc committee to review the challenge and recommend potential changes to address the concerns raised. If such an ad hoc committee is appointed, following its recommendations, the Medical Board will vote on the rule or policy.

Once the vote has been taken by the Medical Board in response to a challenge, with or without recommendations from the ad hoc committee, if formed, any Active Medical Staff member may submit a petition signed by at least [the] ten percent (10%) of the Active Staff members requesting review and possible change of a rule, regulation, policy or procedure to the Chief of Staff.

The Medical Board shall review the differing recommendations of the Medical Board and these members of the Medical Staff. An ad hoc committee for such a review may be appointed and may recommend language that is agreeable to both these members of the Medical Staff and the Medical Board. The Medical Board shall vote again in response to this challenge.

If the Medical Board and the challenging Medical Staff members do not agree on the language of the proposed change, then this disagreement shall be communicated to the entire Active Medical Staff for their deliberation and vote.

Regardless of the vote of the Medical Board or of the Medical Staff, the challenging members of the Medical Staff shall have the opportunity to recommend directly to the Board of

Directors alternative language. If the Board of Directors receives differing recommendations from the Medical Board and members of the Medical Staff, the Board of Directors shall have final authority to resolve the differences between the Medical Staff and the Medical Board.

6.3.1. At any point in the process of addressing a disagreement between members of the Medical Staff and the Medical Board regarding the Bylaws, Rules and Regulations or policies and procedures, members of the Medical Staff, the Medical Board or the Board of Directors shall each have the right to recommend using an outside resource to assist in addressing the disagreement. The Board of Directors shall have the responsibility for the final decision regarding whether or not to use an outside resource and the process that will be followed in doing so.

## ARTICLE VII
DEPARTMENTS OF THE MEDICAL STAFF

7.1. Departments and Divisions.

7.1.1. The Medical Staff shall be divided and organized into the following departments:

7.1.1.1. Department of Anesthesiology

7.1.1.2. Department of Diagnostic Radiology

7.1.1.3. Department of Emergency Medicine

7.1.1.4. Department of Family Medicine

7.1.1.5. Department of Gynecology

7.1.1.6. Department of Medicine

7.1.1.7. Department of Obstetrics

7.1.1.8. Department of Ophthalmology

7.1.1.9. Department of Otolaryngology - Head and Neck Surgery

7.1.1.10. Department of Pathology and Laboratory Medicine

7.1.1.11. Department of Pediatrics

7.1.1.12. Department of Psychiatry

7.1.1.13. Department of Radiation Oncology

7.1.1.14. Department of Surgery

7.1.2. Departments may be subdivided into one or more divisions to provide the most effective framework for patient care and house staff training. The creation of such divisions shall be subject to the approval of the Chairman of the Department concerned, an affirmative vote of two-thirds of the Medical Board, and approved by the Board of Directors. The person in charge of such a division will be designated as "Head" of such a division. Selection of the Division Head will be made by the Chairman from among the various members of the Department participating in this sub-specialty and will be based on abilities and leadership skills.

7.1.3. Additional Departments may be established in the future when it can be clearly demonstrated that the establishment of such new Department is desirable to improve the specialized care of patients or to insure the proper function of the specialty. Requests for the formation of such a new Department shall be submitted to the Board of Directors which may cause the Department to be established after receiving the recommendation of the Medical Board relative thereto.

7.2. Departmental Autonomy. The Departments established under Section 7.1, together with the physical facilities assigned thereto at the time of the opening of the Medical Center, shall not be changed in Departmental status, limited as to size and scope of service or have the assigned physical facilities reduced in availability to the Department assigned thereto by action of the Medical Board without the consent of the Chairman of the Department concerned.

7.3. Organization of Departments.

7.3.1. Each Department shall be organized as a unit of the Medical Staff and shall have a Chairman of Department who shall be responsible for the functioning of the Department and who shall have general supervision over the clinical work falling within his Department, whether it be service or private.

7.3.2. Each Department shall have an Advisory Committee.

7.3.2.1. In the Departments of Diagnostic Radiology, Emergency Medicine, Family Medicine, Pathology and Laboratory Medicine, Psychiatry and Radiation Oncology, the Advisory Committee shall consist of the Chairman of the Department and at least five (5) additional members, three (3) of whom shall, if possible, be members of the Active Staff of that department, and at least two (2) of whom shall be from the Active Staff of other Departments in the Medical Center which use the services of these Departments. The three (3) members from the Departments of Emergency Medicine, Diagnostic Radiology, Family Medicine, Pathology and Laboratory Medicine, Psychiatry and Radiation Oncology shall be elected by the Active Staff in that Department pursuant to Section 7.3.2.5, below. The two (2) members from the other Departments which use the services of these Departments shall be appointed by the Chief of Staff with the concurrence of the Chairman of the Department concerned.

7.3.2.2. In all other Departments, the Advisory Committee shall consist of the Chairman of the Department and at least five (5) members of the Active Staff elected by members of the Active Staff in the Department pursuant to Section 7.3.2.4. below.

7.3.2.3. In all Departments, the Chairman (or Acting Chairman) of the Department shall be a member of the advisory Committee in that Department but shall not be entitled to vote.

7.3.2.4. Members of an Advisory Committee other than those appointed by the Chief of Staff shall be elected in the following manner:

7.3.2.4.1. The Chairman of the Department, in conjunction with the Chairman of the Advisory Committee, shall appoint a nominating committee consisting of two (2) members not currently serving on the Advisory Committee. This committee shall select candidates for the Advisory Committee from the members of its departmental active staff. The Nominating committee shall circulate the list of candidates to the members of the departmental Active Staff no less than one (1) month and no more than four (4) months prior to the election. At a regularly scheduled departmental meeting, these, candidates, in addition to the nominations from the floor, shall be voted upon. Every member of the Active Staff in the Department shall be entitled to vote. Those candidates receiving the largest number of votes shall be elected to replace the members whose terms are ending. The annual election shall be held not more than four (4) months before the Annual Staff meeting.

7.3.2.5. The members of the Departmental Advisory Committee shall elect a Chairman thereof who shall serve for one three-year term. Although not permitted to succeed himself as Chairman, except in the Departments of Diagnostic Radiology, Emergency Medicine, Family Medicine, Radiation Oncology, Pathology and Laboratory Medicine, and Psychiatry, he may remain a member of the Advisory Committee if elected by the members of the Department. He may be reelected Chairman after a lapse of at least one (1) year.

7.3.2.6. The term of office of all other members of the Advisory Committee shall be two (2) years. In order to obtain continuity of experience and service, terms should be staggered.

7.3.2.7. The Advisory Committee of each Department shall advise the Chairman of the Department in all matters relating to the proper functioning and smooth operation of the Department. Pursuant to the procedures prescribed in Article IV, the Advisory Committee shall review with the Chairman all applications for appointment and reappointment of members in the Departments and shall also review with the Chairman all requests for corrective action against a Department member. The Advisory Committee shall hold four (4) or more meetings annually on call by the Chairman or by request of the Chairman of the Department. The minutes of these meetings shall be submitted to the Chief of Staff.

7.4. Chairmen of the Departments of the Medical Staff.

7.4.1. Each Department of the Medical Staff shall be headed by a Chairman who shall be appointed by the Board of Directors as outlined in Article VII.

7.4.2. Departmental Chairmen shall be subject to the requirements of reappointment. Subject to the biennial reappointment process, a Departmental Chairman may continue in office with the consent of the Advisory Committee of his Department, the Medical Board, and the Board of Directors. It will be the responsibility of the Credentials Committee to request the required consents. If during the period of appointment as Chairman, the Chairman of a Department does not fulfill his function adequately or there are justifiable academic or administrative reasons, his appointment as Chairman may be suspended or terminated either in the course of the usual biennial reappointment process or through the corrective action or summary suspension procedures prescribed in Article IV of these Bylaws. Pending final action by the Board of Directors in a reappointment or corrective action proceeding, the Board of Directors, Medical Board, or Chief of Staff after consultation with the Medical Board, may suspend the physician from the duties of his appointment as Chairman in accordance with the procedures prescribed in Article IV. The termination or suspension of a Chief's appointment as Chairman shall not automatically be deemed a termination, suspension, or modification of the Chairman's Active Staff membership or other Medical Center privileges; however, pursuant to appropriate procedures prescribed by these Bylaws, his privileges and Active Staff membership may concurrently be terminated, suspended, or modified.

7.4.3. Selection and Appointment of Chairmen of Departments.

7.4.3.1. A Nominating Committee shall be convened to recommend candidates for the appointment as Chairman of a Department. The Nominating Committee shall consist of five (5) of the members of the Advisory Committee of the Department concerned; appointed by the Chairman of the Advisory Committee; one additional member of the Active Staff of the department concerned, appointed by the Chief of Staff with the approval of the Department Advisory Committee; three members of the Active Staff from other departments, appointed by the Chief of Staff with the approval of the Medical Board; the President of the Medical Center and a member of the Medical Center Board of Directors. The Chairman of the Advisory Committee shall serve as the Chairman of the Nominating Committee.

7.4.3.1.1. If there is no Advisory Committee, the Chief of Staff, with Medical Board approval, shall appoint nine (9) persons, knowledgeable in the appropriate specialty, the majority of whom shall be members of the Active Medical Staff, as members of the Nominating Committee in lieu of the Advisory Committee. The President of the Medical Center and a member of the Board of Directors shall also serve on this Nominating Committee.

7.4.3.1.2. If a member of the Nominating Committee becomes a candidate for the nomination concerned or resigns from the Committee, that person shall be replaced by a new member, whenever possible and appropriate from the same department, appointed by the Chief of Staff with the approval of the Medical Board.

7.4.3.2. The Nominating Committee, by affirmative vote of at least seven (7) members shall select a candidate and shall submit and personally present a report regarding this candidate to the members of the affected Department. Within ten (10) days after meeting with members of the affected Department, the Nominating Committee Chairman shall send a written notice to each member of the Active Staff of the affected Department. This notice shall include a written ballot and shall advise each member that a signed ballot in favor or against the proposed candidate must be returned to the Nominating Committee Chairman within thirty (30) days of the mailing of such notice. Upon request by any Department member the Nominating Committee Chairman shall make available the curriculum vitae of the proposed candidate.

7.4.3.3. If the proposed candidate is approved by a majority vote of the Active Staff members of the affected Department who respond, within five (5) days of such action, the Nominating Committee Chairman shall submit the Department's decision, along with the Nominating Committee's report, to the Medical Board. At the same time, the Nominating Committee Chairman shall post the name of the candidate in the Medical Center. All Medical Staff members may submit comments to the Medical Board regarding a candidate approved by the affected Department. If a candidate is not approved by the affected Department, the Nominating Committee shall advise the Medical Board and the Board of Directors and shall reconvene to select a new candidate. The Board of Directors may elect to meet with the Department in an effort to ascertain the rationale for rejection.

7.4.3.4. Within forty-five (45) days of receiving a favorable Departmental decision and the Nominating Committee's report, the Medical Board shall consider the proposed candidate and, by majority vote of a quorum, decide whether or not to recommend to the Board of Directors that this candidate be approved. The Medical Board's recommendation, the Department's decision, and the Nominating Committee's report shall be submitted by the Chief of Staff to the Board of Directors within five (5) days after the Medical Board's vote.

7.4.3.5. The Board of Directors shall approve or reject a candidate within sixty (60) days after receipt of the Department's decision, the Medical Board's recommendation, and the Nominating Committee's report. If a candidate is not approved by the Board of Directors, the Board of Directors shall notify the Nominating Committee and the Medical Board with their rationale for rejection, and the Nominating Committee shall reconvene to select a new candidate. Disapproval of any candidate for appointment as Chairman of the Department shall not give rise to an evidentiary hearing or other appeal.

7.4.3.6. No one may be appointed a Chairman of a Department unless he is a member of the Active Staff. Any candidate proposed by the Nominating

Committee who is not already a member of the Active Staff shall submit an application to become a member thereof immediately upon nomination.

The applications for initial appointment under Article IV; or if the candidate is already a member of one of the other Departments of the Medical Center, then it shall be processed like an application for reappointment. The Departmental Advisory Committee, the Medical Board, and the Board of Directors shall review the appointment or reappointment application concurrently with the consideration of the candidate's appointment as Chairman.

7.4.3.7. No one may be appointed a Chairman of a Department unless he is certified by one or more specialty boards recognized by the American Board of Medical Specialties. At least one such certification must be in a specialty which falls within the Department of which he is Chairman.

7.4.3.8. All Medical Center committees and boards responsible for evaluating a candidate for appointment as Chairman of a Department shall consider all available information and recommendations concerning the candidate. In addition to the criteria used in evaluating an appointment or reappointment to the Medical Staff, the Medical Center committees and boards reviewing an appointment as Chairman shall consider the candidate's ability to fulfill the duties and responsibilities of a Chairman as set forth in Section 7.4.5 below. Any guidelines established by the Board of Directors shall also be considered.

7.4.3.9. If a Department Chairman dies or becomes ill so that he is unable to fulfill his duties, or if his appointment as Chairman of the Department has been suspended or terminated, the Chief of Staff, upon the recommendation of the Advisory Committee of the Department involved, shall appoint a temporary Chairman to act until the selection and appointment of a new Chairman can be made according to Section 7.4.3.

7.4.4. Duties and Responsibilities of Department Chairmen. The Chairman of each Department shall:

7.4.4.1 Maintain continuing supervision over the medical, financial, educational, administrative, and clinically-related activities of his Department and be responsible at all times for the proper organization and functioning of the Department.

7.4.4.2. Establish and maintain standards of professional practice and procedure in the Department and continually monitor the professional performance of all Medical Staff members who exercise delineated privileges therein.

7.4.4.3. Recommend to the Medical Board the criteria for clinical privileges relevant to the care provided in the Department.

7.4.4.4. Provide appropriate direction and supervision to non-Medical Staff personnel in the Department performing allied health, administrative, and other services.

7.4.4.5. Supervise and report annually on the continuous assessment and improvement of the quality of care, treatment and services rendered within the Department and cooperate fully with all Medical Center committees concerned with the quality of patient care.

7.4.4.6. Organize and maintain a teaching program in the Department for the orientation and education of Medical Staff members appointed thereto, and assure their participation in such programs.

7.4.4.7. Develop, implement and assure compliance with Departmental policies and procedures to guide and support the appropriate provision of services for patients of the Department.

7.4.4.8. Integrate the Department into the primary functions of the Medical Center.

7.4.4.9. Coordinate and integrate interdepartmental and intradepartmental services.

7.4.4.10. Maintain quality control programs, as appropriate.

7.4.4.11. Hold four (4) or more regular meetings annually with the Departmental Advisory Committee, and hold such other special meetings as shall be necessary or appropriate to fulfill the responsibilities and duties of the Chairman and the Advisory Committee under these Bylaws.

7.4.4.12. Pursuant to the procedures prescribed in Article IV of these Bylaws and in conjunction with the Departmental Advisory Committee:

7.4.4.12.1. Review and make recommendations on all applications for appointment and reappointment of members of the Department;

7.4.4.12.2. Review and make recommendations on all requests for delineated clinical privileges in the Department; and,

7.4.4.12.3. Review all requests for corrective action against a Department member.

7.4.4.13. Report regularly to the Medical Board, Medical Center Administration, and to the Board of Directors as requested, concerning the medical, financial, educational, administrative, and professional activities and needs of the Department, including, but not limited to, recommendations for a sufficient number of qualified and competent persons to provide care or other services.

7.4.4.14. Submit a written annual report of the activities of his Department to the Medical Staff, Medical Board and the Board of Directors.

7.4.4.15. Make recommendations to Medical Center Administration regarding space and other resources needed by the Department.

7.4.4.16. In cooperation with Medical Center Administration and other appropriate Management personnel, participate in determining the qualifications and competence of Department personnel who are not Medical Staff members and who provide patient care, treatment and services.

7.4.4.17. Cooperate with and assist all Medical Center committees and personnel in patient care services. Cooperate with and assist all Medical Center committees and personnel in the performance of their duties and the preparation of reports necessary to the smooth and proper functioning of the Medical Center, and participate in the planning of the Department budget.

7.4.4.18. Implement and enforce the Bylaws of the Medical Center and the Bylaws of the Medical Staff as the same may be in effect from time to time, including any and all Rules and Regulations, protocols and policies duly promulgated thereunder; all guidelines, requirements, and ethical and professional standards of the American Medical Association and the Joint Commission on Accreditation of Healthcare Organizations; and all government laws, rules, regulations, guidelines, orders and other requirements, all as may apply in any way to the activities or the functioning of the Department.

7.4.4.19. Recommend and assess off-site sources for needed patient care, treatment and services not provided by the department and Medical Center.

7.4.5. Joint Responsibility. Matters of overlapping responsibility shall be considered jointly by the Chairmen of the Departments concerned and shall be resolved by mutual agreement.

## ARTICLE VIII
OFFICERS

8.1. Officers. There shall be three (3) officers of the Staff who shall also be officers of the Medical Board. They shall be the Chief of Staff, the Vice Chief of Staff, and the Secretary-Treasurer.

8.2. Terms and Methods of Election.

8.2.1. The officers shall be elected by the written ballot of the members of the Active Staff present at the annual meeting from those nominees submitted by the Nominating Committee for officers and from such other nominations as may be made from the floor. An officer to be elected must receive at least 50 percent of the vote; run-offs will take place until this is achieved.

8.2.2. The Chief of Staff shall be elected biennially by the entire voting Staff and shall be a member of the Active Staff. He shall serve a term of two (2) years and may succeed himself for four (4) additional terms for a total of ten (10) years.

8.2.3. The Vice Chief of Staff shall be elected biennially by and from the Active Staff and may succeed himself indefinitely.

8.2.4. The Secretary-Treasurer shall be elected biennially by and from the Active Staff and may succeed himself indefinitely.

8.2.5. If the position of Chief of Staff becomes vacant during the Staff year, a successor shall be elected by the Medical Board for the remainder of that Staff year. The procedure of election specified in Section 8.2.1 above shall be followed in electing a successor.

8.2.6. If a vacancy occurs in the office of Vice Chief of Staff or Secretary-Treasurer, the Medical Board may at any meeting elect a successor to fill the vacancy for the remainder of the term.

8.3. Duties.

8.3.1. The Chief of Staff shall be responsible to the Medical Staff for its status pertaining to hospital accreditation and shall assist the President and Chief Medical Officer in maintaining the accreditation status of the hospital. He shall preside at and call all regular meetings and may call special meetings. He shall preside at all meetings of the Medical Board. He shall appoint members of all standing committees from representatives of the appropriate Departments based on recommendations of the Departmental Chairmen and their Advisory Committees and subject to approval by the Medical Board. He shall be an ex-officio member of the Board of Directors and of all Standing Committees of the Medical Staff, except the Nominating Committee for Officers of the Staff, and may appoint a parliamentarian.

8.3.2. The Vice Chief of Staff shall act for the Chief when necessary and is assistant to the Chief as the latter shall designate. He shall be an ex-officio member of the Board of Directors.

8.3.3. The Secretary-Treasurer shall give notice of all meetings of the Medical Board and of the Active Staff and shall keep accurate and complete minutes of all proceedings thereat. He shall receive and conduct all correspondence of the Medical Board and of the Medical Staff and shall perform all of the usual duties pertaining to his office. In the absence of the Secretary -Treasurer, the Medical Board may appoint a Secretary-Treasurer pro tempore to perform his duties.

8.4. Suspension, Termination. If during his term, an officer does not fulfill his functions adequately, his term in office may be suspended or terminated by the Medical Board, subject to a two-thirds vote for either action. In addition, each member of the Active Staff may initiate suspension or termination of an officer by requesting formal consideration of such in writing to the Chief of Staff or to the Vice Chief of Staff if the officer in question is the Chief of Staff. Ratification by the Medical Staff of such action is required at its next regular or special meeting. The suspension or termination shall be handled in the same manner as a vacancy under Sections
8.2.5. and 8.2.6.

## ARTICLE IX
COMMITTEES

9.1. The Medical Board.

9.1.1. Composition.

9.1.1.1 The Medical Board includes physicians and may include dentists and podiatrists. It shall consist of:

9.1.1.1.1 All Chairmen of Departments;

9.1.1.1.2. The three (3) elected officers of the Staff;

9.1.1.1.3. Two (2) additional members from the Advisory Committee of the Department of Medicine;

9.1.1.1.4. Two (2) additional members from the Advisory Committee of the Department of Surgery;

9.1.1.1.5. One (1) additional member from the Advisory Committee of each of the remaining departments;

9.1.1.1.6. Four (4) members-at-large;

9.1.1.1.7. The Quality Assurance Officer; and,

9.1.1.1.8. The Medical Director of the Cancer Center.

9.1.1.1.9. The Chief of Staff shall have discretionary ability to expand the Medical Board by appointing up to two (2) additional voting members whose term shall be for two (2) years. Appointments are to be based on recognition of the individual's contribution and importance to the Medical Center's mission and vision. Such members can be reappointed by the Chief of Staff for an additional two (2) year term. All such appointments must be ratified by the Medical Board.

9.1.1.2. Two (2) members of the Board of Directors, as designated by the Chairman, shall attend all meetings of the Medical Board but shall have no vote.

9.1.1.3. There shall also be the following ex-officio members, who shall sit without vote: the President of the Medical Center or his designee, the Chief Medical Officer of the Medical Center and the Director, Advanced Practitioners.

9.1.1.4. Each member of the Medical Board, except those previously designated as ex-officio non-voting members, is entitled to vote. When the Chairman of a Department cannot attend a Medical Board meeting, he may designate an alternate who will have full voting privileges. This designation must be by written notification to the Chief of Staff. The presiding officer shall cast a vote only to break a tie in the event of a tie vote.

9.1.1.5. At all meetings of the Medical Board, twelve (12) members present shall constitute a quorum.

9.1.2. Methods of Election.

9.1.2.1. The officers shall be elected as outlined in Article VIII.

9.1.2.2. The members of Departmental Advisory Committees shall be elected as outlined in Article VII.

9.1.2.3. Election of the four (4) members-at-large will take place at the same time the Medical Staff officers are elected as described in the Rules and Regulations.

9.1.3. Authority and Responsibilities. The Medical Board shall be the governing body of the Medical Staff. The responsibilities of the Medical Board shall be:

9.1.3.1. To determine the basic policies affecting medical practices within the Medical Center and to put such policies into effect after they have been recommended to and approved by the Board of Directors. If members of the Medical Staff disagree with a policy or procedure enacted by the Medical Board, they can utilize the conflict resolution mechanism contained within these Bylaws (Article VI). Such policies shall include, but not be limited to:

9.1.3.1.1. The structure of the Medical Staff;

9.1.3.1.2. The mechanism used to review credentials and to delineate individual clinical privileges;

9.1.3.1.3. The mechanism by which Medical Staff membership may be terminated; and,

9.1.3.1.4. The mechanism for fair hearing procedures.

9.1.3.2. To consider medical-administrative and clinical matters referred to it by the Board of Directors, the President, or physicians on the Active Staff, or reported or recommended to it by Medical Staff Committees, Departments and assigned work groups and to take action upon such matters providing the same do not conflict with the provisions of these Bylaws and Rules and Regulations.

9.1.3.3. To render such advice in medical matters to the President and the Board of Directors as may be required, including, but not limited to, the participation of the Medical Staff in performance improvement activities.

9.1.3.4. To act for the Medical Staff between regularly scheduled meetings of the Medical Staff. The Chief of Staff and Chief Medical Officer or their designees shall jointly be empowered to correct emergency patient safety or quality of care issues that cannot wait until the next scheduled Medical Board meeting. These shall require the approval of the President or his designee (other than the Chief Medical Officer in such situations). Medical Board members shall be immediately notified of such emergency issues and the corrective actions taken. These actions will be discussed at the next regularly scheduled Medical Board meeting (or at a special meeting, if necessary) and timely disseminated to the Medical Staff.

9.1.3.5. To consider all applicants for membership on the Medical Staff and make recommendations to the Board of Directors as outlined in Article IV.

9.1.3.6. To consider all requests for delineated clinical privileges for each eligible individual and make recommendations to the Board of Directors as outlined in Article IV.

9.1.3.7. To report, through the Chief of Staff, at each annual meeting of the Active Staff upon the actions taken by the Medical Board since the last meeting.

9.1.3.8. To supervise generally and coordinate the work of all committees of the Medical Board.

9.1.3.9. To be responsible for and direct the expenditures of the Medical Staff Fund.

9.1.4. Suspension, Termination. If during his term, a Medical Board member does not fulfill his functions adequately, his term in office may be suspended or terminated by the Medical Board , subject to a two-thirds vote for either action. The concerned Department Chairman shall appoint his replacement from among his Advisory Committee members, subject to the approval of the Chief of Staff.

9.2. Standing Committees.

9.2.1. In recognition of the need for ongoing consideration of matters affecting the Medical Staff, or the relationship between the Medical Staff and the Medical Center, or for the purpose of adhering to the requirements of the Joint Commission on Accreditation of Hospitals, or other related regulatory or advisory agencies, the Medical Board shall from time to time establish committees, which will meet regularly and report to the Medical

Board with information and/or recommendations. The Standing Committees shall be listed and shall function as described in these Rules and Regulations.

9.2.2. The Chief of Staff upon election or re-election shall appoint the Standing Committee members, who shall serve throughout his elected term and for sixty (60) days thereafter. These appointments are made with the approval of the Medical Board and based upon recommendations by the various Department Chairmen and their Advisory Committees.

9.2.3. Standing Committees may be created or deleted from time to time by action of the Medical Board.

9.3. Special and Ad Hoc Committees.

9.3.1. The Chief of Staff may when necessary, with the approval of the Medical Board, appoint special committees to study and report on the particular matters coming before the Board. The composition, duties, and authority of special committees shall be determined at time of appointment. Such special committees shall submit their report in writing to the Medical Board. The Hearing Committee provided for in Article IV of these Bylaws shall be a special committee within the meaning hereof. Other special committees shall be listed and shall function as described in these Rules and Regulations.

9.3.2. Upon the request of the President or the Chairman of the Board of Directors, the Chief of Staff shall appoint committees on an ad hoc basis to study or investigate any other matters concerning the Medical Center or Medical Staff. The composition, duties, and authority of such ad hoc committees shall be determined at the time of appointment. Such ad hoc committees shall report their findings in writing to the Chief of Staff and to the person requesting the study or investigation.

9.4. Membership of Committees.

9.4.1. With the approval of the Medical Board, the Chief of Staff shall first appoint the Chairman of a Standing Committee or special committee and, after conferring with him, shall then appoint the other committee members from the appropriate Departments as recommended by the Chairmen of such Departments and their Advisory Committees. Each Standing Committee shall consist of a Chairman and at least two (2) other members. An effort shall be made to maintain reasonable continuity of membership on such committees from year to year. Each Standing and special committee shall be subject to call by its Chairman and shall also be subject to call by the Chief of Staff.

9.4.2. The Chief of Staff shall be a member ex-officio of all Standing Committees except the Nominating Committee. The President or his designee may be ex-officio without vote.

9.4.3. At all meetings of each Standing Committee, special committee or ad hoc committee, one-third (1/3) of the voting members shall constitute a quorum.

## ARTICLE X
MEETINGS

10.1. Active Staff.

10.1.1. There shall be at least two (2) regular meetings of the Active Staff each year. The annual meeting shall be held in the month of July.

10.1.2. Special meetings of the Active Staff may be held at any time upon call of the Medical Board or by a written petition signed by twenty-five (25) or more of the members of the Active Staff and presented to the Chief of Staff. Only such business may be transacted thereat as may be summarized in the notice of the meeting.

10.1.3. Quorum. At all meetings of the Active Staff, sixty (60) members of the Active Medical Staff present shall constitute a quorum.

10.2. Medical Board. Regular meetings of the Medical Board shall be held as provided for in the Rules and Regulations. Special meetings may be held at any time upon call by the Chief of Staff.

10.3. Attendance Requirement. The number of Medical Staff meetings and departmental or sectional conferences which each member of the Medical Staff shall be required to attend annually shall be fixed in the Rules and Regulations hereinafter set forth.

10.4. Rules of Order. The Standard Code of Parliamentary Procedure (Sturgis) shall govern the conduct of all meetings of the Medical Board, its committees, and the Active Staff.

## ARTICLE XI
RULES AND REGULATIONS

11.1. Rules and Regulations which may be necessary for the proper conduct of the work of the Medical Staff under these Bylaws shall be adopted with the approval of the Board of Directors. Such Rules and Regulations shall be a part of these Bylaws, and amendments to them may be initiated by either the Medical Board or the Board of Directors and shall be referred to the Bylaws Committee. This committee shall review these proposals and report its recommendation to the Medical Board.

11.2. A proposed amendment to the Rules and Regulations may be presented at any regularmeeting of the Medical Board. The Medical Board may recommend approval of the proposed amendment to the Rules and Regulations by a two-thirds (2/3) vote of the eligible voting members present at a meeting at which a quorum is present. Any recommended amendment to the Rules and Regulations shall be communicated to the Medical Staff for comment, the results of which will be conveyed to the Board of Directors

11.3. A proposed amendment to the Rules and Regulations may also be initiated and presented directly to the voting Medical Staff by petition bearing signatures of at least ten (10) percent of the members of the Active Medical Staff and circulated three (3) weeks prior to the next Medical Staff meeting. The Medical Staff may recommend approval of the proposed amendment to the Rules and Regulations by a two-thirds (2/3) vote of the eligible voting Staff present at the meeting at which a quorum is present. Any recommended amendment to the Rules and Regulations shall be reviewed by the Medical Board. The results of such review will be conveyed to the Board of Directors.

11.4. All amendments to the Rules and Regulations recommended by the Medical Board or Medical Staff shall become effective following approval by the Board of Directors by a majority vote at a meeting of the Board of Directors at which a quorum is present. Amendments to the Rules and Regulations approved by the Medical Board or Medical Staff shall automatically become effective within sixty (60) days if no action is taken by the Board of Directors.

11.5 The Medical Board may recommend such provisional amendment(s) to these Rules and Regulations that are in the Medical Board's judgment necessary for legal or regulatory compliance. If the Medical Staff supports the proposed provisional amendment(s), the amendment(s) will stand. If the Medical Staff does not approve of the provisional amendment(s), the conflict resolution mechanism in these Bylaws (Article VI*)* will be followed. If a substitute amendment is ultimately proposed, it will follow the approval process appearing in this article.

## ARTICLE XII
AMENDMENT

12.1. Proposed changes in the Bylaws may be initiated by any member of the Active Medical Staff or Board of Directors and shall be referred to the Bylaws Committee. This committee shall formalize these proposals and report its recommendation to the Medical Board.

12.2. The Medical Board shall decide, by a two-thirds (2/3) vote of the eligible voting members present at a meeting at which a quorum is present, whether to recommend approval of the proposed amendment to the Bylaws. Any proposal that was initiated by the Board of Directors and is not approved by the Medical Board shall be referred back to the Board of Directors. All other proposals not approved by the Medical Board may be presented directly to the eligible voting Medical Staff by petition bearing signatures of at least ten (10) percent of the members of the Active Medical Staff and circulated a minimum of three (3) weeks prior to the next Medical Staff meeting.

12.3. Any proposal approved by the Medical Board shall then be sent by mail to all members of the eligible voting Medical Staff at least two (2) weeks prior to a special meeting or the next regular meeting of the Medical Staff. The Medical Staff may approve proposed amendments submitted to it by a two-thirds (2/3) vote of the eligible voting staff present at the meeting at which a quorum is present.

12.4. Amendments to the Bylaws approved by the Medical Staff shall become effective following approval by the Board of Directors at which a quorum is present. Bylaws amendments approved by the Medical Staff shall automatically become effective within sixty (60) days if no action is taken by the Board of Directors.

12.5. These Bylaws shall be reviewed annually by the Bylaws Committee which shall report to the Medical Board any need for further revision.

## RULES AND REGULATIONS

## RULES AND REGULATIONS

1. Standing Committees of the Medical Staff:

   A. Bylaws Committee

   The Bylaws Committee shall assist the Medical Board in keeping abreast of and in compliance with recommendations of The Joint Commission. Proposals to amend these Bylaws and Rules and Regulations shall be referred to the committee which, after reviewing the said paragraphs or amendments, shall present its recommendations with respect thereto to the Medical Board.

   The committee shall see that all amendments to those Bylaws, Rules and Regulations, in the form approved by the Board of Directors, are properly noted and such amendments are circulated to members of the Medical Staff and the House Staff. The Bylaws Committee shall consist of at least five (5) members, one (1) of whom shall be appointed from the Medical Board.

   B. Cancer Committee

   The Cancer Committee shall be responsible for the ongoing review of the care of patients who are treated for cancer at the Greater Baltimore Medical Center according to established departmental protocols. This committee shall review, support, augment, and approve all cancer therapy programs at the Medical Center. The committee shall serve as liaison between the Medical Staff and the Administration and Board of Directors of the Medical Center for the purpose of enhancing cancer treatment. Membership of this committee shall include a representative from the Departments of Diagnostic Radiology, Radiation Oncology, Surgery, Gynecology, Pathology, and the Divisions of Medical Oncology and Urology and such other members of the Medical Staff as may be deemed necessary for the effective functioning of this committee. In addition, there shall be a representative from the Administrative staff.

   C. Library and Continuing Medical Education Advisory Committee

   The Library and Continuing Medical Education Advisory Committee shall be charged with the continuing education of the Medical Staff and all other medical and paramedical personnel who are authorized by law or these Bylaws to treat patients at the Medical Center, as well as be responsible for the maintenance and functioning of the Medical Library which shall contain all books and periodicals necessary, in the judgment of the committee, for the use and education of the Medical Staff and House Staff. In addition, this committee shall prepare and submit annually to the Medical Board a budget for the ensuing year, upon the basis of which the Medical Board may allocate Staff Funds to the committee. The President of the Medical Center or his designee shall be a member of the committee.

D. Credentials Committee

The Credentials Committee shall review the applications of all applicants for appointment and reappointment to the Medical Staff and report its findings and recommendations in accordance with Article IV of these Bylaws. The Chief of Staff shall appoint one (1) Active Staff member from at least seven (7) Departments and one (1) additional Active Staff member to be Chairman of the Committee. The Chairman shall not be a Chairman of a Department. The Chairman of the Committee shall not be entitled to vote except in the case of a tie. The Chairman of the Board of Directors shall appoint a sufficient number of members of the Board of Directors to be members of the committee so that the number of Directors equals the number of Medical Staff members on the Credentials Committee, not counting the Chairman of the Committee. The President shall appoint one (1) administrator of the Medical Center to be a member of the committee who shall not be entitled to vote. The committee shall meet at least every two (2) months to consider applications for appointment and reappointment submitted during that time. A majority vote of a quorum of the committee shall be required to sustain any decision.

E. Critical Care Committee

The Critical Care Committee shall have general supervision over matters related to patient care in these units and shall, from time to time, make recommendations with respect thereto to the President and Medical Board. The committee shall be responsible for developing policies and procedures designated to maximize the quality and effectiveness of patient care in these units, subject to the approval of the Medical Board. The Committee includes, but is not limited to, a member of the Department of Anesthesiology, the Director of the Critical Care Units, the supervisors of the Critical Care units, and a member of Emergency Services.

F. Infection Prevention Committee

The Infection Prevention Committee shall oversee the GBMC Infection Prevention Program. The Committee includes, but is not limited to, the Infection Prevention Officer, Infection Prevention Practitioner(s), and representatives from Employee Health, Central Sterile Processing, Facilities, Microbiology, Nursing Administration, Perioperative Services, Pharmacy, Infectious Disease, Critical Care, Materials Management, Pathology, Neonatology, and Pediatrics. Leadership representation includes the Chief of Staff, Vice President (VP) of Quality of Patient Safety, Medical Director of Quality and Patient Safety, VP of Patient Care Services-Chief Nursing Officer (CNO), Chairman of the Department of Medicine, and Chairman of the Department of Pathology.

G. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee shall be an interdisciplinary committee. It shall include representatives from the medical, nursing, pharmacy, and senior management staff, as well as others who are able to contribute to the therapeutic process. Members shall be appointed by the Chief of Staff. The Pharmacy and Therapeutics

Committee shall oversee the GBMC Drug Formulary; develop policies for managing drug use, monitor the effectiveness of medication use throughout the health system, and serve as a resource to the department of Pharmacy Services.

Specific Pharmacy and Therapeutic Committee functions shall include:

1. management of the formulary system;

2. participation in the development of drug therapy guidelines for various clinical pathways;

3. participation in performance improvement activities related to distribution, administration and use of medications, including drug utilization evaluations (DUE's), and monitoring medication incidents and adverse drug reactions;

4. education of physicians, nurses and other professionals in matters pertaining to the use of drugs;

5. development of programs to promote cost effective therapy.

H. The Transfusion Committee

The Transfusion Committee shall be an interdisciplinary committee. It shall include representatives from the Medical, Nursing, and Senior Management Staff, as well as others who are deemed able to contribute appropriately. Members shall be appointed by the Chief of Staff. It shall be chaired by a member of the active medical staff, appointed by the Chief of Staff. The Transfusion Committee shall develop policies that regard and oversee the reporting and use of blood and blood products at GBMC.

I. Medical Staff Peer Review Committee

The Medical Staff Peer Review Committee (MSPR) is an interdepartmental group to provide oversight and guidance to the departments and to their departmental peer review committees (DPR) regarding the measurement and improvement of physician performance. The MSPR shall oversee the accountability and effectiveness of the DPRs and any other medical staff committee conducting physician performance evaluations, develop systematic approaches for evaluating and improving physician performance, and coordinate necessary multi-specialty evaluation of individual case reviews, with a full scope of responsibilities as enumerated in the MSPR Charter.

The MSPR will be comprised of fourteen (14) voting members who are active members of the medical staff. Twelve members will be determined based on their positions as follows: the Vice-Chief of Staff; Chairmen of the Departments of Medicine, Surgery, Obstetrics, Anesthesia, and Emergency Medicine; the Medical Director of the Cancer Institute; and, the Chairmen of the Departmental Peer Review Committee (DPR) of Medicine, Surgery, Pediatrics, Emergency Medicine, and Diagnostic Radiology. Two (2) additional at-large members to provide appropriate balance and expertise to the committee shall be appointed by the Chief of Staff. The term of these at-large members

shall be for two (2) years with the possibility of successive terms at the discretion of the Chief of Staff with the approval of the Medical Board. Practitioners from other specialties may be invited to the meeting as needed.

The Chief of Staff, the Vice President for Quality and Patient Safety, the Chief Nursing Officer (CNO), and the quality support staff, as determined by the MSPR Chairman, shall be ex-officio members of the MSPPOC without vote. The MSPR Chairman shall be the Vice Chief of Staff.

The MSPR shall meet at least four (4) times per year.

2. Special Committees of the Medical Staff

A. Medical Ethics and Patient Advisory Committee

The Medical Ethics and Patient Advisory Committee is an advisory committee which serves as a resource to the institutional staff and administration in clarifying complex ethical issues arising out of the practice of medicine. The functions of the committee are:

1. To provide for the education of Medical Staff and other Medical Center personnel in matters concerning ethical issues.

2. To provide a discussion forum for the review of ethical issues relative to the care of patients.

3. To serve as an advisory body for the Medical Center Board of Directors, Administration, and Medical Staff on the formulation of policies and/or guidelines dealing with ethical issues.

4. To serve as a resource for the Medical Staff, nurses and other health professionals, patients, and/or families in dealing with ethical questions related to hospitalization and treatment.

5. To review ethical decisions, questions, and dilemmas arising in the Medical Center and to discuss options available in specific circumstances.

6. To monitor relevant legislation and legal proceedings in the field of bioethics.

Membership on the committee shall include three physicians appointed by the Chief of Staff, three members of the Board of Directors appointed by the Chairman of the Board, and such other members deemed necessary to the effective functioning of the committee.

Meetings will be on a regular basis as determined by the committee. Special meetings will be held as requested by the Medical Staff, Board of Directors, Administration, other health professionals, patients and their families. The committee will report to the Medical Board and the Board of Directors.

B. Nominating Committee

The Nominating Committee for officers of the Staff shall be elected by ballot by the entire Medical Board, and shall be composed of four (4) members of the Medical Board from the members of the Staff not Chairmen of Departments, and one Chairman of a Department. They shall elect their own Chairman. The Committee shall prepare a selection of candidates for election as Chief of Staff, Vice Chief of Staff and Secretary-Treasurer. The report of this Committee shall be submitted to the Medical Board and to the July Medical Staff meeting.

A nominating committee for the at-large members of the Medical Board shall be appointed by the Chief of Staff in conjunction with his fellow officers and shall be composed of one member from each of the Departments of Medicine, Surgery, Ophthalmology, Otolaryngology - Head and Neck Surgery, Gynecology, Obstetrics, Pediatrics and Family Practice. Departmental Chairmen will not be members of the committee. Although nominees shall not be limited to the departments represented by the committee, no more than two (2) candidates from any department may be nominated. The Nominating Committee shall recruit candidates and recommend a slate of nominees, to be voted on at the Annual Meeting of the Medical Staff. Nominees may be taken from the floor. Only two (2) nominees shall be elected each year to replace the members-at-large whose terms are ending; each will serve for a two (2) year term. The members-at-large shall only serve for one (1) two-year term, but may be renominated after a lapse of one (1) year. In no case shall any Department have more than two (2) at-large members. Should the case arise in which there are more than two (2) candidates elected from one Department, the rules of plurality shall apply. If a vacancy occurs in a member-at-large position, the Medical Board will elect a successor to fill the vacancy for the remainder of the term.

3. Meetings

A. The meetings of the Medical Board shall be as specified by the Medical Board. Regular meetings shall be no more frequent than monthly and no less frequent than quarterly.

B. The meetings of the Medical Staff shall be held as held as provided for in Article X of these Bylaws. Each member of the Active Medical Staff shall be encouraged to attend these meetings. Records of attendance and minutes shall be kept.

C. Each Department shall have periodic Departmental meetings and conferences. Each Active member of the Department shall be encouraged to attend these meetings. Records of attendance and minutes shall be kept.

D. Notwithstanding the foregoing, nothing contained herein shall prevent any Department from establishing pursuant to Section 4.1.5.4 more stringent criteria for meeting attendance by members of the Department.

4. Dues, Assessments, Fees and Funds

A. Dues shall be $250 yearly, billed in advance on June 1 for the year to follow, July 1 – June 30, for all members of the Medical Staff, except for those members of the Affiliate, Emeritus or Distinguished Emeritus Staffs.

B. Dues shall be $100 yearly for members of the Affiliate Staff.

C. No dues, assessments or fees shall be charged to members of the Emeritus or Distinguished Emeritus Staffs

D. Members of the Active, Associate and Contractual Staff upon reaching the age of 65 may apply for reduction in dues to one-half (50%) of the then prevailing dues rate and no assessments. Such reductions in dues and assessments will be subject to the approval of the Chief of Staff.

E. The Secretary-Treasurer of the Medical Staff will notify by registered mail any member of the Medical Staff whose dues and assessments are in arrears sixty days after the mailing date of the invoices. The letter shall call attention to the amount of the unpaid assessment and state that with continued absence of payment for one month, resignation from the Medical Staff will be considered automatic. In the case of prolonged illness or other mitigating circumstances, the Medical Board, by a two-thirds (2/3) vote of those present at any regular meeting, may waive for one year the delinquent staff member from dues and assessments.

F. Fees for processing initial applications and reappointment applications will be set by the Medical Staff Office according to criteria developed by the Medical Staff Office and approved by the Medical Board.

G. Dues, assessments and fees shall constitute a Staff Fund which shall be administered by the Medical Board.

5. Resignations

Resignations from the Staff are to be presented for information to the Medical Board and Board of Directors.

6. Admission of Patients and Line of Command

A. Patients may be admitted to any service only by a physician with privileges on that service. The request for patient admission must be made directly by the physician with privileges.

B. Emergency admissions shall be seen promptly by the attending physician and a note justifying the admission be entered within 24 hours.

Documentation by the attending physician as to medical necessity of non-emergency admissions shall be provided within twenty-four (24) hours of admission.

C. In the event of an emergency when the attending physician or his designate is not immediately available, the Chief of Service or his designate may summon any member of the Medical Staff he considers necessary to attend the patient.

D. A physician is not allowed to admit or treat, as inpatients, members of his immediate family.

7. Inter-Service Transfer of Patients

A. In the case of inter-service transfer, the authority to transfer is solely the privilege of the physician to whom the patient had been previously admitted.

B. The transfer is completed when the second physician accepts the care of the patient. This should be recorded as an order or by a progress note in the chart; but in any event, it must be clear that primary responsibility for the patient's care has been both requested by the first physician and accepted by the second.

C. These measures apply equally to the resident service where only the resident or, in his absence, the senior resident on call may accept a patient in transfer or admit a patient to the care of the resident service.

8. Basis for Treatment

A. Except in emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

B. In cases where a tissue or cytologic diagnosis has been made elsewhere and in which the diagnosis established by that material is the basis for definitive primary treatment at this hospital, the material establishing the diagnosis shall be reviewed by the Pathology Department prior to the institution of treatment, unless the condition of the patient precludes prior review. If treatment must begin before review, the review shall be completed at the earliest possible time following initiation of treatment.

C. In cases in which diagnostic studies performed elsewhere, such as radiologic studies, electrocardiograms, endoscopies, or other diagnostic procedures, are the basis for treatment at this hospital, the attending physician shall furnish either a copy of the report of the study or a note detailing the procedure and its result in the patient's medical record.

D. In the event a patient is admitted for a drug overdose or attempted suicide, the attending physician must request a psychiatric consultation. This consultation will consist of an evaluation of the patient's condition to determine a recommended course of treatment.

9. Therapeutic Abortion and Female Sterilization

A. Induced abortion and female sterilization shall be performed in accordance with the internal rules and regulations of the Department of Obstetrics as approved by the Medical Board. Appropriate consent forms properly executed must accompany the patient to the operating room in all instances.

B. Induced abortion shall be performed in accordance with the guidelines promulgated by MedChi, the Maryland State Medical Society. The internal rules of the Department of Obstetrics permit elective termination of pregnancy up to twenty (20) weeks gestation. Only those cases of proven and documented fetal abnormality may be aborted up to twenty-six (26) weeks gestation.

10. Emergency Department Patients

Ill or injured individuals presenting to the Emergency Department for care will be assessed, treated and referred according to the following procedures:

A. Patients will be initially assessed by the triage nurse. Patients requiring immediate physician attention will be taken directly to the treatment area. Other patients will be directed to the registration area or transported to Obstetrical admitting, as appropriate.

B. Once in the treatment area, patients will be assessed by the Emergency Department physician on duty. Patients requiring specialty assessment will be seen by the house officer on call in the appropriate specialty or by the specialist listed on the current on-call roster. An on-call physician should respond to a page from the ED physician within thirty (30) minutes by phone. Physicians who do not respond by phone within the thirty (30)-minute time frame may be reported to the Department Chairman. If the patient wishes to be seen by an appropriately credentialed private member of the GBMC staff other than the specialist on call, and in the judgment of the Emergency physician there is adequate time to safely await his arrival, the patient may be assessed by that physician.

C. Treatment will be rendered by the Emergency physician if within the Emergency physician's delineation of privileges, unless otherwise desired by the patient. If not within the Emergency physician’s delineation of privileges, or if inpatient admission is required, treatment will be rendered or the patient will be admitted by a house officer, on-call specialist or, if appropriately credentialed, such other private physician as requested by the patient.

D. Patients who request transfer to another facility in writing will be transferred once stable if, in the judgment of the Emergency physician, the benefit of transfer outweighs the risk, and the receiving facility has available space and qualified personnel and has accepted the transfer. A copy of the Emergency record will be sent with the patient.

E. Patients who are discharged home from the Emergency Department and who unexpectedly require follow-up care will be seen by an Emergency physician for follow-up. If the patient so desires or if the necessary follow-up is not within the delineation of

privileges of the Emergency physician, the patient will be referred to the resident service, on-call specialist or other specialist appropriate for the patient's condition. If upon assessment the patient was found not to require emergency treatment, the patient may be referred to an appropriately-credentialed member of the GBMC Medical Staff, or, if requested by the patient, to another physician in the appropriate specialty. For routine follow-up care, the patient will be referred to his or her primary care physician or an appropriately credentialed specialist.

F. Emergency care is provided by credentialed Emergency physicians and credentialed physician extenders such as physician assistants or nurse practitioners according to their individual delineations of privileges. The Emergency physicians and physician extenders have the responsibility to assess and treat all patients who present to the Department, regardless of ability to pay, including, but not limited to, the provision of an appropriate medical screening examination in accordance with the requirements of Federal law.

11. Surgical Operations and Invasive Procedures

A. A surgical operation shall be performed only on written consent of the patient or his or her legal representative except in life-saving emergencies.

B. With two exceptions; i.e., (1) tissues retained for a Tissue Bank, and (2) tissues which have been specifically exempted from pathological study and report by formal Medical Board approval, all tissues and other material removed at surgery shall be forwarded to the Department of Pathology for examination as may be considered necessary to arrive at a pathological diagnosis or for the purpose of identification, and shall provide a permanent signed report of this examination. Certain tissues which may be used for subsequent transplant may be sent instead to a Tissue Bank, provided the surgeon notes this in the record and such notation is countersigned by another physician or nurse who witnessed the procedure.

C. Surgeons must be in the operating room and ready for surgery at the time scheduled. If general or regional anesthesia is to be given, this will not be started until both the surgeon and the anesthesiologist have verified that the patient's chart contains documentation of informed consent to the surgery and the anesthesia, the surgeon and anesthesiologist have made their presence known to the patient, surgical verification checklist reviewed, site marking, if appropriate, performed and time out observed..

D. If the anesthesiologist states that the patient is not in proper condition for surgery, the attending physician may cancel the case if he agrees, or the surgeon may request a second anesthesiologist to consult. If both anesthesiologists agree that the situation is too risky, the surgeon must postpone the case. If the second anesthesiologist agrees with the surgeon, the operation may be carried out.

E. Immediately* after an operative or invasive procedure an operative note will be completed and placed in the electronic medical record. The operative report, where

required, shall be completed and signed within thirty (30) days. Operative reports should include the following elements: surgeon and assistants; operative procedure performed; findings; description of procedure; estimated blood loss; specimens removed; and, pre and postoperative diagnosis, type of anesthesia, complications, and prosthetic devices , grafts, tissues, implanted, if any.

*Immediately after a procedure is defined as "upon completion of the operation or procedure, preferably before the patient is transferred to the next level of care. Prioritization of appropriate hand-offs must be facilitated.

12. Orders for Treatment – See hospital policy and procedure.

13. Referring Practitioners Ordering Outpatient Services

Orders for outpatient services rendered at the hospital or its off-campus locations, may be made by any practitioner who is:

Responsible for the care of the patient;
Licensed in, or hold a license recognized in the jurisdiction where he/she sees the patient; and;
Acting within his scope of practice under State law.

A. Verification

Orders for outpatient services must be submitted in writing or via computerized order entry. In instances when the practitioner is not credentialed through the medical staff membership or allied health professional process, the registration office will submit an electronic request to add the referring practitioner to the hospital's patient registration system. Within twenty four (24) hours of the request, the Medical Staff Office will verify the practitioner's license and status with the Office of the Inspector General (OIG).

The practitioner's information will be entered into the hospital's patient registration system, as a referring practitioner. If the practitioner's license has any adverse action against it, or if the practitioner is sanctioned by the OIG, the Medical Staff Office will, within twenty-four (24) hours notify the Compliance Office for follow-up. The practitioner will not be entered into the hospital's patient registration system, under these circumstances.

Certain outpatient services, such as, but not limited to, chemotherapy or outpatient therapeutic nuclear medicine services, may require review and counter signature by a credentialed provider involved in the patient's care.

The Compliance Office will provide oversight concerning the status of the referring practitioners in the hospital patient registration system for any subsequent orders for outpatient services submitted by the same practitioner.

14. Laboratory Procedures

A. The Medical Center will accept as valid only laboratory work performed by laboratories licensed by the State of Maryland. The above notwithstanding, the Medical Center also will accept as valid laboratory work performed by its visiting and house staff physicians in their office or clinic in the case of hematocrit, white count, and urinalysis testing.

B. Minimum standards for laboratory work for either outpatient or inpatient surgery requiring general or major regional anesthesia may be established by the Department of Anesthesiology as approved by the Medical Board. It is not the prerogative of the attending physician to alter the approved minimum requirements for admission laboratory work.

15. Blood Transfusion Procedures

A. The blood vacutainer for type and cross-match sample is to be labeled in the patient's room.

B. A drug charge ticket stamped with the patient's identification plate is to be used for obtaining blood from the Blood Bank. The drug charge ticket could be left in the patient's chart as soon as the order is written, one (1) ticket for each unit of blood.

C. When it is necessary to procure blood for transfusion from sources other than the hospital's own donors, the Baltimore Chapter of the American Red Cross and the American Association of Blood Banks Clearing House will be used as the supply sources. Their standards of blood procurement meet the minimum standards of this hospital and the American Association of Blood Banks. Only in a dire life-saving emergency shall any other non-approved blood procurement source be used.

16. Autopsy

A. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without consent of a relative or legally authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty.

B. Indications for which an autopsy is especially encouraged and for which, at the least, a request for an autopsy should be made and documented in the medical record are:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

2. All deaths in which the cause of death is not known with certainty on clinical grounds.

3. Cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or public regarding the death.

4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedure and/or therapies.

5. Death of patients who have participated in clinical trials (protocols) approved by institutional review boards.

6. Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction.

7. All obstetric deaths.

8. All neonatal and pediatric deaths.

9. Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

10. Deaths known or suspected to have resulted from environmental or occupational hazards.

C. In possible medical-legal cases (which include any death resulting, wholly or in part, from a casualty, violence, poisoning, suicide, criminal abortion, rape, therapeutic misadventure, drowning, or any death of suspicious or unusual nature, or of an apparently healthy person), the County Medical Examiner's Office must be contacted before any suggestions regarding autopsy permission are made to the family of the deceased.

D. All dead-on-arrival cases are the responsibility of the Medical Examiner until he releases the case. An autopsy will be performed at GBMC only if the patient is a former patient well known to the Medical Center and there is a valid medical indication for an autopsy.

17. Medical Records

A. All records are the property of the hospital and shall not be taken from the hospital except by court order, subpoena or statute.

B. The medical record of each discharged patient shall be completed within thirty (30) days following discharge as required by The Joint Commission and these Rules and Regulations. It shall be the responsibility of the Health Information Management Department to process records to the Medical Staff in sufficient time to meet this standard.

ADMINISTRATIVE ACTION PROCEDURE

Notification of impending administrative action will be sent to any provider with at least one (1) deficient medical record seven (7) days or older post discharge. This notification will be sent via e-mail and/or Epic In Basket and will inform the provider that he will be

placed on administrative action if they fail to complete all of these records by the date specified in the letter.

Completion of medical records within the allotted 30 days post discharge absolve a provider from administrative action.

The names of the providers on administrative action will be sent weekly to the Executive Vice President and Chief Medical Officer, Chief of Staff and the Vice President of Quality and Performance Improvement.

The Department Chairman will be provided with a weekly list of providers on administrative action within their department and will contact those individuals that week.

Providers on administrative action may continue to care for patients according to his approved clinical privileges.

SUSPENSION PROCEDURE

Failure to complete the delinquent medical record by thirty (30) days after being placed on administrative action (60 days after patient's discharge) will result in the suspension of the provider's clinical privileges.

Notification of impending suspension of clinical privileges will be sent via e-mail and/or Epic In Basket to physicians who have failed to complete their delinquent records after being on administrative action for more than thirty (30) days.

LOSS OF MEMBERSHIP AND CLINICAL PRIVILEGES

Failure to complete delinquent medical records within fifteen (15) days of the suspension of clinical privileges (75 days after patient's discharge) will result in the automatic revocation of Medical Staff membership and clinical privileges and clinical privileges for Allied Health Professionals, as appropriate. Reinstatement of Medical Staff membership and clinical privileges and clinical privileges for Allied Health Professionals would be considered upon completion of all delinquent records, the appropriate application and payment of the reinstatement fee.

C. Standards and criteria for complete medical records include accurate progress notes and complete, signed operative notes. Progress notes must be recorded at regular intervals by the attending physician or his designee to include covering physicians, physician assistants, nurse practitioners and residents in accordance with the applicable Department policy. These notes should be no less frequent than daily. The attending physician is responsible for recording progress notes as often as is necessary to document any significant change in the patient's condition and to provide a rationale for continued hospitalization.

D. Recertification of the necessity of continuing hospitalization, estimated length of additional stay, and plans for post-hospital care are required at the 12th, 18th, and 30th days of hospitalization of Medicare patients and at each thirty (30) day interval thereafter. These recertifications must be completed by the attending physician within twenty-four (24) hours of the occurrence of the stipulated intervals.

E. A discharge order is not considered acceptable without at least a provisional diagnosis recorded in one of the following places: on the face sheet, on the doctor's order sheet, or within the context of the final progress note or discharge summary.

F. Symbols and abbreviations may be used in medical records only when they have been approved by the Medical Board. Dangerous abbreviations as defined by hospital policy are prohibited from use in all forms of clinical documentation at the Medical Center.

G. For the purpose of filing, the Chairman of the applicable Clinical Department is authorized to declare an incomplete record complete under these conditions:

1. The attending physician or surgeon has expired.

2. The attending physician or surgeon has terminated clinical privileges at the Medical Center.

In the event that resident staff assigned to complete a record has terminated employment and/or completed a rotation at GBMC, reassignments will be made as follows:

1. House cases - Records will be reassigned to the current chief resident of the particular service; OR,

2. Private cases - Records will be reassigned to the attending physician for completion.

H. All patients may be granted access to and/or receive copies of their medical records, except in the following instances:

1. If the attending physician has stated in the record that the review of the record by the patient would be medically contraindicated because it pertains to a psychiatric or psychological problem. Under this provision, the patient or authorized representative must, upon written request, be given a summary of the record by the attending physician.

2. If the patient has been declared incompetent by the court to handle his own affairs. Under this provision, the patient's court appointed guardian, who must have proof of such appointment, may have access to the record on the patient's behalf.

3. If the patient is under the age of eighteen (18). Under this provision, the parent or legal guardian must give consent on the patient's behalf and the parents must be

present during the review of the record unless the patient has the legal capacity to consent for medical treatment as an adult, i.e., in the following instances:

a. The minor is seeking treatment or advice concerning venereal disease, drug abuse or addiction, or alcoholism;

b. The minor is seeking treatment or advice concerning pregnancy and/or contraception not amounting to sterilization;

c. The minor is seeking treatment or advice for alleged rape or sexual assault;

d. The minor, who is at least sixteen (16) years of age, professes to have a mental or emotional disorder;

e. The minor is married or the parent of a child.

A complete policy and procedure including forms is available in the Medical Record Department.

I. The following may document diagnoses in the medical record:

A physician who is involved in the patient's care;
Nurse practitioner or physician assistant working with treating physician;
Physical therapist;
Speech language therapist;
Audiologist;
Occupational therapist;
Nutritionist;
Wound care specialist.

18. Medical Staff Credentials Files

A. The credentials files maintained on individual members of GBMC's Medical Staff are the property of GBMC and its organized Medical Staff, and shall be maintained as confidential. Access to such files and the information in them shall be limited to:

1. Duly appointed officers and committees of the Medical Staff and/or Board of Directors, and other authorized GBMC personnel, for the purpose of discharging the duties delegated to them by GBMC's Board of Directors in evaluating the qualifications, competence, and performance of providers of health care, and evaluating and acting on matters that relate to the discipline of providers of health care;

2. A medical review committee, as defined by Maryland Annotated Code;

3. Such other recipient as required by applicable law or regulation; or,

4. The Medical Staff member on whom the file is maintained, subject to the provisions of Paragraph B, below.

B. A Medical Staff member shall be granted access to his own credentials file subject to the following provisions:

1. Where there has not been a valid request made for a hearing to be conducted in accordance with Article IV of the Medical Staff Bylaws, timely notice of such shall be made by the member to the Chief of Staff or his designee, and the review take place in the Medical Staff Office during normal working hours, with the Chief of Staff or his designee present.

2. The member may review and receive a copy of only those documents provided by or addressed personally to him/her. A summary of all other information, including peer review committee findings, letters of reference, complaints, etc., shall be provided to the member in writing by the Chief of Staff or his designee at the time the member reviews his credentials file. Such a summary shall disclose the substance, but not the source, of the information summarized.

3. Whenever a member or applicant for membership on the Medical Staff is to have an evidentiary hearing under Article IV, the member or applicant shall be entitled to review and receive a copy of any material in the member or applicant's file.

4. The member of the Medical Staff shall be given right to respond in writing to information contained in the file that he/she believes is inaccurate or damaging.

19. Patient Isolation

Uniform patient isolation practices will be followed throughout the Medical Center. The isolation techniques and practices used will be those recommended by the Infection Prevention Committee and approved by the Medical Board.

Standard Precautions will be utilized in the care of all patients in both inpatient and outpatient settings, regardless of any suspected or confirmed infectious agent.

Transmission-Based Precautions (Isolation) will be implemented in addition to Standard Precautions for inpatients who are known or suspected to be colonized or infected with certain epidemiologically important pathogens, including but not limited to Multi-Drug Resistant Organisms (MDROs).

The implementation and discontinuation of Transmission-Based Precautions is the responsibility of authorized prescribers, Registered Nurses and Infection Preventionists. Physician orders are not required to implement isolation precautions.

Empiric Isolation Precautions will be implemented for certain clinical syndromes or conditions that warrant Isolation pending identification of the causative agent due to their

highly contagious nature and/or potential to cause serious disease.

In matters of patient isolation, the burden of proof is on the individual who maintains that isolation is unnecessary. In other words, if isolation is initiated by whatever means, it will remain in effect until a final resolution is obtained as outlined above.

Patients with known contagious and infectious conditions cannot be admitted to multi-bed rooms. Diagnosis of such conditions when known or suspected by the attending physician must be given to the admitting office either prior to admission or when the patient is being admitted.

A private room will be utilized for the patient placed on any Isolation Precautions. Exception: when a private room is not available, seek Infection Prevention Committee guidance, as the patient may be able to be placed in a room with a patient who is infected or colonized with the same microorganism (cohorting).

20. Visiting Affiliates

A. In General

Visiting Affiliates shall include physicians, dentists, podiatrists, and doctoral candidates in those professions present at the Medical Center as participants in educational or consultative activities in the clinical setting, but who do not admit, treat or otherwise provide patient care services independently. They shall not be members of the Medical Staff of the Medical Center.

B. Approved Observers

Upon recommendation by the appropriate Department Chairman, and with the approval of the President of the Medical Center in consultation with the Chief of Staff, physicians, dentists and podiatrists at the postdoctoral level and medical, dental, and podiatry students who are not appointed to the Medical Staff may observe educational activities in a clinical setting at the Medical Center as Approved Observers. Because Approved Observers are not members of the Medical Staff, they shall not participate independently in patient care or management, perform any clinical act unless at the express direction of the attending Medical Staff member, under his direct supervision and in his physical presence, or otherwise engage in the practice of their profession while at the Medical Center. Approved Observer status shall be granted for a period of not more than six months and may be renewed once at the request of the Medical Center supervising physician. Other Observers may be allowed in accordance with hospital policy.

C. Advisory Consultants

At the request of an attending member of the Medical Staff and upon the recommendation of the appropriate Department Chairman, the President of the Medical Center in consultation with the Chief of Staff, may grant Advisory Consultant status to physicians, dentists, or podiatrists who are not appointed to the Medical Staff. This status

shall permit the Advisory Consultant to (1) Provide monitoring of proficiency to current Medical Staff members in newer techniques; or, (2) review the medical records and perform non-invasive examination of a single patient specified by the Chairman in his recommendation, to record his findings in the medical record, and enter in the record his recommendations to the attending Medical Staff member regarding the patient's management. The Advisory Consultant shall not enter any order for or perform any therapeutic or diagnostic treatment or procedure, or otherwise participate in direct or indirect patient care or management. Advisory Consultant status shall be granted only for the duration of the required training session(s), and/or current admission of the specified patient, as appropriate.

D. Application; Approval; Termination

1. Physicians, dentists and podiatrists applying for Visiting Affiliate status shall submit a current curriculum vitae. The information provided shall include, at minimum, information regarding education, training and professional qualifications including but not limited to professional licensure, board certification, and affiliations with other health care institutions. Any such practitioner who participates in patient care or performs any clinical act or otherwise engages in practice of his profession while at the Medical Center shall also furnish a certificate of professional liability insurance coverage and a copy of his current professional license, and a professional reference attesting to the practitioner's current clinical or technical competence. Applicant shall adhere to the hospital's existing patient safety requirements.

   Medical, dental and podiatric students applying for Approved Observer status shall submit a letter from the dean of their professional school**,** or designee including satisfactory evidence of professional liability coverage through their professional school or other source satisfactory to the Medical Center. The Chief of Staff may, in his discretion, waive the latter requirement for good cause shown.

   Applicants for Visiting Affiliate status shall pay an application fee in an amount to be determined by the Medical Board. This fee may be waived by the Chief of Staff in his discretion.

2. Before a Visiting Affiliate status is granted to a physician, dentist or podiatrist, the Medical Staff Office shall document the applicant's professional school graduation, current licensure, Board certification or satisfactory completion of residency/fellowship training.

3. Visiting Affiliate status may be terminated with or without cause by the President of the Medical Center with notification to the appropriate Chairman and Chief of Staff, and denial or termination of Visiting Affiliate status shall not constitute a professional review action or entitle the applicant or professional affiliate to an evidentiary hearing or any other due process right under these Bylaws.

21. Allied Health Professionals

A. Allied Health Professionals ("AHPs") are health care professionals who, because they are not physicians, dentists, podiatrists are not eligible for membership in the Medical Staff. They include advanced practice registered nurses, physician assistants, clinical psychologists, radiologist assistants, and other individuals who may be licensed or certified by the State of Maryland in a health care profession or otherwise designated by Medical Center policy and procedure. They shall not be permitted to practice independently in the Medical Center or to admit patients. They may hold clinical privileges if eligible and appropriately credentialed and are subject to such requirements for physician supervision as provided by Medical Center Policy and Procedure.

Physician assistants, advanced practice registered nurses, clinical psychologists, and radiologist assistants shall be credentialed according to the policies approved by the Medical Board and Board of Directors. The scope of practice for clinical psychologists is limited to providing mental health services in the emergency department under the general supervision of the group contracted to provide such services to the Medical Center. The scope of practice for radiologist assistants is limited to providing radiology assistance in the Department of Diagnostic Radiology under the supervision of the group contracted to provide such services to the Medical Center.

B. AHPs shall be entitled to the due process and hearing procedures of Article IV of the Medical Staff Bylaws. The decision of the President of the Medical Center or his designee shall be final in all matters having to do with the approval, discipline, suspension and termination of all AHPs in accordance with Medical Center policy, except for those instances where the due process and appeal provisions of Article IV are invoked where the decision of the Board of Directors shall be final.

22. Code Blue Procedures

A. An adult patient who has been resuscitated from a cardiopulmonary event should be taken to a monitored bed, preferably in an intensive care area. A cardiologist or physician credentialed by GBMC in intensive care medicine, should be responsible with the original attending physician for the cardiac status of the patient. The original attending physician shall remain in charge of the overall care of the patient, unless by agreement between the original attending and the intensivist, the patient is transferred to the service of the intensivist. If the patient is post-operative, the attending surgeon should notify the anesthesiologist of the occurrence, so that appropriate departmental review can be done. The patient will not leave or be discharged from the intensive care area without an order from both the attending physician and the cardiologist or the physician credentialed in intensive care medicine.

B. The patient will be transferred from the site of the arrest to the critical care unit accompanied by a physician member of the Code Blue Team and should be monitored during transfer.

C. The senior medical resident or his designee is responsible for directing the resuscitation as well as deciding when to terminate resuscitative efforts.

D. Once the full cardiac team arrives on the scene when the Code Blue is called, the Senior Resident in charge of the team should ask that non-members of the team clear the room.

E. Orders for No Code Blue may be issued as per The Management Policy and Procedure Manual.

23. Institutional Review Board

The Institutional Review Board shall serve as the research committee and shall receive, study and approve all protocols of proposed research projects to be conducted within the hospital. It shall also seek possible sources of funds for support of research projects. The Institutional Review Board shall have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. It will function as an independent body and report to the Medical Board for informational purposes.

24. Supervision of Resident Staff

The specific functions of the Resident Staff and mechanisms for their supervision are set forth in the policies of the various teaching programs and the job descriptions and contracts of the residents. The following rules are generally applicable to all teaching departments:

A. Unless otherwise directed by the attending physician on a general basis or with respect to a given patient, the Resident Staff of a given department may participate in the care of any patient admitted by an attending member of that department.

B. The records of history and physical examinations performed by Resident Staff must be countersigned by the attending physician. Such resident histories shall not take the place of the attending admission note.

C. The attending physician shall approve the discharge summary and final diagnosis on all patients.

D. Residents assigned to the care of a given patient may write medication, blood, treatment and diagnostic orders for that patient, provided, however that the attending physician and any anesthesiologist or radiologist or consultant assigned to the patient's care shall not be precluded from also writing orders. The attending physician, through his signed order, may cancel or change any order entered by a resident.

E. No surgical procedure shall be performed except under the supervision of an attending member of the Medical Staff. No patient shall be scheduled for surgery without prior consultation with a member of the attending staff.

F. A faculty member or private member of the attending staff shall attend all deliveries.

G. The senior resident of each service is immediately responsible for the supervision of the junior residents assigned to that service and shall round daily on each patient to which a junior resident is assigned. The Director of the Residency Program in each teaching department is ultimately responsible for the supervision of all residents within the department and shall discharge that responsibility either directly or by delegation to an attending member of the Medical Staff of the department, who shall enter an appropriate attending note in the inpatient record at least every 72 hours.

25. Medical Students

A. Medical students who are not receiving their training experience under a formal agreement with GBMC and their medical school, must be granted Visiting Observer status in accordance with the provisions of the Medical Staff Rule and Regulation No. 20.

B. Medical students may perform history and physical examinations and other non-invasive examinations appropriate to their training and experience and to the service to which they have been assigned. Their history and physical examinations will not stand as the official history and physical for that admission.

C. As permitted by the applicable service, students serving formal third or fourth-year clerkships may enter orders for medication, treatments and diagnostic studies. All such orders shall be co-signed by the attending Medical Staff member before being carried out.

D. All medical student notes and orders shall be signed with the student's full name and the designation "MS__ (I,II,III or IV)," depending upon the medical student's year of study.

26. Procedure for Initial Appointment

An applicant for initial appointment to the Medical Staff shall apply for medical staff membership and clinical privileges. The application shall contain the following information:

A. Qualifications. A request for information bearing on the applicant's professional qualifications and competence for the particular Medical Staff privileges requested including, but not limited to, education, licensure, relevant training, experience, current competence, and ability to perform the privileges requested.

B. Request for Privileges. A delineation of specific Medical Staff privileges in the Department(s) in which the applicant requests privileges.

C. Other Affiliations. A request for the name and address of any other hospital or other health care institution or practice where the applicant currently has or in the past has been granted medical privileges.

D. References. A request for the names of two (2) or more persons, preferably members of the Medical Staff, to whom evaluation forms may be sent and who have worked with the

applicant and observed his professional performance in the recent past and who can provide reliable information, based on significant personal experience, about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism and any other qualifications relevant to eligibility for Medical Staff membership under these Bylaws.

E. Professional Sanctions. A request for information about whether:

1. the applicant has ever been denied medical staff membership or clinical privileges or had his medical staff membership or clinical privileges revoked, suspended, reduced or not renewed, limited, or placed on probation at the Medical Center or any other hospital or health care institution;

2. any of the following have ever been revoked, denied, suspended or placed on probation: (a) membership in any local, state or national professional health care society, institution or organization, including managed care organizations, (b) license to practice any health care profession in any jurisdiction, or (c) Drug Enforcement Administration (DEA) registration or other drug registration;

3. the applicant is the subject of any pending or threatened investigation or proceeding which, if decided adversely t the applicant could result in any section named in Article IV.

4. either the following have ever been voluntarily relinquished: (a) license to practice any health care profession in any jurisdiction or (b) DEA registration or other drug registration;

5. the applicant has ever voluntarily or involuntarily relinquished or agreed to the limitation or reduction of a medical staff appointment or clinical privileges or withdrawn an application at any hospital, health care institution or managed care organization for quality of care reasons or unprofessional conduct;

6. the applicant has ever been reprimanded, censured or admonished or the subject of any adverse action or finding for quality of care reasons or for unprofessional conduct by any hospital, other health care organization, professional organization, government agency, or managed care organization;

7. the applicant had ever been ever been excluded from, found liable, received any other sanction from, or entered into any settlement with any governmental agency, including, but not limited to, Medicare or Medicaid, regarding any aspect of his professional practice;

8. the applicant has or ever had any health problems, including, but not limited to, alcohol or drug abuse, which might impair his ability to properly care for patients at the Medical Center;

9. the applicant is engaged in the use of illegal drugs.

The applicant shall provide a detailed written explanation of any affirmative response to the above.

F. Professional Liability Insurance. A statement that the applicant carries professional liability insurance at least in the minimum amount and in the form of coverage as may be required by the Medical Center from time to time and a request for information regarding his malpractice claims history and experience, including a consent to the release of information from his present, and any past, malpractice insurance carriers and a waiver of any privilege relating thereto.

Applicant is responsible for notifying the Medical Staff Office of any changes in insurance coverage. Immediate notification is required for any lapses in coverage, including cancellation or termination of coverage. Failure to do so will lead to automatic revocation of privileges.

G. Verification and Agreement. The applicant shall sign a statement that all information provided by him is true, correct and complete in all material respects to the best of his knowledge and that he has had access to the current Medical Staff Bylaws and Rules and Regulations and agrees to be bound by the terms thereof and any amendments thereto.

H. Identification. The applicant shall present the Medical Staff Office with a valid government-issued photo identification issued by a State or Federal agency or a current picture hospital identification card.

27. Content of Application for Reappointment

The reappointment application shall request information about the following:

A. Continuing Education. Relevant continuing education, training and experience related to the privileges requested by the applicant;
B. Physical and Mental Health Status. The current physical and mental health status and emotional stability of the applicant;

C. Other Affiliations. The name and address of any other hospital or other health care organization or practice where the applicant has been granted privileges or under whose auspices the applicant for reappointment rendered professional services during the expiring term;

D. Professional Societies. Membership or honors awarded, granted, denied, revoked or suspended by any professional health care society, institution or organization during the expiring term;

E. Professional Sanctions.

1. Sanctions of any kind imposed by and health care organization, professional society, or licensing or drug control authority during the expiring term;

2. any pending or threatened investigation or proceeding which, if decided adversely to the applicant, could result in the imposition of sanctions as described in the foregoing section E1: or

3. the voluntary relinquishment, reduction, limitation or loss of any medical staff membership, clinical privileges, professional license or Drug Enforcement Administration registration:

4. Malpractice Claims. Details about any malpractice claims experienced during the expiring term;

5. Professional Liability Insurance. Details about any changes in the amount or form of coverage during the expiring term. Maintaining coverage is a condition of membership on the Medical Staff.

6. Staff Privileges. A delineation of specific clinical privileges in the Department(s) in which privileges are requested, and, if applicable, the applicant's reasons for seeking a change in his present privileges.

7. Current Address. The reappointment applicant's current home and office addresses and telephone numbers;

8. Miscellaneous. Any other information bearing on the applicant's qualifications, professional ethics, competence, ability, and insurance coverage as the Medical Board or the Board of Directors may require; and

9. Verification. The applicant shall sign a statement that all information provided by him is true, correct and complete in all material respects to the best of his knowledge.