NORTHWEST HOSPITAL CENTER, INC.

MEDICAL STAFF BYLAWS

PART II

January 2024

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MEDICAL STAFF BYLAWS

PART II

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CHAPTER I

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I. MEMBERSHIP ON THE MEDICAL STAFF

A. QUALIFICATIONS AND OBLIGATIONS FOR MEMBERSHIP

1. General

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and such policies as are adopted from time to time by the Board. No individual is automatically entitled to membership on the Medical Staff or to exercise particular clinical privileges in the Hospital regardless of any license to practice membership in any professional organization, certification by any clinical examining board, past or present clinical privileges or past or present clinical privileges on medical staff membership at the Hospital or any other health care facility or residence or practice of the Hospital.

2. Specific Qualifications

Only physicians, dentists, podiatrists, physician assistants, nurse practitioners, nurse anesthetists, and nurse midwives that meet the following threshold criteria shall be qualified for membership on the Medical Staff. A qualified applicant shall:

a) have and maintain a current unrestricted license to practice in this state and, where applicable to his/her practice, have and maintain a current unrestricted DEA certificate (if applicable) and Maryland Controlled Substances certificate;

b) have and continuously possess current, valid professional liability insurance coverage in the amount of at least one million dollars per claim and three million dollars in the annual aggregate, or in such other amount as may be determined by the Board, with a company licensed or approved by the state of Maryland, or a self-insurance arrangement approved by the Board. Applicants must submit either a current certificate of insurance or other document that verifies compliance with this requirement;

c) have successfully completed an accredited medical, podiatry, physician assistant, or advanced practice nursing school program and an ACGME/AOA/AOPM post-graduate training program in the primary specialty in which the applicant seeks clinical privileges (this qualification shall not apply to individuals appointed to the Medical Staff prior to July 1, 1994);

d) **Active Members** must be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association (AOA), or fulfill the requirements for candidacy for board eligibility in the specialty in which the applicant is applying for privileges. The applicant must become board certified; all non-physicians must meet the Board certification requirements of their respective discipline.

e) achieve board certification within five years of initial appointment to the Medical Staff; and for applicants certified by another medical specialty group outside of the U.S. and its territories, the certification must be considered equivalent to certification by the American Board of Medical Specialties or the American Osteopathic Association as determined by the Credentials Committee and the Board. All non-physicians must meet the Board certification requirements of their respective discipline. (This requirement applies to new applicants after July 1, 1994);

f) meet CME/CEU requirements of the State of Maryland;

g) be able to document that he/she is qualified with regard to his/her:

(1) background, experience, training, and demonstrated competence,

(2) adherence to the ethics of his/her profession,

(3) good reputation and character, including the ability to safely and competently perform the clinical privileges requested, and

(4) ability to work harmoniously with others sufficiently so that all patients treated by him/her at the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner; and

h) not being currently excluded or precluded from participation in Medicare, Medicaid or other federal or state government health care program

3. Non-Discrimination.

No individual shall be denied appointment on the basis of sex, race, creed, religion, color, national origin, or disability unrelated to performance.

4. General Obligations Regarding Appointment/Reappointment Application

a) The applicant must appear, if requested, for personal interviews in regard to the application.

b) The applicant must provide to the Vice President, Chief Medical Officer, without the need for a specific request, new or updated information, as it occurs, that is pertinent to any question on the application form.

c) The applicant must agree that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute voluntary relinquishment of clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in this Medical Staff Manual or the Medical Staff Bylaws.

d) The applicant must authorize the release of all information necessary for an evaluation of his/her qualifications for initial and/or clinical privileges.

e) The applicant must agree that the hearing and appeal procedures set forth in this Part II shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital.

f) The applicant must extend immunity, as set forth in Part I of the Medical Staff Bylaws, to the fullest extent permitted by law, to the Hospital, its Medical Staff, and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to appointment and clinical privileges or his/her qualifications.

g) The applicant shall have the burden of producing information deemed adequate by the Hospital and Medical Staff for a proper evaluation of competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

h) The applicant shall have the burden of providing evidence that all the statements made, and information given on the application are true and correct.

i) Should information provided in the application change during the course of an appointment period, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

j) The applicant agrees that, to the extent information is "protected health information", as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder ("HIPAA"), he/she will comply with the requirements of HIPAA and:

(1) protect the privacy of such "protected health information" in accordance with the most restrictive legal requirements applicable to him/her or to the Hospital;

(2) use appropriate safeguards and take all reasonable and necessary steps to prevent unauthorized or improper disclosure and use of such "protected health information";

(3) abide by all Hospital policies, as exist now or may later be adopted or amended, regarding patient and medical record confidentiality and transmission of protected health information; and

(4) include the requirements of this Section I.A.4.j. in any agreement or arrangement with any subcontractor with whom he/she contracts with respect to such health data or with any person to whom he/she will provide or allow access to any or all of such health data.

k) The applicant must review Parts I and II of the Medical Staff Bylaws and sign an acknowledgment agreeing to be bound by them.

B. PROCEDURE FOR INITIAL APPOINTMENT AND GRANTING OF PRIVILEGES

An application for appointment to the Medical Staff shall be sent upon request.

1. Submission of Application

a) The application shall contain detailed information concerning the applicant's professional qualifications. In addition to any other information required,
the application should contain the following:

(1) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary conditions, reduced, or not renewed at any other hospital or health care facility;

(2) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration or state CDS registration is or has ever been suspended, modified, terminated, or restricted, is currently being challenged, or has been voluntarily or involuntarily relinquished;

(3) complete information concerning the applicant's professional liability litigation experience, including: (i) the substance of the allegations; (ii) the findings; (iii) the ultimate disposition; (iv) any open claims; and (v) any additional information concerning such proceedings or actions as the Credentials Committee may deem appropriate;

(4) information concerning the applicant's current or pending investigations or settlements with regard to Medicare/Medicaid or other federal or state government sanctions or exclusions;

(5) a request for the specific clinical privileges desired by the applicant;

(6) information on the applicant's ability to safely and competently perform the privileges requested, including information provided by peers of the applicant;

(7) a list or copy of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration and state CDS registrations (if applicable), medical or dental school diploma, and certificates from all post graduate training programs completed; and

(8) such other information as the Board may require.

b) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated in connection with any application for appointment or reappointment and the granting of particular clinical privileges, in order to determine whether questions of clinical competence are raised and/or pose a liability risk to the Hospital.

2. The application for appointment shall be submitted by the applicant to the Vice President, Chief Medical Officer. The application must be accompanied by payment of the processing fee in an amount established by the Medical Staff and be accompanied by a valid government issued photo ID.

   a) After reviewing the application to determine that all questions have been answered and all references and other information or materials are pertinent, and after verifying the information provided in the application with the primary sources including, but not limited to: a query of the Maryland Board of Physicians, Maryland Board of Nursing, and the National Practitioner Data Bank, the Vice President, Chief Medical Officer shall transmit the complete application and all supporting materials to the appropriate Department Chair.

   b) It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An application form shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified.

   c) For the application to be deemed and remain complete, all requested additional or clarifying information required at any time during the evaluation must also be supplied. Failure to supply additional required information will render the application incomplete. An incomplete application will not be processed. The fact that the Hospital has not processed an incomplete application shall not constitute grounds for hearing or appeal rights pursuant to this Part II. Any application that remains incomplete 45 days after the applicant has submitted the application shall be deemed to be withdrawn.

   d) The maximum period of time for consideration of a completed application for Medical Staff membership by the applicable Departments, the Credentials Committee, and the Medical Executive Committee shall not exceed 90 days, unless extended for good cause.

   e) The applicant will be advised in writing that a drug screening and criminal background check are required prior to completion of the credentialing process. Results from the drug screening and criminal background check must be received prior to a credentialing decision.

3. Department Chair Procedure

   a) The Chair of each Department in which the applicant seeks clinical privileges shall evaluate the applicant's education, training, and experience. Such evaluation may include telephone inquiries directed to the applicant's past or current Department Chair(s), Residency Training Director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. As part of the process of performing this evaluation, a Department Chair has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges.

b) Each applicable Department Chair shall provide the Credentials Committee with a written report concerning the applicant's qualifications for appointment and requested clinical privileges. This report or reports shall be appended to the Credentials Committee's report and shall address whether the applicant satisfies the current criteria for the clinical privileges requested.

c) In the event the Department Chair is unable to evaluate an applicant's qualifications for appointment, the Chair should make this fact known to the Credentials Committee.

4. Credentials Committee Procedure

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

b) If, during the processing of a particular applicant's appointment application, it becomes apparent to the Credentials Committee or its Chair that a recommendation may be unfavorable so as to deny appointment or modify requested clinical privileges, the Chair of the Credentials Committee or the Medical Executive Committee may, in its discretion, notify the appointee of the general tenor of the possible recommendation and ask if the applicant desires to meet with the Committee prior to any final recommendation.

At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute it.

This interview shall not constitute a hearing and none of the procedural rules provided in this Part II with respect to hearings shall apply. The applicant is not permitted to bring an attorney to this meeting. Minutes of the discussion in the meeting shall reflect the concerns that were raised, the fact that the affected applicant was notified of the concerns, and the individual's response.

c) After determining that an applicant is qualified, the Credentials Committee may, based on information obtained during the application review, require the applicant to undergo a physical and/or psychiatric examination by a physician or physicians satisfactory to the Credentials Committee. The results of any such examination shall be made available to the Committee and shall remain confidential. Failure of an applicant to undergo such an examination within a reasonable time after being requested in writing to do so, shall constitute a voluntary withdrawal of the application for appointment and clinical privileges and the application shall be processed no further.

d) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the

applicant, with a copy to the Medical Executive Committee and to the Vice President, Chief Medical Officer, explaining the reasons for the delay.

e) The Credentials Committee shall forward its recommendation, in the form of a written report, including the Department Chair's report, to the Medical Executive Committee for review. If the Credentials Committee recommends that the individual be appointed to the Medical Staff with the requested privileges, the report shall recommend provisional Department assignment. All recommendations to appoint, including provisional appointment, must specifically recommend the clinical privileges to be granted. The Credentials Committee may, in its discretion, recommend that certain limitations, conditions, or restrictions be imposed on the initial granting of clinical privileges.

5. Medical Executive Committee Procedure

The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation. If the Medical Executive Committee disagrees with the Credentials Committee recommendation, the Medical Executive Committee shall specify the reasons for that disagreement. The Medical Executive Committee may request the Credentials Committee to reconsider all or part of the Credentials Committee recommendation and return the application to that committee.

6. Performance Oversight Committee

a) Performance Oversight Committee of the Board of Trustees has the delegated authority, as designee of the Board, to act with respect to credentialing and privileging of applicants or appointees for appointment or reappointment to the Medical Staff. If the Board rescinds this delegated authority or designates another committee to perform these duties, all references to the "Performance Oversight Committee" shall be deemed to refer to the newly designated committee, or to the Board, as applicable.

b) Performance Oversight Committee shall review the recommendation of the Medical Executive Committee and take action with respect to the application.

c) Upon receipt of a recommendation from the Medical Executive Committee that an applicant be appointed to the Medical Staff and granted the clinical privileges requested, the Performance Oversight Committee may:

(1) appoint the applicant and grant clinical privileges;

(2) refer the matter for additional research or information; or

(3) reject the recommendation, after reviewing the matter with the Medical Executive Committee as described in Section (e) below.

d) Upon receipt of a recommendation from the Medical Executive Committee that an applicant not be appointed to the Medical Staff or not be granted the clinical privileges requested, the Performance Oversight Committee may:

(1) affirm the recommendation of the Medical Executive Committee;

(2) refer the matter for additional research or information; or

(3) reject the recommendation, after reviewing the matter with the Medical Executive Committee as described in Section (e) below. The Performance Oversight Committee action shall become effective immediately; provided, however, that the Performance Oversight Committee may, in its sole discretion, stay the decision until the applicant has either exercised or waived any rights to a hearing and appeal pursuant to this Part II.

e) If the Performance Oversight Committee anticipates that it may reject a Medical Executive Committee recommendation, the Performance Oversight Committee shall, before taking final action, meet with the Medical Executive Committee to jointly review the circumstances surrounding the individual. Such joint review shall take place within 10 days of the date the Performance Oversight Committee determines its pending decision. Counsel for the Hospital shall attend the joint review.

(1) The joint review process shall not be constrained by, among others, the formal rules of evidence, trial procedure, and/or communication between the parties and other interested persons or entities. The goal of these processes is to consider all information, which may have a bearing on the matter. Communication among persons with such information is encouraged, subject to the rules set forth in this Part II. To this end, the Performance Oversight Committee and the Medical Executive Committee may examine all documents available during each of their prior reviews, including documents reviewed by the Credentials Committee. The Performance Oversight Committee and the Medical Executive Committee may invite members of the Credentials Committee to the joint review and may consult with or invite other witnesses or persons with knowledge of the individual to furnish information during the joint review.

(2) The Performance Oversight Committee may take action at the joint review, or may refer the matter for further review. Any such further review shall be completed within 30 days of the initial joint review.

f) The Performance Oversight Committee action shall become effective immediately; provided, however, that the Performance Oversight Committee may, in its sole discretion, stay the decision until the applicant has either exercised or waived any rights to a hearing and appeal pursuant to this Part II.

C. PROVISIONAL STATUS

1. Duration of Initial Provisional Appointment

a) All initial appointments, regardless of the category of the staff to which the appointment is made, and all initial and additional clinical privileges shall be provisional for a period not to exceed three years from the date of the appointment or granting of clinical privileges. The term of initial appointment may be shortened to allow for the orderly processing of reappointment applications or for other reasons.

b) During the term of this provisional appointment, the individual receiving the provisional appointment shall be evaluated by the Chair of the Department or Departments in which the individual has clinical privileges, the relevant committees of the Medical Staff, and the Hospital as to the individual's clinical competence and general behavior and conduct in the Hospital.

c) Provisional clinical privileges shall be reviewed and, if necessary, adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

d) Continued appointment and/or clinical privileges after the provisional period shall be conditioned on an evaluation of the applicable factors to be considered for reappointment. Provisional appointments may be extended one time only for an additional one-year term.

2. Duties of Provisional Appointees

a) Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

b) During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligation's attendant to his or her staff category.

c) Each appointee must arrange, or cooperate in the arrangement of, any required numbers and types of cases to be reviewed/observed by the Department Chair and/or designated proctors.

d) Failure of the provisional appointee to fulfill all requirements of appointment relating to completing medical records and cooperation with proctoring, as outlined in the Medical Staff or Hospital Bylaws, or Rules and Regulations of the Hospital and Medical Staff, shall also render the appointee ineligible for reappointment.

e) In the event a provisional appointee fails to satisfy the conditions for continued membership on the Medical Staff, at the expiration of provisional appointment all clinical privileges shall terminate, unless the Performance Oversight Committee determines otherwise, and the applicant requests a hearing. After a passage of three years, the appointee may be permitted to reapply for initial appointment, in accordance with this Part II, if the individual evidences a greater commitment to fulfill the duties and responsibilities of appointment.

D. CRITERIA FOR GRANTING OF PRIVILEGES

1. Clinical Privileges

a) Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Performance Oversight Committee. Neither Medical Staff appointment nor reappointment as such shall confer any clinical privileges or right to

practice at the Hospital.

b) The granting of clinical privileges shall carry with it acceptance of the obligations of such privileges including emergency service and other obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and other applicable requirements or standards.

c) The clinical privileges granted shall be based upon consideration of the following:

(1) the applicant's ability to meet all current criteria for the requested clinical privileges;

(2) the applicant's education, training, experience, demonstrated current clinical competence and clinical judgment, technical skills, references, utilization patterns, and ability to safely and competently perform the privileges requested;

(3) availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability to provide patient care;

(4) adequate levels of professional liability insurance coverage in such amounts as required by the Board with respect to the clinical privileges requested;

(5) the Hospital's available resources and personnel;

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

(7) any information concerning professional review actions, the voluntary or involuntary termination of Medical Staff appointment; or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and

(8) other relevant information, including the written report and findings by the Chair of each of the clinical Departments in which such privileges are sought.

d) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

e) The reports of the Chair(s) of the clinical Department(s) in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

2. Clinical Privileges for Dentists

a) The scope and extent of surgical procedures that a dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

b) Surgical procedures performed by dentists shall be under the overall supervision of the appropriate Department. A medical history and physical examination of the patient shall be made and recorded by a physician who is a Member of the Medical Staff and holds clinical privileges before any dental surgery shall be scheduled. If dental surgery is performed, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization. Any exception, if granted, shall be reconsidered on a yearly basis.

c) Oral surgeons may be granted clinical privileges to perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient. However, if in the course of performing such history and physical an underlying health problem is discovered, the oral surgeon shall seek an appropriate medical consultation.

d) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Hospital and Medical Staff Bylaws.

3. Clinical Privileges for Podiatrists

a) The scope and extent of surgical procedures that a podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Department of Orthopedic Surgery. A medical history and physical examination of the patient shall be made and recorded. Before podiatric surgery shall be scheduled for performance, a physician on the Medical Staff shall assume responsibility for the medical (non-podiatric) care of the patient throughout the period of hospitalization.

c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders within the scope of their license and consistent with the Hospital and Medical Staff Bylaws.

d) A podiatrist may update a perioperative history and physical examination done by an MD, DO or NP. A podiatrist may proceed with a procedure done under no, or local, anesthesia (but not moderate sedation, general, or Anesthesia Department administered block) after completing and documenting an appropriate history and physical examination within 30 days of the procedure. The requirements for updating the history and physical remain in effect.

e) That henceforth "Podiatric Board Certification must come through the American Board of Podiatric Surgery". This change is to go into effect January 1, 2012 and physicians will be given the same 5-year period by which to secure their board certifications. Those already board certified prior to this change, will be grandfathered in.

E. CRITERIA AND PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

1. Temporary Clinical Privileges for Applicants

   a) Temporary privileges shall not routinely be granted to applicants. However, in certain situations such privileges may be granted. Before temporary privileges are granted, the completed application form and all relevant information, as specified in Section B.2, must be reviewed by the appropriate Department Chair and Division Chief and Credentials Committee Chair or designee. After the Credentials Committee Chair or designee deems the application complete, and after the Department Chair determines that the application is likely to receive a favorable recommendation for appointment and clinical privileges, the Chair may submit the applicant's request for temporary privileges to the President of the Medical Staff, who shall then make a recommendation to the Hospital President for the granting of temporary privileges.

   b) The following situations are evaluated on a case-by-case basis and usually result in ineligibility for temporary privileges:
      1) There is a current challenge or a previously successful challenge to licensure or registration.
      2) The applicant has received an involuntary termination of medical staff membership at another organization.
      3) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges OR
      4) The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

   c) The maximum period for which temporary privileges are valid is 45 days. The temporary privileges may be renewed for one 45-day period at the discretion of the President of the Hospital.

   d) The applicant must review Parts I and II of the Medical Staff Bylaws and sign an acknowledgment agreeing to be bound by them.

   e) The applicant must submit for a drug screening and criminal background check. Results of both queries must be obtained prior to approval of temporary privileges.

2. Temporary Clinical Privileges for Non-Applicants

   Temporary clinical privileges for care of a specific patient or patients may be granted by the President of the Hospital, with the concurrence of the Chair of the Department concerned and the President of the Medical Staff, to a physician who is not an applicant for appointment. Such individual shall complete an application package and furnish all information specified in Section B.2. Dues will not be assessed. The President of the Hospital shall first inform the individual that he or she is bound by all Hospital and Medical Staff Bylaws, and all related policies and procedures in all matters relating to temporary clinical privileges and shall obtain the individual's written acknowledgment of this obligation. Clinical privileges shall be restricted to the specific patients/or specific teaching rounds for which they are granted.

3. Locum Tenens

a) The President of the Hospital, with the concurrence of the Chair of the Department concerned and the President of the Medical Staff, may grant an individual serving as a locum tenens for an appointee of the Medical Staff temporary admitting and clinical privileges to attend patients of that appointee for 30 days, with the ability to extend that period if necessary, not to exceed a total of 90 days. This shall be done in the same manner and upon the same conditions as set forth in Section E.2 above.

b) The individual serving as a locum tenens must complete a full application and request for clinical privileges form, and must have in force and effect a current license to practice in this state, a DEA and state CDS registration, if applicable, and professional liability insurance in such amount as may be required by the Board.

4. Emergency Privileges

a) In the event the Hospital's Emergency Management Plan is activated and immediate patient care needs cannot be met with the current level of accredited practitioners, the President of the Hospital, the President of the Medical Staff, the VP, Medical Affairs, or their designee(s) ("Authorized Personnel) shall be empowered to grant "Emergency Privileges" pursuant to identifying parameters created by the Authorized Personnel.

b) Any practitioner granted Emergency Privileges must agree at a minimum to abide by Medical Staff Bylaws, Hospital and Department specific policies, and accept direction from appropriate Chairs of Departments/Divisions of the Medical Staff.

c) The Department and Division Chiefs, as well as on-site disaster coordinators, shall be responsible for the overall direction and supervision of these practitioners for the duration of the Emergency Management Plan by direct observation, mentoring, and/or medical chart review.

d) Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital must obtain his or her valid government issued photo identification (for example, a driver's license or passport) and at least one of the following:

1. A current picture identification card from a health care organization that clearly identifies professional designation;

2. A current license to practice.

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

4. Identification indication that the individual has been granted authority by a government entity to provide patient care, treatment, or service in a disaster circumstance.

5. Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

6. Presentation by a current hospital staff/Medical Staff member with personal knowledge of the practitioner's identity.

e) As soon as the immediate disaster situation is under control or within 72 hours, whichever comes first, or if not possible, as soon as practicable, a verification of these practitioners' credentials pursuant to the current credentialing procedures shall be processed immediately. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If the volunteer has not provided care, then primary source verification is not required.

5. Special Requirements

Special requirements of supervision and reporting may be imposed by the Department Chair concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the President of the Hospital, upon notice of any failure by the individual to comply with such special conditions.

6. Termination of Temporary Clinical Privileges

a) The President of the Hospital may terminate temporary privileges at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the Chair of the Department responsible for the individual's supervision. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a termination of temporary clinical privileges may be imposed by the President of the Hospital, the Department Chair, or the President of the Medical Staff, and such termination shall be immediately effective.

b) The appropriate Department Chair or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of the terminated individual's patients until such patients are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

c) The granting of any temporary admitting and clinical privileges is entirely a courtesy on the part of the Hospital and any or all may be terminated if a clinical question or concern has been raised. Neither the granting, denial, or termination of such privileges shall entitle the individual to any of the procedural rights provided in this Part II.

d) Temporary privileges shall be terminated automatically at any time the Credentials Committee recommends not to appoint an applicant. For non-applicants, temporary privileges shall be terminated automatically upon discharge of the patient(s) for whose care the individual received temporary privileges. Similarly, temporary clinical privileges shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted clinical privileges differing from the temporary privileges.

F. EMERGENCY CLINICAL PRIVILEGES

In the event of an emergency, any practitioner, regardless of Department, staff status, or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. For the purpose of this section, "emergency" is defined as a condition which could result in serious or permanent harm or death to a patient and in which any delay in administering treatment would add to that harm or danger.

G. PROCEDURE FOR REAPPOINTMENT

1. Terms

All terms, conditions, and procedures relating to initial appointment apply to an appointee's ongoing appointment and clinical privileges and to reappointment.

2. Application

a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form.

b) To be eligible to apply for reappointment, an appointee must have:

(1) Completed all medical records;
(2) Met all Medical Staff responsibilities and fulfilled all duties assigned by the Department Chair; and
(3) Continued to meet all qualifications and criteria outlined in the Medical Staff Bylaws or any policy adopted from time to time by the Board.

c) To be eligible to apply for renewal of clinical privileges an appointee must have performed a sufficient number of procedures, treatments, or therapies during the previous appointment term (at the Hospital or other institutions where privileged) to enable the Department Chair to assess the appointee's clinical competence for the privileges requested.

3. Reappointment Process

a) At least **six** months prior to the expiration of the appointment term, the Credentialing Office, shall provide each appointee whose term is scheduled to expire, with an application form. The reappointment application shall be submitted to the Vice President, Chief Medical Officer, at least four months prior to the expiration of the appointee's current appointment period. Failure to submit an application by that time may result in automatic expiration of the appointee's appointment and clinical privileges at the end of the appointee's current term of appointment.

b) Reappointment, if granted, shall be for a period of not more than three years. Following the initial appointment term, appointees will be reappointed in the month of their second anniversary of initial appointment, unless the Board adopts a different schedule. If the conduct or performance of an appointee warrants further review or investigation, and if this cannot be accomplished prior to expiration of the appointment, the Performance Oversight Committee may grant an extension of the practitioner's appointment for a specified period in order to accomplish further review.

c) Failure to complete and submit a timely application will result in a voluntary resignation from the Medical Staff. This resignation shall not entitle the appointee to a hearing or appeal.

4. Factors to be Considered

Each recommendation concerning reappointment of an appointee to the Medical Staff shall be based upon such appointee's:

a) compliance with Hospital and Medical Staff Bylaws and other policies and procedures which shall be disseminated as necessary;

b) ethical behavior, clinical competence, clinical judgment in the treatment of patients, and technical skills;

c) participation in staff duties;

d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital, and its personnel;

e) use of the Hospital's facilities for patients;

f) ability to perform safely and competently the essential functions of the privileges sought with or without accommodation;

g) capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications;

h) ability to present documentation of 50 hours of CME during the three -year period preceding reappointment. The Physicians Recognition Award of the American Medical Association certificate will serve as documentation of this requirement. Physicians submitting a listing of CME will be

required to have a minimum of 50 hours of Category I credit;

i) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, settlements, and information about pending or potential Medicare/Medicaid sanctions during the three years prior to the reappointment application or not otherwise covered in the previous application;

j) current licensure and DEA/CDS registration, where applicable, including currently pending challenges to any license or registration;

k) professional review actions, voluntary or involuntary termination of Medical Staff appointment, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and

l) hospital query of National Practitioner Data Bank; and

m) other reasonable indicators of continuing qualifications as determined by the Credentials Committee or the Vice President, Chief Medical Officer.

5. Department Chair Procedure

a) Once the application is complete, Credentialing Office, shall send to the Chair of the appropriate Department a description of the clinical privileges held by the appointee, accompanied by a copy of the reappointment application.

b) After evaluation of the appointee, the Department Chair shall provide the Credentials Committee with a written report concerning each appointee seeking reappointment. The Chair shall include in each written report, when applicable, the reasons for non-reappointment and any recommended changes in staff category or clinical privileges.

c) The Department Chair concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report. In the event the Department Chair is unable to evaluate an appointee's qualifications for reappointment, the Chair should make this fact known to the Credentials Committee.

6. Credentials Committee Procedure

a) The Credentials Committee shall review all available pertinent information, including all information provided from other committees of the Medical Staff and from Hospital Administration, for the purpose of determining its recommendations for staff reappointment, change in staff category, and the granting of clinical privileges for the ensuing appointment period.

b) The Credentials Committee shall follow the procedure set out for the initial appointment process in Section I.B.4, provided, however, that the

term “appointee” shall be substituted for “applicant.”

7. Medical Executive Committee Procedure

The Medical Executive Committee shall follow the procedure set out for the initial appointment process in Section I.B.5, provided, however, that the term “appointee” shall be substituted for “applicant.”

8. Performance Oversight Committee Review and Action

The Performance Oversight Committee shall follow the procedure set out for the initial appointment process in Section I.B.6, provided, however, that the term “appointee” shall be substituted for “applicant.”

9. Procedures for Requesting Additional Clinical Privileges

a) Application for Additional Clinical Privileges

(1) Whenever additional clinical privileges are desired, the applicant requesting increased privileges shall apply in writing to the Department Chair. The application shall state in detail the specific additional clinical privileges desired and the appointee’s relevant recent training and experience justifying the additional privileges.

(2) After review by the Department Chair, the application shall be processed in the same manner as an application for initial clinical privileges.

b) Factors to be Considered

(1) Recommendations for additional clinical privileges shall be based upon:

(a) relevant recent training;

(b) observation of and review of the clinical activities regarding patients treated in this and other hospitals;

(c) whether the applicant meets the qualifications and criteria for the clinical privileges; and

(d) other reasonable indicators of the individual’s continuing qualifications for the privileges in question.

(2) The recommendation for additional privileges may carry with it such requirements for supervision or consultation or other conditions as necessary.

II. PROFESSIONAL REVIEW ACTIONS

A. CORRECTIVE ACTION

When a concern or a question is raised about an appointee's behavior or clinical practice by a Board member, Medical Staff Member, or Hospital employee, the person raising the issue shall notify in writing the Vice President, Chief Medical Officer. The Vice President, Chief Medical Officer shall inform the President of the Medical Staff, the appropriate Department Chair, and the President of the Hospital. These individuals shall make sufficient inquiry to satisfy themselves as to whether the concern or question raised is credible. If a determination has been made that further investigation is needed, the President of the Medical Staff shall turn the matter over to the Quality Oversight Committee via a written request for an investigation. Any of the above persons may, but is not required to, discuss the matter with the appointee in question before taking further action.

Actions taken pursuant to this section shall not constitute a formal investigation.

This section of this Part II shall complement and shall be applied in conjunction with Hospital and Medical Staff policies dealing with disruptive and impaired practitioners.

1. Initiation of an Investigation

    a) Upon receipt of a written request for an investigation, the Quality Oversight Committee shall meet as soon as possible but no later than the next scheduled meeting after receiving the request. The Quality Oversight Committee shall, in its discretion, determine whether to discuss the matter with the individual concerned or to begin an investigation.

    b) An investigation shall begin only after a formal resolution of the Quality Oversight Committee to that effect.

    c) Notwithstanding Section (b) above, if the Board or the Medical Executive Committee wishes to begin such an investigation, it shall formally resolve to do so but will then delegate the actual investigation to the Quality Oversight Committee, unless it finds there is good cause to follow a different course in a specific instance.

    The Chair of the Quality Oversight Committee shall keep the President of the Hospital and Medical Executive Committee fully informed of all action taken in connection with the investigation.

2. Investigative Procedure

    a) The Quality Oversight Committee may either immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee.

    b) In the event the Quality Oversight Committee appoints an ad hoc investigating committee, that committee shall consist of at least three persons, who may or may not hold appointments to the Medical Staff. This committee shall not include partners, associates, relatives, or direct competitors of the individual being investigated.

c) The individual being investigated shall have an opportunity to meet with the investigating committee, or the Quality Oversight Committee if there is no separate investigating committee, before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it through either a written or oral statement or both. If the individual elects to make an oral or written statement, he must notify the appropriate committee no later than one business day before the meeting of his intent to make an oral statement or submit his/her written statement at least one business day prior to the meeting. This interview shall not constitute a hearing and none of the procedural rules provided in this Part II with respect to hearings shall apply. The individual may not bring counsel to the interview and must answer all of the questions posed to him by the committee. A summary of such interview shall be made by the investigating committee and shall be included with its report to the Quality Oversight Committee.

d) The Quality Oversight Committee may, at its discretion, require the individual to meet with the investigating committee, or the Quality Oversight Committee if there is no separate investigating committee, with respect to the investigation.

e) The Quality Oversight Committee, its subcommittee, or the ad hoc investigating committee shall have the authority to review relevant documents and conduct interviews with any individual whom it deems to have relevant information. The applicable committees shall have available to them the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. The Quality Oversight Committee may also require a physical and mental examination by a physician or physicians satisfactory to the Committee of the individual being investigated to ensure that the individual can perform job functions, and shall require that the results of such examination be made available to the Committee for its consideration.

f) If a subcommittee or ad hoc investigating committee is used, the Quality Oversight Committee may accept, modify, or reject any recommendation it receives from that entity.

3. Procedure Following the Investigation

After the investigation, the Quality Oversight Committee shall submit a written report to the Medical Executive Committee recommending appropriate corrective action, including but not limited to, a recommendation:

a) that no action is justified;

b) that a written warning be issued;

c) that a letter of guidance be sent;

d) that terms of probation be imposed;

e) that requirement for consultation be imposed;

f) that clinical privileges be reduced;

g) that clinical privileges be suspended for a term;

h) that Medical Staff appointment be revoked;

i) that the individual appears, without counsel, before the Medical Executive Committee; or

j) that a combination of the above and/or other actions be taken as it deems necessary or appropriate.

The Medical Executive Committee shall either accept or reject the recommendation of the Quality Oversight Committee, and, if rejected, the Medical Executive Committee shall propose an alternate corrective action. If the Medical Executive Committee disagrees with the Quality Oversight Committee's recommendation, the Medical Executive Committee shall specify the reasons for that disagreement and may request the Quality Oversight Committee to reconsider all or any part of its recommendation before the Medical Executive Committee makes its recommendation.

The Quality Oversight Committee's recommendation and the Medical Executive Committee's recommendations shall be forwarded through the President of the Hospital to the Performance Oversight Committee for review and action. The action shall take effect immediately.

If the action taken would entitle the individual to a hearing and appeal, the Performance Oversight Committee shall notify the affected individual through the President of the Hospital. Notwithstanding the above, the individual's request for a Hearing will not delay imposition of the action taken by the Performance Oversight Committee.

B. SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

1. Grounds for Summary Suspension

a) The President of the Medical Staff, the Vice President, Chief Medical Officer, the Chair of the applicable clinical Department, and the President of the Hospital shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever it is reasonably believed that failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of the Hospital. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension, nor shall it constitute a start of an investigation.

b) Such summary suspension shall become effective immediately upon imposition and shall remain in effect unless or until modified by the President of the Hospital or the Performance Oversight Committee.

2. Investigation and Procedure Following Investigation

The individual who suspended the Member of the Medical Staff must notify the Quality Oversight Committee and Medical Executive Committee via the respective

Department Chair within 24 hours of the suspension. The Quality Oversight Committee shall investigate the matter, as provided for in Section II.A., and shall recommend to the Medical Executive Committee that the suspension be either continued, lifted, or modified. The Medical Executive Committee shall make a recommendation to the Performance Oversight Committee with respect to the recommendation. If the Performance Oversight Committee does not lift the suspension, the individual shall be entitled to a hearing and appeal as provided in this Part II. The Quality Oversight Committee and Medical Executive Committee shall complete their investigations and make recommendations within 30 days after the date of the initial suspension and must specify to the Performance Oversight Committee reasons for any delay.

3. Care of Suspended Individual's Patients

a) Immediately upon the imposition of a summary suspension, the appropriate Department Chair or, if unavailable, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the Hospital. The assignment shall be effective until such time as the patients are discharged. To the extent possible, the wishes of the patient shall be considered in the selection of the assigned appointee.

b) It shall be the duty of all Medical Staff appointees to cooperate in enforcing all suspensions.

C. INTERRUPTION OF PRIVILEGES

1. Voluntary Relinquishment of Clinical Privileges or Medical Staff Membership

a) A Medical Staff appointee may voluntarily relinquish any or all of his/her clinical privileges at any time, so long as that relinquishment is not found by the Credentials Committee to be for the purpose of avoiding a duty or obligation of Medical Staff appointment.

b) A Medical Staff appointee may voluntarily relinquish his/her Medical Staff appointment at any time.

2. Failure to Timely Complete Medical Records.

The medical record must be completed within 30 days of the patient's discharge. A medical record incomplete for more than 30 days following discharge is considered "delinquent" and is grounds for interruption of privileges.

3. Illegible Medical Records

All aspects of the medical record are expected to be completed in a legible manner. Failure to do so is grounds for interruption of privileges.

4. Action by Licensing Agencies

Action by a State or Federal licensing board or agency revoking or suspending an individual's professional license, or the loss or lapse of a required state license to practice for any reason, shall result in interruption of all Hospital clinical privileges as of that date, until the matter is resolved and an application for reinstatement of

privileges have been approved by Performance Oversight Committee. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted.

5. Failure to be Adequately Insured

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges shall be deemed to be interrupted or restricted, as applicable, as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

6. Failure to Provide Requested Information for Peer Review

a) If at any time an appointee fails to provide information pursuant to a formal request by the Vice President, Chief Medical Officer, Medical Executive Committee, President of the Medical Staff, Chief of the Department, Physician Advisor to the Quality Risk Management Department, any and all investigating committees, the appointee's clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party.

b) For purposes of this section "information" shall include physical or mental examinations, information necessary to answer an inquiry by any of the above parties, and information necessary to explain an investigation, disciplinary action, or resignation from another facility or agency.

c) If after 30 days of voluntary relinquishment in (a) the information requested is not forthcoming, the appointee's Medical Staff membership shall be deemed to be voluntarily resigned.

III. PRACTITIONER HEALTH

In order to facilitate the prompt identification of, and intervention with, practitioners suspected of a health or emotional impairment that might adversely affect their ability to practice safely and competently, or might result in a disruption of the orderly functioning of the Hospital, there is here established a process which strives to maintain confidentiality for those involved while ensuring the safety and well-being of the patients and staff.

1. An impaired practitioner is one whose ability to practice medicine with reasonable skill and safety is impaired because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.

2. Practitioners who are suspected of being impaired shall be reported to the President of the Medical Staff, the Vice President, Chief Medical Officer, or the Chief of the Department to which the practitioner belongs. Reports may be made anonymously, and either verbally or in writing. Such reports, however, must state specifically the facts and circumstances and witnessed behavior upon which the suspicion is based. Practitioners may also self-report impairment to such individuals. The person receiving the report of suspected impairment will share the report with the involved practitioner's Department Chief within three days of receipt. The Department Chief will then discuss the report of suspected impairment with the involved practitioner and may further investigate the matter if warranted.

3. Within ten days after receiving the report of suspected impairment, if warranted, the Department Chief shall request that the President of the Medical Staff call a meeting of the Impaired Practitioner Committee (the "IPC"). The IPC shall meet within 14 days of such request. The IPC is an ad hoc committee of the Medical Staff which shall be convened upon request of the President of the Medical Staff and which shall consist of the Vice President, Chief Medical Officer, the President of the Medical Staff, the involved practitioner's Department Chief, and a Member of the Medical Staff who shall be chosen by the President of the Medical Staff. If the suspected impairment concerns a mental health issue, the President of the Medical Staff shall choose a mental health provider as the fourth member.

4. The IPC shall review the complaint alleging the suspected impairment, as well as any findings and conclusions of the Department Chief stemming from his/her discussion with the involved practitioner and any investigation to evaluate the credibility of the complaint, allegation, or concern. The IPC may further investigate the matter, if warranted, and may request the involved practitioner to appear before it to answer any questions. Within 30 days of its initial meeting, the IPC shall make a determination as to whether the practitioner involved is impaired or is potentially impaired.

5. Upon a finding of impairment or potential impairment, the IPC shall recommend to the involved practitioner a course of action to be taken. Such recommendation may include, but is not limited to the following: taking no action, further investigation, confronting the practitioner informally or formally with an offer of assistance and/or a demand for a change in behavior, or mandating that the practitioner seek professional counseling, either through the Employee Assistance Program, the Medical and Chirurgical Faculty of Maryland Physician Rehabilitation Program, or another outside specialist chosen by the IPC (at the Hospital's expense). If counseling is mandated, the practitioner shall consent to release to the IPC a report of the counselor's findings and recommendations, as well as the practitioner's progress and the implications if any for the safety of the practitioner's patients. The IPC shall then convene as often as necessary to monitor the practitioner's progress and to re-evaluate the practitioner's condition. Any concerns of the IPC shall be reported directly to the MEC.

   The IPC shall also determine whether the practitioner's clinical privileges require modification, suspension, or termination. If the IPC determines that action against the practitioner's clinical privileges is warranted, the IPC shall make that recommendation to the Credentials Committee.

6. Any modification, suspension, or termination of the practitioner's clinical privileges shall be taken in accordance with the procedures set forth in the Medical Staff Bylaws. In all instances in which the IPC finds the practitioner to be impaired or potentially impaired, and the practitioner is permitted to retain clinical privileges, the IPC shall establish a monitoring mechanism by which the practitioner may continue to practice. Any concerns of the IPC shall be reported directly to the MEC.

7. All reports of suspected impairment, the identity of the practitioner suspected to be impaired, IPC proceedings and investigations relating thereto, and actions taken as a result of such reports, proceedings, and investigations, with the exception of actions taken with respect to the practitioner's clinical privileges, shall remain confidential except as limited by law, ethical obligation, or when the safety of a patient is threatened.

8. A copy of the complaint, findings, and recommendations of the Department Chief and IPC shall be made a part of the practitioner's permanent credentialing record.

9. If the involved practitioner fails to cooperate with the process outlined above, or if the IPC determines that he/she is not making progress in any mandatory counseling, the disciplinary processes set forth in the Medical Staff Bylaws shall be invoked.

IV. PROCEDURE FOR LEAVE OF ABSENCE DURING TERM OF APPOINTMENT

Members of the Medical Staff may, for good cause, be granted leave of absence by the Performance Oversight Committee for a definitely stated period of time not to exceed one year. Absence for longer than one year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Performance Oversight Committee. Any medical leave beyond the terms of the appointment or reappointment will result in expiration of membership and privileges.

Any request for leave of absence shall be made to the Chair of the Department in which the individual applying for leave holds clinical privileges and shall state the beginning and ending dates of the requested leave. The Department Chair shall transmit the request together with a recommendation to the President of the Hospital for action by the Performance Oversight Committee.

No later than 60 days prior to the conclusion of the leave, the individual may request to be reinstated by filing with the President of the Hospital a request for reinstatement of privileges, which shall summarize the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at that time.
If the leave was for medical reasons, then the individual must submit a report from his or her attending physician indicating that the Medical Staff appointee is physically and/or mentally capable of resuming a Hospital practice and performing the clinical privileges that are requested to be reinstated. The individual shall also provide such other information as may be requested by the Hospital at that time.

All information will be sent to the Chair of the applicable Department and then to the Credentials Committee for evaluation. After considering all relevant information, the Credentials Committee shall make a recommendation to the Medical Executive Committee and the Performance Oversight Committee for final action.

In acting upon the application for reinstatement, the Performance Oversight Committee may approve reinstatement either to the same or to a different staff category and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

V. CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this portion of Part II, Section II, Professional Review Actions, and any Departmental credentialing policies and procedures shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to this portion of Part II, Section II, Professional Review Actions, and any Departmental credentialing policies and procedures shall be made by the President of the Hospital or his designee to such governmental agencies as may be required by law.

VI. PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this portion of Part II, Section II, Professional Review Actions, are intended to be covered by current and future federal and state statutes providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings,

recommendations, or investigations pursuant to these policies shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, as amended.

VII. INFORMAL PROCEEDINGS

Nothing in the Medical Staff Bylaws or other credentialing policies shall preclude collegial or informal efforts to address questions or concerns relating to an individual's practice and conduct in the Hospital. It is the policy of the Hospital and Medical Staff to specifically encourage voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the appointee and the Board.

VIII. AMENDMENTS TO CREDENTIALING/PEER REVIEW PROCEDURES

A. This Chapter I may be amended as provided in Article XIII of the Medical Staff Bylaws.

B. Notwithstanding the above, this Chapter I, may be amended by the Board on its own motion for the following purposes:

1. to comply with changes in federal and state laws that affect the Hospital and any of its affiliates;

2. to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals; and

3. to comply with requirements imposed by the Hospital's insurance carrier.

The Board shall notify the Medical Executive Committee and the Credentials Committee of any such action taken pursuant to this Section.

CHAPTER II

HEARING AND APPEALS PROCEDURES

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HEARING AND APPEALS PROCEDURES

I. HEARINGS

A. GROUNDS FOR HEARING

1. Subject to Section I.B.2., a Medical Staff Member shall be entitled to request a hearing whenever an unfavorable action has been taken by the Board. The following actions shall constitute "unfavorable action":

    a) denial of initial Medical Staff appointment;

    b) denial of Medical Staff reappointment;

    c) suspension or revocation of Medical Staff appointment;

    d) denial of requested initial clinical privileges;

    e) denial of requested increased clinical privileges;

    f) involuntary limitation or reduction of clinical privileges; or

    g) imposition of individualized mandatory consultation requirement.

    Subject to Section I.B.2., if a Medical Staff Member's clinical privileges are limited or suspended for more than 30 consecutive days, such suspension shall, for purposes of these hearing and appeal procedures, be deemed an involuntary limitation of clinical privileges by the Board.

2. No other actions except those enumerated in paragraph (1) above shall trigger the right to a hearing and appeal. Failure to meet eligibility criteria as defined in Section I.A.2. of the credentialing and peer review procedures of Chapter I, or any other eligibility criteria, shall not be grounds for a hearing or appeal. Without limiting the scope of the preceding sentence, the following actions shall not entitle a Medical Staff Member to a hearing or appeal.

    a) voluntary relinquishment of clinical privileges;

    b) loss of privileges or membership due to loss of professional liability coverage;

    c) imposition of any medical staff consultation requirement that is applicable to an entire class of Members of the Medical Staff;

    d) imposition by an external regulatory agency of a requirement for retraining, additional training, or continuing education;

    e) disciplinary action by an external regulatory agency resulting in an action being taken against the Medical Staff Member's license or otherwise resulting in the inability of the Medical Staff Member to meet eligibility requirements;

    f) loss of employment;

g) loss of privileges due to establishment of, or change in terms of, an exclusive relationship or termination of a contract where privileges are coterminous with the contract;

h) denial, limitation, or revocation of temporary privileges;

i) suspension for failure to complete medical records in a timely fashion; or

j) loss of privileges or Medical Staff membership due to failure to obtain board certification within the required time frame.

3. The hearing and appeal process shall not be constrained by, among others, the formal rules of evidence, trial procedure, and communication between the parties and other interested persons or entities. The goal of the hearing and appeal process is to consider all information which may have a bearing on the matter, and communication among persons with such information is encouraged, except as specifically restricted in these hearing and appeal procedures.

B. NOTICE OF HEARING

1. Notice of Action

When an action is taken which, according to these hearing and appeal procedures, entitles a Medical Staff Member to a hearing, he/she shall promptly be given notice by the President of the Hospital, in writing, either by personal delivery or by certified mail, return receipt requested. This notice shall contain:

a) a statement of the action taken and the general reasons for it;

b) notice that the Medical Staff Member has the right to request a hearing on the action within 30 days of receipt of this notice; and

c) a copy of these procedures.

2. Request for Hearing

a) The Medical Staff Member shall have 30 days following the receipt of such notice within which to request a hearing. The request shall be in writing and shall be directed to the President of the Hospital. If the Medical Staff Member does not request a hearing in this manner, he/she shall be deemed to have waived the right to the hearing and any appellate review, and to have accepted the action involved. Unless otherwise specified by the person or body taking the action, the fact that a Medical Staff Member is entitled to request, or has requested, a hearing will not delay imposition of the action.

3. Notice of Hearing

a) The President of the Hospital shall, within 10 days of receiving the request for a hearing, schedule the hearing and shall give written notice, either personally or by certified mail, return receipt requested, to the Medical Staff Member who requested the hearing. The hearing date shall be set not less than 30 and no greater than 60 days from receipt of the request. The notice shall include:

(1) the time, place, and date of the hearing;

(2) the names of the Hearing Panel members or Hearing Officer, if known, or of the Presiding Officer, if applicable; and

(3) a statement of the specific reasons for the action as well as the list of patient record numbers and information supporting the action (if applicable). This statement, the list of supporting patient record numbers (if applicable), and other supporting information may be revised or amended at any time, even during the hearing, so as to give the Hearing Panel or Presiding Officer as complete a record as possible.

C. PROCEDURE

1. Hearing Panel, Hearing Panel Chair, and Hearing Officer

a) Hearing Panel

(1) When a hearing is requested, the President of the Hospital, after considering the recommendations of the President of the Medical Staff and the Chair of the Board of Trustees, shall appoint either a Hearing Panel of not less than three and no more than five members, or a single Hearing Officer. When the hearing is to be heard by a Hearing Officer, the term "Hearing Officer" shall be substituted for all references to "Hearing Panel" and/or "Hearing Panel Chair" in these hearing and appeal procedures, unless the context clearly indicates otherwise.

(2) No member of the Hearing Panel shall be in direct and substantial economic competition with, professionally associated with, or personally related to, the Medical Staff Member who is the subject of the hearing. Further, no person who participated actively in the consideration of the matter involved at any previous level shall serve as a member of the Hearing Panel. However, no person shall be precluded from service on the Hearing Panel solely by virtue of being in practice in the same specialty as the Medical Staff Member who has requested the hearing, nor shall any person be precluded from serving on the Hearing Panel by virtue of having knowledge of the matter being considered.

b) Hearing Panel Chair

(1) The President of the Hospital, with the advice of the President of the Medical Staff and the Chair of the Board of Trustees, shall appoint a Hearing Panel Chair from among the members of the Hearing Panel. The Hearing Panel Chair must act neither as a prosecuting officer nor as an advocate for either side at the hearing. He or she may participate in the private deliberations of the Hearing Panel and may vote.

(2) The Hearing Panel Chair shall perform the following procedural duties:

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

(b) prohibit conduct or presentation of evidence that is cumulative, excessive, or abusive or that causes undue delay;

(c) maintain decorum throughout the hearing;

(d) determine the order of procedure throughout the hearing;

(e) have the authority and discretion, in accordance with these hearing and appeal procedures, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence; and

(f) hear argument by counsel on procedural points outside the presence of the Hearing Panel unless panel members wish to be present.

(3) The Hearing Panel and the Hearing Panel Chair may be advised by legal counsel to the Hospital and may engage expert witnesses.

2. Witness List

a) Within 10 business days after receiving notice of the hearing, the Medical Staff Member requesting the hearing shall provide a written list of the names and addresses of the persons expected to offer testimony or present evidence on his or her behalf. The witness list of either party shall include a brief summary of the nature of the anticipated testimony.

b) The Hospital shall provide its proposed witness list, including a summary of the expected nature of the testimony, to the Medical Staff Member requesting the hearing within 15 days after receiving the Medical Staff Member's proposed witness list.

c) Failure to provide a witness list in a timely manner will be grounds for the Hearing Panel Chair to refuse testimony from any person not identified. However, the witness list of either party may, in the discretion of the Hearing Panel Chair, be supplemented or amended at any time prior to the date of the hearing, provided that notice of the change is given to the other party.

d) The Hearing Panel Chair shall have the authority to limit the number of witnesses, especially character witnesses and witnesses whose testimony is merely cumulative.

3. Discovery

a) The Medical Staff Member requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

(1) (if applicable) copies of, or reasonable access to, all patient medical records referred to in the hearing notice, at the Medical Staff Member's expense;

(2) reports of experts relied upon by the Credentials Committee, the Medical Executive Committee, or the Board;

(3) redacted copies of relevant committee or department minutes (such provision does not constitute a waiver of the state peer review protection statute); and

(4) copies of any other documents relied upon by the Credentials Committee, the Medical Executive Committee, or the Board.

b) Prior to the hearing, on dates set by the Hearing Panel Chair or agreed upon by both sides, each party shall provide the other party with a copy of all exhibits that will be relied upon at the hearing. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing in advance of the hearing. The Hearing Panel Chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

c) Neither the Medical Staff Member, nor his/her attorney, nor anyone else acting on his/her behalf shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless such is specifically agreed upon by both parties' counsel in writing.

4. Pre-Hearing Conference

The Medical Staff Member and the Hospital, and/or their legal counsel or other representative, shall participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Hearing Panel Chair may specifically require that:

a) all documentary evidence to be submitted by the parties be presented at this conference, and any objections to the documents shall be made at that time and resolved by the Hearing Panel Chair;

b) evidence unrelated to the reasons underlying the action being challenged be excluded;

c) the names of all witnesses and a brief statement of their anticipated testimony be submitted;

d) the time granted to each witness's testimony and cross-examination be agreed upon, or determined by the Hearing Panel Chair, in advance; and

e) witnesses and documentation not provided and agreed upon in advance of the hearing be excluded from the hearing.

5. Attendance by Panel members

At least three Hearing Panel members shall attend all hearing sessions.

6. Failure to Appear

Failure, without good cause, of the Medical Staff Member requesting the hearing to appear and proceed at the hearing shall constitute voluntary acceptance of the action(s) that was to be the subject of the hearing.

7. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne equally by the Hospital and the Medical Staff Member. The cost of copies of the hearing transcript shall be borne by the party requesting the transcript.

8. Rights of Both Parties

a) At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Hearing Panel Chair:

(1) to call and examine witnesses to the extent available;

(2) to introduce exhibits;

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

(4) to be represented by counsel, by a Member of the Medical Staff, or by a member of the local professional society, who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit a written statement at the close of the hearing**.**

b) The Medical Staff Member who requested a hearing may be called as a witness for the Hospital even if he/she chooses not to testify in his or her own behalf.

9. Admissibility of Evidence

a) The formal rules of evidence shall not apply, and the Hearing Panel may consider any material it deems relevant to the issues involved. Any relevant evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. For example, hearsay evidence shall not be excluded merely because it constitutes

hearsay. The guiding principle shall be that the Hearing Panel shall have before it all information relevant to the issues being addressed.

b) The Hearing Panel may question the witnesses, call additional witnesses, or request additional documentary evidence. The Hearing Panel or the Hearing Panel Chair may, without notice, recess the hearing and reconvene it at a later date for the convenience of the participants or to obtain new or additional information or consultation.

10. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Procedures may be requested by either side but shall be permitted only by the Hearing Panel Chair or the President of the Hospital on a showing of good cause.

11. Order of Presentation

The Hospital shall first present evidence in support of its action. Thereafter, the Medical Staff Member who requested the hearing shall have the opportunity to present evidence in support of his/her position.

D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

1. Basis of Decision

a) The Hearing Panel shall recommend upholding the action being challenged unless it finds that the Medical Staff Member who requested the hearing has proved that the action was not supported by substantial evidence.

b) The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(1) oral testimony of witnesses;

(2) written statements presented in connection with the hearing;

(3) any other information admitted into evidence at the hearing;

(4) any and all applications, references, and accompanying documents; and

(5) other documentary evidence, including medical records.

2. Adjournment and Conclusion

The Hearing Panel Chair may adjourn and reconvene the hearing as needed. The hearing shall conclude when the Hearing Panel Chair, after consultation with the panel, finds that no more evidence is to be presented or questions are to be asked or that the remaining evidence will be cumulative only.

3. Deliberations and Recommendation of the Hearing Panel

Within 30 business days after final adjournment of the hearing, which shall be designated as the date the Hearing Panel receives the last post-hearing memorandum, the Hearing Panel shall begin deliberations. The Hearing Panel's deliberations shall be conducted outside the presence of any other person. The Hearing Panel shall render a recommendation, accompanied by a written report, which shall contain a concise statement of the basis for the recommendation.

4. Disposition of Hearing Panel Report and Final Board Action

a) The Hearing Panel shall deliver its written recommendation to the President of the Hospital, who shall forward it, along with all supporting documentation, to the Chair of the Board of Trustees. A copy of the report and supporting documentation shall be sent to the Medical Staff Member who was the subject of the hearing, and to other individuals and entities identified by the President of the Hospital or the Chair of the Board.

a) The Hearing Panel's report and recommendations shall be placed on the agenda for the next regularly scheduled Board meeting (or, if such meeting is scheduled to occur within fifteen days after issuance of the Panel's report, at the next meeting thereafter). At that meeting, the Board, acting in light of the Hearing Panel report and such other information as the Board in its discretion wishes to consider, shall affirm, modify, or reverse its prior action, or, in its discretion, it may refer the matter back to the Hearing Panel for further review and recommendations in accordance with the Board's instructions. The President shall notify the Medical Staff Member who was the subject of the hearing of the Board's action by certified mail, return receipt requested.

II. APPEALS

A. TIME FOR APPEAL

Unless the Board has referred the matter back to the Hearing Panel for further action, if the Medical Staff Member objects to the Board's action, he/she may, within ten business days after receiving notice of the Board's action, request an appeal. The request shall be submitted in writing to the President of the Hospital, either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances that justify further review. If an appeal is not requested in this manner, the Medical Staff Member shall be deemed to have waived appeal and the Board's action shall be final.

B. GROUNDS FOR APPEAL

The grounds to be argued on appeal shall be limited to the following:

1. that during or prior to the hearing there was substantial failure to comply with these Procedures and/or with the Hospital or Medical Staff Bylaws so as to deny due process or a fair hearing; or

2. the Board of Trustees' action, when considered in light of the Hearing Panel's recommendation, was not supported by substantial evidence.

C. TIME, PLACE, AND NOTICE

Whenever an appeal is requested as set forth in these hearing and appeal procedures, the Chair of the Board of Trustees shall schedule and arrange for a review of the appeal as promptly as possible after receipt of the request. The Medical Staff Member shall be given notice of the time, place, and date of the appeal. The date of appellate review shall be no more than 30 business days from the date of receipt of the request for appellate review, unless extended by the Chair of the Board for good cause.

D. APPEAL PROCEDURE

1. The Chair of the Board shall appoint a Review Panel composed of not less than three individuals, or, in its discretion, the Board as a whole may review the appeal, in which event references herein to the Review Panel shall be deemed to refer to the entire Board. The Review Panel may include members of the Board of Trustees and/or other reputable individuals not regularly employed by the Hospital.

2. The appeal shall be based on the record from the Hearing Panel proceedings; provided, however, that each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. Additional evidence may be accepted by the Review Panel, at its sole discretion, if the party seeking to admit it can demonstrate that such evidence was not developed at the time of the hearing, or that the opportunity to admit such evidence at the hearing was unfairly and improperly denied. If the Review Panel elects to receive additional evidence, the submission of such evidence shall be governed by the same rules as applied at the Hearing Panel proceedings.

3. The Review Panel shall commence deliberations within 15 days after the conclusion of its review, which shall be deemed to occur when the last written statement is submitted. The Review Panel may affirm, modify, or reverse the Board's action or, in its discretion, may refer the matter back to the Hearing Panel for further review and recommendations. Neither the individual nor members of the Board (other than those on the Review Panel) shall be entitled to participate in the deliberations of the Review Panel, nor shall the members of the Board who are not on the Review Panel be permitted to vote on the final action.

4. Within five days after concluding its deliberations, the Review Panel shall issue a written report and recommendations to the Board.

E. FINAL DECISION OF THE BOARD

Within 30 days after the issuance of the Review Panel's report and recommendations, the full Board of Trustees shall meet to take final action with regard to the matter that was the subject of the appeal. At that meeting, the Board may affirm, modify, or reverse the prior action of the Board, or refer the matter for further review for a period not to exceed 30 days (unless the individual involved consents to a longer period), following which the Board shall again take up the matter for final action. Within 30 days after taking final action, the Board shall render a final written decision, including specific reasons therefor. The Chair of the Board shall ensure that copies of the Board's reports are delivered in or by certified mail, return receipt requested, to the Medical Staff Member involved, to the President of the Hospital, and to the Chairs of the Credentials and Medical Executive Committees. A

decision of the Board following appellate review shall be effective immediately and shall not be subject to further review.

III. RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No Medical Staff Member shall be entitled to more than one hearing and one appeal in connection with any particular action, or any group of actions based on a common set of facts. If the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, he/she may not apply for Medical Staff appointment or for the denied clinical privileges for a period of three years unless the Board provides otherwise.

CHAPTER III

RULES AND REGULATIONS

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RULES AND REGULATIONS

I. SCOPE

The term "Physician" shall refer to all physicians, surgeons, podiatrists and dentists who furnish care to patients in the Hospital. It shall include House Physician Staff and other medical practitioners, except where clearly stated otherwise or where the context indicates that the provision affects only attending physicians who are members of the Hospital's Medical Staff. To the extent Physicians are employed or contracted by the Hospital, these Rules and Regulations shall not be deemed to alter the terms and conditions of their employment or contract.

II. BASIC RESPONSIBILITIES OF PHYSICIANS

A. Core Responsibilities:

Each Physician shall, as appropriate, fulfill the following responsibilities, which shall apply as well to individuals granted temporary privileges:

1. Provide appropriately continuous quality care and supervision to all patients within the Hospital for whom the Physician has responsibility. It is expected that each patient admitted to an appointee's service shall be visited at least once every calendar day unless extraordinary circumstances dictate otherwise.

2. Perform only procedures for which they have been granted privileges by the Board of Trustees of the Hospital, provided, however, in case of an emergency involving threat to life or limb, this rule may be waived.

3. Work cooperatively with other Physicians and Hospital personnel so as not to adversely affect patient care or employee relations. Abusive language and harassment in any form will not be tolerated.

4. Accept committee assignments and such other reasonable duties and responsibilities, including professional review activities, quality assessment activities, service call, and patient care rotations as shall be assigned.

5. Participate in the monitoring and evaluation activities of clinical departments.

6. Use the Hospital and its facilities sufficiently to allow the Hospital, through assessment by appropriate Medical Staff committees and Department Chairs, to evaluate the ongoing clinical competence of the individual; or provide evidence of competence from other accredited institutions or peer references.

7. To seek consultation whenever treating a patient that presents with a degree of complexity or acuity that requires advanced expertise. It is expected that, when such consultation is requested, that there be a direct communication between requesting practitioner and consultant. Only members of the Medical Staff may call medical consultations. It is not appropriate to order a consult by leaving this communication to a secretary, unit clerk or nurse.

8. Complete in a timely manner the medical and other required records for all patients, as required by the Hospital and Medical Staff Bylaws.

9. Participate in continuing education programs, as required by their professional licensing board.

10. Abide by generally recognized ethical principles applicable to the individual's profession.

11. Abide by all Bylaws, Policies, and Procedures of the Medical Staff and Hospital as they exist from time to time during the term of appointment.

12. Promptly pay any applicable Medical Staff dues.

13. Accurately represent to the patient the identity of the operating surgeon and any other individual providing treatment or services.

14. Refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised.

15. Refrain from illegal fee splitting or other illegal inducements relating to patient referral.

16. Promptly notify the President of the Hospital of any of the following:

    a. change in eligibility for payments by third-party payors or for participation in Medicare, including, but not limited to, any notification of sanction(s) imposed or recommended by the federal Department of Health and Human Services or related agencies, or any state program;

    b. disciplinary actions;

    c. license attachments or limitations, or removal by any hospital or health care facility, or professional organizations.

B. Medical Staff Code of Conduct and Performance Expectations

1. Purpose:

   This code of conduct and professional standards expectations has been formulated to avoid disruptive, intimidating, and threatening behaviors that result in an environment that fosters potential safety concerns, medical errors, and adverse outcomes.

2. Philosophy

   It is the expectation that Medical Staff members, as well as Allied Health Personnel, will behave according to the principles of Caring, Respect, and Teamwork that guide the performance requirements of all Northwest Hospital personnel. It is of paramount concern that there not be a disruption in the orderly operation of the Hospital and the delivery of care. Only in this fashion will the interests of patients and their families be protected, including the guarantee of the provision for safety, quality of care, and treatment with dignity and respect.

3. Appropriate Conduct for all Practitioners:

   - Practitioners will abide by all ethical and legal standards as adopted by the American Medical Association in its Principles of Medical Ethics, in accordance with the Health Care Occupations Statute of the State of Maryland, and in accordance with the Medical Staff Bylaws.

   - Practitioners will follow all standards of patient privacy and confidentiality as defined in HIPAA regulations.

   - All communication, whether verbal, non-verbal, or written, will be conducted with respect and dignity.

   - Communications, including answering calls from hospital staff or other Medical Staff members, will be timely and appropriate; direct practitioner to practitioner communication is expected when sensitive and important information or requests for consultations are imparted.

   - All interactions will be conducted with honesty and integrity- in word and deed.

4. Examples of Inappropriate Behaviors

   - Shouting in anger, or the use of profanity or vulgar language.

   - Disparaging remarks, either verbal or written, about other practitioners, Hospital personnel, or patients and families.

   - Inappropriate and unwelcomed physical contact or assault.

   - Sexual harassment, whether physical or verbal, or demands or pressure for sexual favors.

   - Inappropriate expressions of anger, including the throwing of objects or destruction of property.

   - It is considered a violation of ethical standards to make disparaging or embarrassing entries into the medical record.

   - Any other behaviors that result in intimidation, disrespect, the creation of a hostile work environment, or the disruption of the orderly operation of Hospital function.

   - Retaliation, or the threat of same, to anyone reporting such behavior.

5. Process

   Investigation, adjudication, and resolution of complaints with respect to disruptive behavior will be handled according to the “Professional Conduct Complaint Process,” denoted in Rules and Regulations II C.

6. Special Considerations:

   - There will be a policy of “zero tolerance” for professional standards complaints in that all such queries will be investigated promptly and thoroughly with due process for all involved parties.

   - All complainants will be afforded complete immunity from retaliation or other adverse consequences when such complaints are made in good faith.

- Complaints are encouraged to be in writing; anonymous complaints will be evaluated by the appropriate personnel but are to be discouraged, in that they are by nature more difficult to investigate, adjudicate, and allow for due process for the practitioner.

- All practitioners will be expected to sign a statement acknowledging these principles and agreeing to abide by them, as a condition of credentialing at Northwest Hospital.

B. PROFESSIONAL CONDUCT COMPLAINT PROCESS:

To ensure that all persons who have been granted clinical privileges to practice at Northwest Hospital conduct themselves in a professional manner, in accordance with the Principles of Medical Ethics adopted by the American Medical Association, the Code of Conduct and Expectations, the standards adopted by the various licensing boards of the State of Maryland, as applicable, professional standards of their particular discipline, and the Medical Staff Bylaws.

POLICY:

This Professional Conduct Complaint Process Policy is intended to provide a process for addressing conduct that does not meet the above standards, without formally limiting or revoking a practitioner's clinical privileges. It is not intended to limit in any way the Hospital's right to take any form of Corrective Action provided for in Chapter I of this Part II of the Medical Staff Bylaws. This Process is not intended to be a prerequisite to the taking of Corrective Action, including abridgment or revocation of privileges, in accordance with Chapter I.

As used in this Process, the term "Medical Staff member" means any practitioner with clinical privileges at the Hospital, regardless of whether such individual is officially a member of the Medical Staff; it specifically includes Allied Health Personnel, Fellows, and Residents.

IMPLEMENTATION/PROCEDURE:

1. A complaint may be made against a member of the Medical Staff at any time, by any person, for any conduct perceived to be inappropriate, unprofessional, or below the standards of the Medical Staff or the Hospital, as delineated in Rules and Regulations, Section II B. Complaints made by a member of the Medical Staff shall be made directly to the appropriate Chief. Other persons with complaints shall submit the complaint to the appropriate Chief or the appropriate Manager. All complainants shall be strongly encouraged to submit their complaint in writing. A Chief may also initiate this process on his/her own initiative. Complainants are afforded complete immunity from retaliation in any form as a result of bringing forward such complaints.

2. When the Chief receives a complaint directly, or initiates this process on his/her own initiative, the Chief may take action in accordance with this Professional Conduct Complaint Process beginning with step six below, or he/she may refer the complaint to the appropriate Manager for investigation and possible resolution in accordance with steps three through five below.

3. If the complaint is made directly to the Manager, or if the Chief refers the complaint to the Manager, the Manager shall inform the complainant (if the identity of the complainant is known) that the complaint will be investigated and addressed in accordance with this Professional Conduct Complaint Process, and shall briefly describe the steps of the process. The Manager shall initiate an investigation of the complaint and shall document his/her findings. This investigation shall be completed within 10 business days of complaint receipt.

4. If the Manager believes the complaint could be effectively resolved through a meeting between the complainant and the Medical Staff member, and both parties agree to such a meeting, the Manager shall schedule a meeting between them. The Manager shall be present, and shall record the outcome of the discussion, which record shall be forwarded to the appropriate Chief. If the meeting results in the satisfactory resolution of the complaint, the matter shall be considered closed.

5. If the Manager does not believe that the complaint could be effectively resolved through a meeting between the complainant and the Medical Staff member, or if the meeting between the complainant and the Medical Staff member takes place but does not resolve the issue, it shall be the responsibility of the Chief to take further action. The Manager shall submit a report to the Chief, including a copy of the complaint, a summary of the findings from the Manager's investigation, and, if applicable, a report of the meeting between the complainant and the Medical Staff member, within 72 hours of the conclusion of the meeting, or, if no meeting occurred, within 72 hours of first receiving the complaint.

6. Unless the complainant was notified by a Manager in accordance with step three above, the Chief shall send a notice to the complainant (if the identity of the complainant is known) acknowledging his/her receipt of the complaint and confirming that the issue will be properly addressed in accordance with this process. This shall be done within 3 business days of complaint receipt.

7. The Chief shall take such additional fact-finding steps as he/she determines to be necessary. If a conflict of interest exists between the Chief and the Medical Staff member or the complainant, the Chief shall refer the matter to the President of the Medical Staff or another Chief for further action in accordance with this process.

8. The Chief conducting the investigation shall have broad discretion as to how to address the complaint, subject to his/her duties and obligations under the Medical Staff Bylaws and any applicable Hospital policies. The Chief may involve other leaders of the Medical Staff in the matter if he/she believes it appropriate to do so. The decision of the Chief shall be based upon the nature of the complaint, the frequency and severity of the conduct at issue, and any other circumstances that he/she deems relevant to the matter at issue. A Chief shall not impose disciplinary action without first notifying the Medical Staff member of the nature of the complaint and providing the Medical Staff member with an informal opportunity to explain his/her conduct, except in extraordinary circumstances. This investigation shall be completed within 10 business days of the Chief's receipt of the complaint.

9. A Medical Staff member informed of a complaint shall be directed to have no contact with the complainant other than that required in the performance of the Staff member's professional activities. Any attempt by a Medical Staff member to harass or retaliate against a complainant (or suspected complainant) shall be grounds for suspension of clinical privileges and further Corrective Action in accordance with Chapter I of this Part II of the Medical Staff Bylaws.

10. If the Chief believes that disciplinary action is warranted, the Chief may choose to take action from among those listed below, or the Chief may, with the concurrence of the Chair of the Medical Executive Committee, choose a course of action not listed below.

11. Actions taken against a Medical Staff member under this Professional Conduct Complaint Process will progress from Level I to Level III as described below, unless, in the opinion of the Chief investigating the matter, the conduct is of such an egregious or ongoing nature that a higher level of action is warranted.

12. Refusal of a Medical Staff member to cooperate with this Professional Conduct Complaint Process shall be grounds for invocation of Corrective Action in accordance with Chapter I of this Part II of the Medical Staff Bylaws and be considered in the interim a voluntary resignation of all clinical privileges.

13. Neither the invocation of this Professional Conduct Complaint Process nor the imposition of disciplinary action pursuant to this process shall be considered an Adverse Action, and a Medical Staff member who is the subject of action taken under this Professional Conduct Complaint Process shall not be entitled to a fair hearing or appellate review.

14. Actions taken under this Professional Conduct Complaint Process shall remain confidential and shall not be disclosed to persons other than in accordance with this Process or as otherwise required by law or accreditation standards. This process shall be considered a peer review activity and not subject to disclosure.

15. The relevant Chief shall maintain a copy of all documents related to investigations and disciplinary actions taken in accordance with this Professional Conduct Complaint Process. Such documents shall be reviewed and taken into consideration when the Medical Staff member applies for renewed Medical Staff membership and clinical privileges or applies to have his/her privileges modified.

    Level I

    If the Medical Staff member has had no other disciplinary action within the preceding 12 months, the Chief may issue a written warning to the Medical Staff member.

    Level II

    If, during the preceding 12 months, the Medical Staff member has not been the subject of Corrective Action or been required to undergo counseling, the Chief may mandate that the Medical Staff member seek counseling by an outside specialist chosen by the Chief. The cost of such counseling shall be borne by the Hospital. The Medical Staff member shall consent to the release of the specialist's findings and recommendations to the investigating Chief and to the QOC Committee, the MEC and the Professional Oversight Committee. The Chief shall provide a copy of the complaint and all related documentation to the QOC Committee, the MEC and the Professional Oversight Committee.

    If any of the members of the QOC Committee, the MEC or Professional Oversight Committee has a conflict of interest serving in such role due to a relationship with the Medical Staff member or with the complainant, the QOC or POC Chair shall appoint another person to the Committee in his/her place.

    The QOC or a delegated QOC subcommittee shall be responsible for monitoring compliance of the Medical Staff member with the mandated counseling, and for determining, based on the specialist's report, whether the counseling appears likely to have addressed the underlying problem. At any time, the QOC may recommend that Corrective Action or other formal disciplinary procedures be instituted against the Medical Staff member in accordance with these Bylaws if the Medical Staff member has not followed the recommendations of the specialist, or if the Committee determines that further action is warranted.

Level III

If the matter has reached a level of seriousness that exceeds the scope of this process, the Chief shall refer to and address the matter in accordance with the formal disciplinary action provisions set forth in these Bylaws.

III. CARE OF PATIENTS:

A. Admission/Emergency Department

1. All Medical Staff Members, except those prohibited by these Bylaws, may admit patients requiring inpatient or observation level care, however, all patients shall have an attending physician who has been credentialed and delineated in the appropriate department and, if applicable, division.

2. The Medical Staff Member shall furnish a provisional diagnosis for all patients admitted for inpatient treatment or rendered outpatient care.

3. Members of the Medical Staff admitting patients shall furnish such information as may be necessary to protect other patients from those who are a source of danger from any cause whatsoever, or to protect the patient from self-harm. The attending physician shall be responsible for obtaining from the patient, and documenting in the medical record, informed consent for procedures performed on the patient.

4. The Medical Staff may admit any patients for which the Hospital can provide appropriate services. Admission for the following is specifically excluded:

    a. Obstetrical patients for scheduled delivery, and

    b. Children under the age of fourteen (14) years.

5. Emergency Room Procedures

    a. All patients presenting at the Emergency Room, including patients in active labor, will be offered a medical screening examination and appropriate triage. A Medical Staff Member may transfer a patient to another health care facility only as long as the requirements of the Emergency Medical Treatment and Labor Act (EMTALA), as described in the EMTALA policy set forth in the Hospital Administrative Policy Manual, are met. Physicians must not consider the patient's ability to pay in any decision regarding screening, treatment, or transfer. Medical Staff Members must complete all EMTALA related paperwork prior to any transfer.

    b. Each attending physician on call to provide care to admitted patients shall name a member of the Medical Staff who may be called to attend patients in an emergency. In case of failure to name such associate, the Vice President, Chief Medical Officer, the President of the Medical Staff, the Department Chair, or President of the Hospital shall have authority to call any appropriate member of the Staff should he or she consider it necessary.

    c. Attending physicians shall respond to requests from Emergency Department physicians promptly. Referring providers shall notify Emergency Department physicians when a patient has been referred to the Emergency

Department and shall follow up with the Emergency Department promptly. The Emergency Department shall not be used by members of the Medical Staff as a private office during normal working hours.

d. All Medical Staff Members have the privilege of treating patients in the Emergency Department provided they function only within the scope of their departmental or divisional area and within the scope of their delineated privileges.

e. Medical Staff Members who have only Department of Emergency Medicine or Department of Pathology privileges may not admit patients to the Hospital.

B. Discharge

1. Patients will be discharged from the Hospital upon a written order, provided that a primary discharge diagnosis explaining the reason for admission by the physician responsible for the medical supervision and care of the patient has been entered on the Face Sheet. (Note: When laboratory or other data are not yet available on date of discharge, the working impression at discharge may be given, temporarily.)

2. If a patient has been admitted to and discharged from the Hospital in 24 hours or less, a combined admission history and physical examination and discharge summary may be dictated. The discharge slip shall specify the following:

    a. medication(s) ordered, specifying dose, frequency and route of administration;
    b. diet;
    c. special instructions;
    d. follow up appointment(s)

3. For any patient admitted for more than one calendar day, the attending physician or his/her designee shall dictate a discharge summary listing the following:

    a. discharge diagnosis
    b. hospital course
    c. pertinent laboratory evaluations and results
    d. surgical procedures
    e. medication(s) on discharge
    f. follow up process
    g. diet
    h. condition on discharge

    For routine cases, an attending physician may delegate the preparation of the discharge summary but for complex cases involving, for example, long lengths of stay or potential medico-legal questions, the attending shall complete the discharge summary.

C. Infection Control

1. If the Hospital Operations Coordinator (HOC) feels that an infection control measure should be initiated and has attempted to contact the attending physician, but no specific order can be obtained, he/she will contact the Infection Control Nurse who will contact the attending physician, and if necessary, the Chairman of the Infection Control Committee for appropriate orders.

2. If in the judgment of the Infection Control Nurse the patient must be isolated in order to protect the patient or others, the Infection Control Nurse may do so prior to conferring with the attending physician. This action should be reported to the attending physician and to the HOC.

D. Discontinuation of Services

1. An attending physician who later wishes to cease providing further care, shall, prior to stopping care, refer the patient to another qualified attending physician who is competent and willing to treat that patient and, who, in fact, accepts that patient in writing. The attending physician shall seek the Chief of his/her department's advice or intervention, as necessary, prior to stopping care for the patient.

2. Cessation of treatment prior to the patient's being accepted by another attending physician shall constitute abandonment of the patient.

3. It is the responsibility of the attending physician to extend coverage to his/her patients at all times, to inform the appropriate Hospital staff when that coverage is delegated to another physician, and to document any transfer through a written order which must be accepted by the receiving physician with a written order before the transfer can be effected.

E. Consultation

1. Only members of the Medical Staff who have submitted proper credentials and have been duly privileged for membership on the Medical Staff appropriate to the consultation may provide such consultations.

2. Consultation is appropriate in those cases in which:

   a. the patient is a poor risk for operation or treatment;
   b. the diagnosis is obscure; or
   c. there is doubt as to the best therapeutic measures to be utilized.

3. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant shall be determined by the Department Chair of the appropriate department on the basis of an individual's training, experience and competence.

4. A satisfactory consultation includes examination of the patient and review of the record. A report signed by the consultant must be included in the medical record. When operative procedures are involved, the consulting physician shall record a consultation note, except in emergency, prior to the operation and shall follow up with a note.

5. The attending physician is responsible for requesting consultations when indicated. It is the duty of the Department Chair and Medical Executive Committee to make certain that members of the Staff call for the appropriate consultations as needed.

6. A consultant who does not have privileges on the Staff must be requested by the attending physician and must be approved by the Department Chair. The attending physician should state in the patient's medical record that a consultant has been requested and his/her name, if possible. Such a consultant must be credentialed for temporary privileges, as appropriate,

by the Medical Staff and Hospital according to the procedures set out in the Credentialing/Peer Review section of these Bylaws.

F. Use of Physician Assistants, Nurse Practitioners, Nurse Anesthetists, and Nurse Midwives

1. In order for a physician to utilize Physician Assistants, Nurse Practitioners, Nurse Anesthetists, and Nurse Midwives in care of patients they have admitted, the physician must agree in writing to act as a supervising or collaborating physician, as required under state law.

2. The Physician Assistant, Nurse Practitioners, Nurse Anesthetists, and Nurse Midwives may write prescriptions for medications and other therapeutic needs as directed by the attending physician and in accordance with his or her individual departmental delineation of duties and applicable state regulations and/or statute.

G. Medical Screening Examinations and Qualified Medical Personnel (EMTALA)

1. A Medical Screening Examination, appropriate to a medical complaint and sufficient to determine the existence of an emergency condition, shall be conducted by Qualified Medical Personnel when any individual presents to the Hospital and requests, or has such a request made on his or her behalf, examination or treatment for what may be an emergency medical condition. All members of the Active Medical Staff shall be considered Qualified Medical Personnel for these purposes. In addition, each Department shall maintain a policy setting forth additional categories of health care professionals, if any, who shall be considered Qualified Medical Personnel and who may conduct Medical Screening Examinations on behalf of that Department, such as physician assistants, nurse practitioners, etc. Emergency Department Registered Nurses (R.N.s) who have been trained in triage of patients presenting to the Emergency Department may, in collaboration with a Member of the Medical Staff serving in the LifeBridge Health "tele-triage" program, be considered Qualified Medical Personnel for purposes of completing the Medical Screening Exam.

IV. MEDICAL RECORDS

A. Preparation of Medical Record

The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall be prepared in compliance with applicable state and federal law and regulations, including the regulations of CMS and the Standards of the Joint Commission. All providers are responsible for entries appropriate to their encounter with the patient, including consultation notes and progress notes where applicable.

B. Information to be Recorded

Medical Staff Members shall record the following information in the patient record:

1. chief complaint and reason for admission, admitting diagnosis, social history, medications, family history, history of present patient illness, past medical and surgical history, review of systems, allergies, and medication intolerances;

2. rectal and pelvic examinations are required when clinically relevant as defined by Department guidelines. Documentation of pap smear during past 12 months;

3. physical examination, which should include, where indicated, specific information on breast, pelvic and rectal exams as well as documentation of pap smear during the past 12 months;

4. planned investigations and intended treatment plan;

5. special reports such as consultations, clinical laboratory, x-ray, and others;

6. provisional impression;

7. medical or surgical treatment, operative reports, pathological findings, progress

8. notes;

9. final diagnosis, condition on discharge, dictated discharge summary, discharge instructions, follow up arrangements; and

10. autopsy when indicated.

C. History and Physical Examination

1. The medical history and physical examination must be completed and documented by The Medical Staff Member Podiatric surgeons must complete the podiatric history and physical examination with the non-podiatric portion of the history and physical examination to be completed by a physician, osteopathic physician, physician assistant or nurse practitioner.

   A complete and legible history and physical examination shall in all cases be completed within 24 hours after admission of the patient and shall be fully described by a written note or dictated within 24 hours. If dictated, a brief admission note should be written indicating that a complete history and physical has been dictated. This note shall contain sufficient information to allow for proper care of the patient. A history and physical examination completed up to 30 days prior to admission may be used provided:

   a. An update to the patient's condition is noted in the medical record by the Medical Staff Member at the time of admission or outpatient operative procedure. The update to the history & physical includes an examination of the patient, including any changes in the patient's condition.

   b. In the situation where the patient is going to surgery within the first 24 hours of admission, the update of the patient's condition and the pre-anesthesia assessment may be accomplished in a combined activity.

2. If a patient has been admitted to and discharged from the Hospital within 24 hours or less, a combined admission history and physical examination and discharge summary may be dictated and shall be dictated within 24 hours.

3. When such history and physical examinations are not recorded before the time stated for an operative procedure, the procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. Once the emergency has passed, the H&P must be completed

within 24 hours. If the H&P is dictated, an admission note with sufficient detail to permit staff to manage care of the patient shall be written in the record immediately post-op by the attending physician. This is in addition to the required written immediate post-op note by the operating surgeon or assistant.

D. Operative Notes

1. An operative note, to include names of primary surgeon and assistants, name of anesthetist, type of anesthesia, preoperative and postoperative diagnoses, procedure(s) performed, operative findings, specimens removed if any, estimated blood loss (as applicable) and complications if any shall be dictated within 24 hours for all operative cases requiring anesthesia except for those cases utilizing local anesthesia only. Dictation for cases involving no or local anesthesia is optional.

2. A brief written progress note must be recorded immediately postoperatively with the above elements included for all operative cases regardless of type of sedation.

E. Form of Entries

1. The physician must enter all appropriate information legibly and completely and must authenticate and (except as provided below re: verbal orders) date any information reflecting any services ordered, provided or evaluated by the physician. "Hold" orders for diagnostic tests will be considered cancellation orders and tests must be rescheduled to be performed. An order shall be considered to be in writing if dictated to a Medical Staff Member, Pharmacist, Physical Therapist, Respiratory Therapist or Nurse Anesthetist. The individual who recorded the order must sign, date, and time. All verbal/telephone orders must be signed within 30 days. This is a Center for Medicare & Medicaid Services (CMS) requirement. When such verbal/telephone orders are entered on paper (e.g. CPOE downtimes), the date and time of this authentication of such verbal/telephone orders must be recorded. Verbal orders should be limited to situations in which there is no practical alternative. The physician shall legibly enter progress notes, appropriately dated and timed, whenever he or she has seen a patient or has designated another individual to see the patient. Stamped or typed notes can be used in progress notes as long as they are appropriate to the patient's condition and countersigned by the physician.

2. The Attending Physician must ensure that the record contains information to justify admission and continued hospitalization to support the diagnosis and describe the patient's progress and response to medications and services.

3 When a "DNR" or "DNI" order is written, there must be documentation in the progress notes that the patient or a qualified representative has consented to this. Verbal "DNR" and "DNI" orders are not permitted.

F. Delinquent Medical Records

1. Incomplete Medical Records

   A. The medical record must be completed within thirty (30) days of the patient's discharge. An incomplete medical record is considered "delinquent."

   B. The notification process for incomplete medical records is initiated every 15 days. A letter will be sent by Medical Records to the Medical Staff Member

stating that he/she has charts to complete within fifteen days of receipt of the letter.

C. Thirty days after discharge, a “thirty-day letter” is sent from Medical Records notifying the physician that his/her name is being placed on the "Interruption of Privileges List." Medical Records shall notify the Vice President, Chief Medical Officer in writing of the non-complying physicians. The Vice President, Chief Medical Officer shall notify the non-complying Medical Staff Member, in writing, by certified mail, of his/her name being placed on the "Interruption of Privileges List" (IOP). At this point, the Medical Staff Member may no longer admit to the Hospital, post-surgery or procedures, care for outpatients or inpatients, cover for other Medical Staff Members or perform consultations.

D. A Medical Staff Member on the IOP list will be unable to perform any surgical case or other procedure other than one which was posted before he/she was placed on the IOP List. Care for the Medical Staff Member’s patients must be assigned to another Medical Staff Member as designated by the responsible Department Chair or the President of the Medical Staff.

E. If a Medical Staff Member is on the IOP list more than three times a year, there will be action taken at the time of reappointment. Members will be warned by their Chair at the end of the year that they may be moved to provisional status. If at the end of the second year (reappointment time) the member has shown no improvement, the Chair will institute remedial action at his/her discretion.

F. To be removed from the IOP List, the Medical Staff Member must complete not only his or her delinquent charts outstanding, but also all charts made available to him/her for which he/she is responsible for completion. When all delinquent charts are dictated and signed and all available non-delinquent charts are dictated, the Medical Staff member may be removed from the IOP list.

G. At sixty days, a non-complying Medical Staff Member will be sent a certified letter, return receipt requested, by the Vice President of Medical Affairs, stating that he/she has ten days from the receipt of the letter to complete all available charts. If the charts are not completed at the end of this time period, his/her privileges will be considered to have been voluntarily relinquished. The Medical Staff Member must reapply for Medical Staff privileges after a waiting period of three months and the completion of any delinquent records.

H. It is the responsibility of the non-complying Medical Staff Member to notify the Chair of the Department and the Director of Medical Records of any circumstances which would impair his/her ability to complete medical records on a timely basis.

I. The Division or Department Chair of the non-complying Medical Staff Member, the President of the Medical Staff or Vice President, Chief Medical Officer, or the current Medical Staff Officers may override the IOP List, or mandatory sanctions at his/her discretion, so long as all charts are completed within the ensuing 48 hours.

J. In the event a Medical Staff Member is no longer available to complete his/her medical record, Hospital Policy addressing Retirement of Incomplete Medical Records is to be followed.

2. Illegible Medical Records

A. In accordance with safe medical practice, it is the goal of Northwest Hospital Center and its Medical Staff, to ensure that all documentation in the medical record meets acceptable standards for legibility.

B. Documentation in the medical record will be reviewed on a regular basis by the Hospital in accordance with Joint Commission, CMS, and other regulatory policies. Reporting of compliance will be to the Multi-Disciplinary Performance Improvement/Risk Management Committee.

C. Providers identified as not meeting the standards will be referred to the Chief of their respective Department/Division.

D. With concurrence of the Chief, the provider will be counseled regarding their deficiency and will agree to an appropriate method of improvement.

E. Providers who do not demonstrate improvement by the next quarterly report will have their privileges interrupted until such time as they complete remediation as directed by the Chief of their Department/Division. In cases of legibility, this remediation will consist of a self-learning, handwriting enhancement program that must be completed prior to regaining privileges.

F. After remediation, providers will be monitored monthly for the following quarter.

G. Providers who fail to comply with remediation within thirty days will be considered to have voluntarily resigned their Medical Staff privileges.

G. Access to Records

Free access to all medical records of all patients shall be afforded to Medical Staff members in good standing for bona fide study and research as approved by the Hospital's Institutional Review Board, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the President of the Hospital, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital, provided the patient consents.

V. PRE-OP DIAGNOSTIC TESTING

The guidelines for pre-operative diagnostic testing are found in the Hospital Policy Manual and posted in the Departments of Surgery and Anesthesia. These values are guidelines only and may be modified as appropriate in specific clinical situations but in any case, only after consultation between the attending surgeon and a representative of the Department of Anesthesia. These guidelines shall not be required to be adhered to in the case of an emergency procedure. All Physicians practicing in the Hospital shall be deemed to have reviewed these guidelines and to have agreed to conform to them in order to perform any procedure in the Hospital.

Blood Bank Pre-Admission Testing

To allow that Blood Bank personnel have adequate opportunity to prepare and have available properly crossmatched blood products ordered preoperatively by OR operators, the following steps are to be followed:

1. Pre-Admission Testing personnel will ask all patients with ordered blood products requiring preliminary crossmatching to report to our Blood Bank between one and seven days before the day of scheduled surgery to provide a blood specimen.

2. Operators will be asked to, whenever possible, refrain from scheduling patients into OR slots before 9:00 am who cannot reasonably provide a specimen prior to the day of surgery.

3. Such patients as in #2 will be asked to report no later than 7:00 am on the day of surgery to provide the needed specimen.

4. Blood Bank personnel will monitor the frequency of surgeries scheduled before 9:00 am without an available specimen before the morning of surgery and report to the Administrative Director of the OR when difficulties are arising so as to allow for appropriate administrative action.

5. The above process is applicable to all blood products ordered requiring crossmatching, including autologous products.

VI. HOSPITAL DEATHS

A. Notification and Cause of Death

Medical Staff Member will notify the attending physician of his/her patient's death, who will, with the attending physician, determine what will be listed on the death certificate as the cause of death.

B. Autopsies

Every member of the Medical Staff will be encouraged to secure, if indicated, an autopsy on patients who expire in the Hospital. No autopsy shall be performed without proper written consent and the wishes of the patient’s family with respect to religious and moral beliefs shall be taken into consideration. All autopsies shall be performed by the Hospital pathologist or by a physician to whom his responsibility has been delegated. Guidelines for autopsies shall follow those of the American College of Pathology.

C. Organ Donations

Upon notification by Hospital personnel that organ donation may be appropriate, physicians will comply with the requirements of the Transplant Resource Center, as described in Hospital Policy.

VII. COMMITTEES

There shall be such committees of the Medical Staff as are established by the Medical Executive Committee. The Chairs of these committees are to be members of the Active Staff. Committee Chairs are appointed by the President of the Medical Staff and may be removed at his discretion.

A. Cancer Committee

The LifeBridge Cancer Committee shall be a network committee and will meet at least six times per year. Membership shall consist of but not limited to representatives of the medical staff from the disciplines of medical oncology, radiation oncology, surgery, diagnostic radiology, and pathology. Designated cancer liaison physicians will also be included in membership. In addition, representatives from the following areas will also be included:

1. Cancer Registry
2. Nursing
3. Outpatient Services
4. Administration
5. Social Services
6. Performance Improvement
7. Community Education
8. Pain Control/Palliative Care
9. Dietary
10. Hospice
11. Pharmacy
12. Clinical Research

The Cancer Committee collaborates with the administrative leadership, to develop, approve, and implement the plans, goals and objectives for the programs and provides oversight for ongoing programs and services.

Objectives:

1. Promote a coordinated multi-disciplinary approach to patient management at all levels.
2. Assure that consultative services in all disciplines are available and that education and tumor conference review activities cover all major cancer sites and issues of cancer care.
3. Initiate patient care audits and review similar data supplied by other Hospital committees.
4. Supervise the cancer registry and assure accurate, timely abstracting, staging, and reporting of data.
5. Assure regular attendance at cancer conference/tumor board by the proportion of the multidisciplinary team required for approval by the American College of Surgeons Commission on Cancer.
6. Evaluate patient care outcomes, financial outcomes, resource utilization, and other designated continuous quality improvements based on service and program goals.
7. Review results of treatment at the facility as part of outcomes assessments.
8. Recommend and support implementation of program enhancements and for new programs.
9. Promotes and evaluates community education efforts for program.

The Cancer Committee will approve and maintain a set of polices unique to the Cancer Committee. The policies will be reviewed at least on a bi-annual basis by the administrative team of the cancer program.

The Cancer Program Medical Director will report progress to the LifeBridge Board of Directors at least on an annual basis.

B. Credentials Committee

1. The Credentials Committee shall consist of five or more members of the Active Staff selected on a basis that shall insure representation of the major clinical specialties, the hospital based specialties and the Medical Staff at large. Any individual(s) in the same specialty or department as the applicant or appointee shall be precluded from voting. The Credentials Committee shall be appointed by the Chair of the Medical Executive Committee in conjunction with the Chair of the Credentials Committee. All such appointments are subject to approval by the Medical Executive Committee.

2. The Credentials Committee shall perform the following duties:

    a. Review, investigate and certify the credentials of all new applicants for membership in compliance with these Bylaws; in addition, to review, investigate and certify credentials of persons who reapply after resignation or leave of absence.

    b. Make report to the Medical Executive Committee on each applicant for Medical Staff membership and clinical privileges for initial appointment to the Medical Staff.

3. The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

C. Critical Care Committee

1. This committee shall consist of at least five members of the Active Medical Staff to include the Director of Critical Care. There shall, in addition, be a member of the House Staff assigned to this committee, an Administration representative and the Director of Nursing Services.

2. This committee shall perform the following duties:

    a. Review the policies and practices in the Critical Care Units (sections of Coronary and Intensive Care) and the Progressive Care Unit.

    b. Review the quality and appropriateness of care rendered by the Critical and Progressive Care Units through monitoring and evaluation as to resolved identified problems.

    c. Recommend policy changes to the Medical Executive Committee to accomplish the above.

3. This Committee shall meet at least bi-monthly.

D. Infection Control Committee

1. This Committee shall consist of appropriate medical staff representation. and at least one each from the Nursing Service, from Pathology Services, and from Hospital Management.

2. The Infection Control Committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities including:

   a. Operating Rooms, post anesthesia care unit, special care units;

   b. Sterilization procedures by heat, chemicals, or otherwise;

   c. Isolation procedures;

   d. Prevention of cross infection by anesthesia apparatus or inhalation therapy equipment;

   e. Disposal of infectious material; and

   f. Other situations as requested by the Medical Executive Committee.

3. This committee shall meet at least every two months, shall maintain a record of its proceedings and activities, and shall report to the Medical Executive Committee.

E. Continuing Medical Education Committee

1. This committee shall consist of at least five members of the Medical Staff.

2. This Committee shall perform the following duties:

   a. Oversee and advise toward the operation of the Hospital Library.

   b. Make recommendations to assist professionals in carrying out their professional responsibilities more effectively and efficiently. In this regard, it must assure that CME/CEU activities are relevant, effectively monitored and adequately supported.

3. This committee shall meet at least twice annually and is considered a sub-committee of the LifeBridge Health CME Committee.

F. Quality Oversight Committee

1. This committee shall consist of one representative from each clinical department of the Medical Staff. Representatives from no more than seven (7) Hospital departments are to be appointed by the President and have equal voting rights. The Board of Trustees Performance Improvement Chairman is an ex-officio without a vote.

2. This committee shall perform the following duties:

   a. Coordinate and integrate those appropriate activities of the subcommittees (Medical Staff and Hospital), and ad hoc committees (Medical Staff and Hospital), departments and services to whom it may delegate review and evaluation authority.

b. Analyze findings from all review and evaluation activities to ascertain whether additional patterns or problems surface when all relevant data is organized, and making recommendation concerning these.

c. Manage the flow of information to the appropriate "use" structures.

d. Oversee the evaluation of the Quality, Patient Safety and Performance Improvement program's effectiveness.

e. Suggest indicated modifications to the Quality and Patient Safety Plan.

f. Recommend approval of criteria, review methods (i.e. Occurrence Screening) conclusions of subcommittees or ad hoc committees.

g. Recommending approval of appointment of ad hoc committees to evaluate multidisciplinary problems.

h. Make recommendations to or seek explanations from the Executive Committees, department directors, managers, or chairmen, and other components of the staff responsible for "information use".

i. Perform investigations of professional review actions as set forth in Chapter I of this Part II.

3. This committee shall meet at least nine times annually and maintain a permanent record of its proceedings and actions. A quorum shall consist of nine members.

Note: Although this is a multidisciplinary (Medical Staff and Hospital) committee, professional review action recommendations involving medical care which are developed by the committee and the various peer review committees shall be submitted for approval to the Medical Executive Committee. (Professional review action recommendations involving other Hospital areas, which are developed by the committee and various other committees, are to be submitted for approval to Administration.) In some instances, however, the President of the Medical Staff or his designee and the appropriate Chief of Service, in consultation with the Quality Oversight Committee Chairman, may assign an individual or group the authority to take immediate professional review action as dictated by the situation.

4. This Committee reports directly to the Medical Executive Committee or, where the Chairman of the Medical Executive Committee decides that the Medical Staff affairs are not involved, to the President of the Hospital.

G. Perioperative Governance Committee

1. This committee shall consist of at least one (1) representative from each full surgical specialty department, one (1) representative from Department of Anesthesiology, one Surgical House Officer, one S.P.D. Representative, two (2) representatives from Department of Nursing, one (1) Surgical P.A., and one (1) from Administration. The committee shall meet at least six times per year.

2. This committee shall perform the following duties:

a. Study and evaluate problems involving the staffs of Anesthesia, Operating Room or post-anesthesia care unit (PACU).

b. To review and evaluate patient care issues brought to its attention.

c. Recommends appropriate professional review action or policy to the Medical Executive Committee.

H. LifeBridge Formulary Review Committee

1. This Committee shall consist of appropriate medical staff representation. and one (1) each from the Pharmaceutical Service, the Nursing Service, and from Hospital Management. The Director of Pharmacy shall be a member of and act as secretary for the committee. The Chairman of this committee shall appoint a non-affiliated lay person as an advisor without vote, when investigational devices are to be reviewed.

2. This committee shall perform the following duties:

a. be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.

b. assists in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.

c. It shall also perform the following specific functions:

1) Serve as an advisory group to the Hospital Medical Staff and the pharmacist on matters pertaining to the choice of available drugs; will examine all adverse drug reactions in an effort to identify their causes and take appropriate action to avoid any recurrence.

2) Will establish and monitor procedures for prescribing and dispensing and administering drugs. Will promote drug education to health professionals. Will facilitate drug therapy cost containment.

3) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

4) Develop and review periodically a formulary or drug list for use in the Hospital;

5) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

6) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

7) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and

8) Review and approve investigational device protocols in accordance with the requirements of the United States Food and Drug Administration (FDA).

3. Meetings

This committee shall meet at least every three (3) months and send quarterly reports to the Medical Executive Committee regarding its activities.

I. Radiation Safety Committee

1. This committee shall consist of the Chiefs of the Departments of Radiology and Pathology; representatives of the areas utilizing radiopharmaceuticals; at least one (1) representative each from Radiology and Pathology; the Radiology Administrative Coordinator; Radiation Health Safety Consultant and the Radiation Safety Officer.

2. This committee shall perform the following duties:

a. Review all film badge reports on an exception basis.
b. Annually review the polices and practices of Nuclear Medicine, Radiology and the Radioimmunoassay portion of the Laboratory (Pathology) section.
c. Review any changes to Maryland State Health Department License for the Possession and Use of Radioisotopes.
d. Monitor and evaluate the quality and appropriateness of patient care rendered and takes any appropriate action.

3. Meetings

This committee shall meet at least quarterly.

J. Utilization Management Committee

1. The Utilization Management (UM) Committee is comprised of at least two Physicians, and representatives of Finance, Care Management, and Administration. The Chairperson of the Committee is the Physician Advisor for Care Management. The UM Committee meets monthly, and as necessary.

2. The Utilization Management Committee will monitor trends and the ongoing utilization of resources by reviewing data and will recommend appropriate action plans. The Committee will also evaluate the criteria used to support utilization review decision-making. The Committee will maintain minutes of its activities.

3. The UM Committee will monitor and evaluate data including, but not limited to, the following measures:

a. ALOS
b. Readmissions
c. Denials
d. Avoidable Days
e. Appeal activity
f. Medical Necessity Issues
g. Status Issues

4. Rationale: CMS requires that all acute care facilities have a UM Committee with at least 2 physician representatives, and carries on the above functions and oversees the implementation of the hospital's UM Plan

5. Utilization Management activities are considered the work of a Medical Review Committee, as defined by the Annotated Code of MD Health, Occupations Article, Section 1-401, and will be reported to the Board through the Hospital's Multidisciplinary Performance Improvement Committee (QOC) and the Performance Improvement Committee (POC) of the Board.

K. Quorum

1. The presence of fifty percent of the Medical Staff Membership of the Committee eligible to vote at any regular or special meeting shall constitute a quorum for all actions, except for the Medical Executive Committee.

2. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

3. In the event that it is necessary for a Committee to act on a question without fifty (50%) percent of its members, the voting members may be presented with the question, in person, by phone, or by mail and their vote returned to the Chairman of the Committee.

4. Such a vote shall be binding so long as the question is voted on by a majority of the committee eligible to vote.

5. No medical staff committee vote shall be binding unless a majority of those voting are members of the Medical Staff except for the Quality Oversight Committee, where voting rights have been determined by the Board of Trustees.

VIII. DUES

The power to levy dues or assessments for any purpose shall reside with the Medical Staff Executive Committee. The annual Medical Staff dues may be changed by the recommendation of the MEC. Emeritus members of the Medical Staff will not be charged dues.

Failure to pay dues within thirty (30) days of billing date without acceptable excuse may cause suspension of Medical Staff privileges until such time as the dues are paid. Failure to pay dues after ninety (90) days, in the absence of a previously acceptable excuse shall be deemed voluntary resignation from the Medical Staff.