SINAI HOSPITAL OF BALTIMORE

MEDICAL STAFF BYLAWS

Table of Contents

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ARTICLE I – NAME, PURPOSE, POWERS, AND DISSOLUTION

1. Name

The organization has been incorporated under the name The Medical Staff of Sinai Hospital of Baltimore.

2. Purpose

The purposes of the Medical Staff are:

A. to assume overall responsibility for the quality of professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body

B. to provide health care and related services to residents of central Maryland and surrounding areas

C. to engage in undergraduate and graduate medical education

D. to stimulate and conduct medical research

E. to establish and maintain continuing medical education programs

F. to facilitate communication among the Medical Staff, the Board of Directors, and the Hospital

G. to perform peer review and make recommendations regarding the clinical privileges of Members; and

H. to engage in other activities related to the above purposes, but not for the pecuniary profit or financial gain of the Medical Staff or any of its members.

3. Powers

The Medical Staff is empowered to engage in all activities necessary to promote and carry out the purposes for which it is organized. Notwithstanding any other provision of these Bylaws, the Medical Staff will not carry on any other activities not permitted to be carried on by an organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, or any successor provision.

4. Dissolution

Upon the dissolution of the Medical Staff, after payment or making provision for payment of all the liabilities of the organization, all assets of the organization will be distributed to other organizations selected by a majority vote of the Members, on the condition that all such organizations must at that time qualify for exemption under the provisions of Section 501(c)(3) of the Code, or any successor provision.

ARTICLE II – DEFINITIONS

1. The following terms will have the meanings assigned to them in this Article, unless the context clearly indicates otherwise.

A. *Board of Directors or Board* – The Board of Directors of the Hospital or its committee to the extent the Board of Directors of the Hospital has delegated its authority to such committee.

B. *Chief* – The physician within a department who is responsible for the clinical and administrative directorship of the Department, including any subsidiary Divisions.

C. *Clinical Privileges* – Authority to provide specific medical, dental, podiatric, or other patient care services in the Hospital within the limits of the Member's appointment to the Medical Staff.

D. *Department* – One of the departments described in Article IX.

E. *Hospital* – Sinai Hospital of Baltimore, Inc.

F. *House Staff* – Graduates of approved medical, osteopathic, dental, or podiatric schools who participate in graduate medical education training programs at the Hospital.

G. *MEC* – The Medical Executive Committee.

H. *Member* – A health care practitioner who has been appointed pursuant to these Bylaws to the Active Staff, the Affiliate Staff, and the Emeritus Staff. Members of the Adjunct Staff will not be Members of the active Medical Staff.

ARTICLE III – MEMBERSHIP

1. General

Physicians, dentists, and podiatrists that meet the qualifications set forth in these Bylaws are eligible for membership on the Medical Staff. No person who is otherwise eligible will be denied Medical Staff membership on the basis of race, color, creed, religion, gender, disability, national origin, gender identity, sexual preference, or any other impermissible criterion.

2. Ethics

The Principles of Medical Ethics adopted by the American Medical Association, the Principles of Medical Ethics adopted by the American Osteopathic Association, the ethical standards adopted by the Council on Dental Education of the American Dental Association, the Code of Ethics of the American Podiatric Medical Association, the ethical standards adopted by other disciplines, wherever applicable, the ethical standards adopted by the various licensing boards of the State of Maryland, as applicable, and the Hospital Code of Ethics will govern the professional conduct of Members and others with clinical privileges.

3. Categories of the Medical Staff

The Medical Staff will be divided into the categories set forth below.

A. Active Staff

The Active Staff will consist of healthcare providers licensed to practice independently under Maryland law. Physicians, dentists, podiatrists are eligible for membership on the Active Medical Staff.

Members of the Active Staff:

1. may attend and admit patients to the Hospital

2. may vote, serve on committees, and hold office

3. during a calendar year, are expected to attend Medical Staff meetings and meetings of the Department and Division, if applicable, to which the Member is appointed; and

4. must pay dues until age 65.

B. Affiliate Staff

The Affiliate Medical Staff shall consist of licensed professionals who are Members of the Medical Staff who do not wish to provide direct care to patients in the Hospital or conduct any other clinical activity in the Hospital, but who wish to have ties to the Hospital and its Medical Staff. Affiliate Staff may attend Medical Staff and Department meetings, participate in continuing medical education functions, and may be granted electronic access to view laboratory and other diagnostic data relevant to their own patients for purposes of continuity of care. They shall not hold clinical privileges, including the ability to write orders or make entries in the medical record. Each Department may specify requirements for Affiliate Staff membership. Affiliate Staff may vote and serve on committees. Affiliate Medical Staff will be required to pay application fees and membership dues until age 65.

C. Emeritus Staff

The Emeritus Staff consists of those former members of the Active Staff who are retired or semi-retired or have moved out of state. Members of the Emeritus Staff –

1. may not attend or admit patients to the Hospital

2. may not write orders, perform procedures, or provide consultations

3. may not vote or hold an elected medical staff position

4. may serve as a member of committees and

5. need not pay dues.

For the purposes of these by-laws "semi-retired" refers to a member who no longer maintains the minimum amount of Malpractice insurance required.

4. Membership Criteria

A. No individual is automatically entitled to membership on the Medical Staff or to exercise particular clinical privileges in the Hospital for any reason, regardless of any license to practice medicine, dentistry, or podiatry in any state, membership in any professional organization, certification by any clinical examining board, or past or present clinical privileges or medical staff membership at another hospital or health care facility.

B. All Members of the Medical Staff must meet the following qualifications.

1. The practitioner must have graduated from:

a. a medical school accredited by the Liaison Committee on Medical Education of the American Medical Association; or

b. a foreign medical school and successfully completed the Federal Licensing Examination (FLEX) or United States Medical Licensing Examination (USMLE); or

c. an osteopathic college accredited by the American Osteopathic Association

d. a dental school accredited by the Council on Dental Education of the American Dental Association; or

e. a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

2. The practitioner must have satisfactorily completed postgraduate clinical training according to ACGME requirements for each specialty as determined by each Department and approved by the MEC, if applicable.

3. The practitioner must possess a current, appropriate professional license from the State of Maryland.

4. The practitioner will also be evaluated on the following factors:

a. relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided

b. adherence to the ethics of his/her profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and his/her professional

c. good reputation and character

d. ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable the practitioner to maintain professional relationships with patients, families and other members of health care teams

e. ability to safely and competently perform the clinical privileges requested; and

f. recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

5. The practitioner must also provide evidence: of the necessary background, training, experience, current competence, and ability to perform the privileges requested, as determined by each Department; of adherence to the ethics of the profession; of good reputation; and of ability to work with others well enough to assure that any patient treated in the Hospital will receive quality medical care.

6. Whenever the practitioner is unavailable to care for the practitioner's patients, the practitioner must have documented on-call coverage by another appropriate Active Member of the Medical Staff.

7. To ensure all providers are immune to all Vaccine Preventable Diseases following professional consensus recommendations as approved by majority vote of the MEC, at initial credentialing all providers will have evidence of immunity (this may be declined using an official OSHA declination form). To further ensure that all Providers have a known tuberculosis immunity status and are free from active disease, all providers must demonstrate the absence of active tuberculosis.

8. To ascertain that providers are not abusing illegal or legal substances, all providers will have a forensic drug panel. Providers may provide evidence if certain exceptions are required. Further determination of which vaccinations, immunity testing and drug testing are required as well as the schedule of when they are due shall be proposed by occupational health and confirmed by majority vote of the MEC.

5. Conditions of Appointment

A. Initial appointments and reappointments to the Medical Staff are made by the Board of Directors after recommendation by the Medical Staff in accordance with these Bylaws.

B. All applications for initial appointment and reappointment to the Medical Staff are evaluated considering the needs of the Hospital and the community and the Hospital's ability to accommodate the expectations of the applicant. Factors considered include but are not limited to: Departmental criteria; current and projected patient care; teaching and research needs; the ability to provide required support services and facilities; current and expected patient load; actual and planned allocations of physical, financial, and human resources to general and specialized clinical and support services; and long- and short-range development plans.

C. A complete description of the appointment and credentialing process as approved by the MEC and the Board of Directors, after providing the opportunity for the Medial Staff to provide input and maintained in the Credentialing Office is contained in the Credentialing Policies and Procedures Manual.

D. All practitioners must indicate in any application for appointment or reappointment the following: any previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration; any voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; any involvement in a professional liability action or arbitration; and any convictions, guilty pleas, or pleas of nolo contendre' with respect to a crime involving moral turpitude.

E. No appointment or reappointment application will be considered unless the following is received and verified by the Credentialing Office: (i) a current appropriate professional license; (ii) an acceptable certificate evidencing professional liability insurance coverage in at least the minimal amount and meeting such criteria as established by the Hospital for the current year; (ii i) Federal and State of Maryland authorization to dispense controlled substances (unless not required by the relevant Department or otherwise approved by the MEC); (iv) references evidencing the applicant's professional and ethical qualifications, current competence, and ability to perform the privileges requested; (v) a criminal background check and drug screening ((v) does not apply to reappointment); (vi) valid government issued photo identification card; and (vii) any other information reasonably requested.

F. Applications for appointment or reappointment will convey the applicant's consent to: (i) the release of information by past and present professional liability insurance carrier(s); (ii) the inspection by persons designated by the Hospital of records and documents pertinent to the applicant's licensure, training, experience, current competence, and ability to perform the privileges requested; (iii) appear for an interview; (iv) provide for continuous care and supervision of his/her patients; and (v) abide by the Medical Staff Bylaws and Rules and Regulations, the Hospital Code of Ethics, and current Hospital policies. The applicant agrees 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 an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery will trigger automatic suspension of the practitioner's clinical privileges and the practitioner will be deemed to have voluntarily relinquished his or her Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in these Medical Staff Bylaws.

G. Medical Staff Members and members of the Adjunct Staff must maintain a current, appropriate professional license and federal and State of Maryland authorization to dispense controlled substances at all times (unless such authorization is not required by the relevant Department, Staff Category, or otherwise approved by the MEC). Medical Staff Members and members of the Adjunct Staff shall meet CME requirements of the State of Maryland. Failure to comply with these requirements will result in an automatic suspension of clinical privileges.

H. Clinically active members of the Active and Affiliate Medical Staff and members of the Adjunct Staff must have 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 licenses or approved by the state of Maryland, or a self-insurance arrangement approved by the Board. The policy must not be a “wasting policy”. A wasting policy is one which the policy limits are reduced or “wasted” with defense-related expense and results in reduced limits available for indemnity payments. These limits shall be individual limits and shall not be shared with any other entity or provider. Applicants must submit either a current certificate of insurance or other document that verifies compliance with this requirement.

I. All practitioners with clinical privileges agree to promptly notify the Hospital of and provide complete information regarding the following: any action initiated by any state or federal regulatory or licensing agency or entity to restrict, modify, or suspend any privilege or license required to practice his/her profession; the voluntary or involuntary termination of medical staff membership or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; any malpractice suit or arbitration proceeding initiated against the practitioner; and any convictions, guilty pleas, or pleas of nolo contendre with respect to a crime involving moral turpitude.

J. Physicians, dentists, and podiatrists that are engaged or employed by the Hospital to provide patient care or administrative services must seek membership and clinical privileges through the same procedure applicable to other applicants.

K. If a physician who performs services for the Hospital pursuant to a contract between the Hospital and an outside group has his/her employment terminated by that outside group, and the contract between the Hospital and the outside group states that the physician’s privileges at the Hospital will automatically terminate upon the group’s termination of physician, that physician’s Medical Staff membership and clinical privileges will immediately terminate without any due process procedures provided for other Members of the Medical Staff.

L. Except as provided in K immediately above and Section 3.B of this Article, no Member whose engagement by the Hospital requires membership on the Medical Staff will have his/her Medical Staff membership or clinical privileges terminated without the same due process procedure provided for any other Member of the Medical Staff, unless otherwise stated in the contract with the Hospital.

6. Procedure for Appointment

A. The Credentialing Office will send an application packet, the applicable documents for initial appointment via access to the online application portal to each individual requesting privileges. It is the responsibility of the applicant to ensure timely submission of all required documentation in support of the application. A candidate who fails to return a completed application within 60 days will be deemed to have voluntarily withdrawn the request for appointment.

B. All applications for appointment to the Medical Staff or Adjunct Staff will be completed on the prescribed form or electronically via the online application portal and signed by the applicant.

C. The Credentialing Office will collect, primary source verified by review, and document, to the extent reasonably possible, all information received about the applicant. Licensure shall be verified by the appropriate State licensure website or via the telephone, if verification is documented. Licensure shall be verified at initial appointment, reappointment, the granting or renewal of clinical privileges, at expiration, and as needed during an appointment cycle. Full details The Credentialing Process for initial appointment and reappointment may be found in the LifeBridge Credentialing Procedures Manual.

D. In addition, the Credentialing Office will query and verify necessary credentials with the following agencies: the American Medical Association (AMA) Profile Service, National Practitioner Data Bank, Office of the Inspector General (OIG) via Medicare/Medicaid sanction subscription service, online Maryland Medicaid listings, current and prior hospital affiliations, all active and inactive professional licenses, certification, malpractice history, peer references, and other relevant entities for information pertaining to the applicant, his/her practice at other health care entities, and other relevant information regarding his/her past performance.

E. After verification of an applicant's information, the Credentialing Office will forward the application to the appropriate Department Chief.

F. Upon receipt of a complete and verified application, the Chief may interview the applicant as soon as possible. Following the interview, the Chief will prepare a written appraisal and recommendation regarding the applicant and the clinical privileges being sought. The Chief's recommendation will be based on the professional criteria developed by the Medical Staff and the Departmental criteria developed by the Chief and the Departmental Committee.

G. The Chief's and Division Director's or AVP for Advanced Practice Provider’s (if applicable) appraisal and recommendation, together with the completed file, will then be forwarded to the Staff Privileges and Credentials Committee for consideration at its next meeting. The Staff Privileges and Credentials Committee will determine if the applicant meets the criteria for membership on the Medical Staff and the delineated privileges being sought and will review the applicant's qualifications in light of the needs of the Department for which the applicant is being considered. Should the Staff Privileges and Credentials Committee disagree with the recommendation of the Chief, the Committee will attempt to resolve the disagreement with the Chief. If unable to resolve the disagreement, the Committee will note the disagreement in its report to the MEC.

H. After determining that an applicant is otherwise qualified for appointment and privileges, the Staff Privileges and Credentials Committee shall review the applicant's requested privileges to determine the applicant’s ability to perform the privileges requested and the responsibilities of appointment. If there are questions about the applicant’s ability, the committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Committee and paid for by the Hospital. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within 90 days after being requested to do so by the Staff Privileges and Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

I. The Staff Privileges and Credentials Committee will make a recommendation to the MEC, which will in turn make a recommendation to the Board of Directors.

J. Except where questions or issues regarding the application arise, completed applications for appointment, reappointment, or revised clinical privileges will be acted upon by the Board of Directors and communicated to the applicant within 120 days. An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required will be deemed to be withdrawn. The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

K. Credentialing Office will collect initial and any reappointment dues for the Medical Staff membership which is required for completion for their application packet for privileges.

7. Initial Appointments

A. New appointments to the Medical Staff will be reviewed for a period not to exceed three years. The term of initial appointment may be shortened to allow for the orderly processing of reappointment applications or for other reasons.

B. Each Department will develop specific guidelines for the focused professional practice evaluation of Members' clinical competence and participation in hospital and departmental activities. These guidelines will be consistent with the general guidelines of the MEC and these Bylaws and may include, among other things, chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other physicians and Hospital employees.

C. At the end of the first year of appointment, a written evaluation of the Member's performance and a recommendation regarding continued appointment (FPPE) will be completed by the Member's Chief, with input from the Departmental Committee, and forwarded to the Staff Privileges and Credentials Committee.

D. If at the end of the first year of appointment, the Member has not had sufficient activity at the Hospital, as determined by the Departmental criteria, for the Chief to make a recommendation, the Chief may, in his/her sole discretion, (i) extend the Member's status for an additional twelve months, or (ii) request an evaluation from the provider’s primary hospital to support continued appointment at Sinai Hospital of Baltimore. The Chief may indicate continued low activity may result in reduction of privileges at reappointment.

8. Reappointment

A. Each Member will be sent via mail, email or electronic link to the online application portal a "Request for Reappointment to the Medical Staff" application by the Credentialing Office at least six months prior to expiration of the Member's current term. The applicant for reappointment must submit any evidence of inability to perform the privileges reasonably requested by the Staff Privileges and Credentials Committee or MEC. The applicant is responsible for submitting all requested information to the Credentialing Office within six weeks of receiving the reappointment package.

B. A Member who is not reappointed will cease to be a Member upon expiration of the Member's then current appointment.

C. Reappointments are for a period not to exceed three years.

D. All Members seeking reappointment and the renewal of clinical privileges shall satisfy the Medical Staff professional criteria and the Departmental criteria, and the factors listed in Article III, Section 4(B). The following factors shall also be considered:

1. the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-

specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);

2. any focused professional practice evaluations

3. verified complaints received from patients and/or staff; and

4. other reasonable indicators of continuing qualifications.

E. Upon receipt of the completed reappointment application, the Credentialing Office will obtain and verify the information contained on the application, as necessary, and obtain evidence of the Member's professional performance, judgment, and clinical or technical skills. The Credentialing Office will query the Maryland Board of Physicians, the National Practitioner Data Bank, Office of the Inspector General (OIG), board certification, current malpractice insurance carrier(s), and any other relevant entities concerning information pertaining to the Member, his/her practice at other health care facilities, and any other information that they might have regarding his/her past performance or ability to perform.

F. The Credentialing Office will forward the reappointment form and attachments to the appropriate Chief and Division Director or AVP for Advanced Providers (if applicable) for review and recommendation. The Chief's (and Director's or Chief Nursing Officer's, if applicable) written recommendation will be forwarded to the Staff Privileges and Credentials Committee. The Chief's and Division Director or AVP for Advanced Providers (if applicable) recommendation will be based on the Member's current competence as indicated by peer recommendations, the professional criteria developed by the Medical Staff and the Departmental criteria, procedures performed by the Member and their outcomes, the results of reviews of operative and other procedures, and performance improvement activities, including, but not limited to, efficiency of clinical practice patterns and departures from established patterns of clinical practice. Relevant practitioner-specific information from organization performance improvement activities will be considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. Should a Chief fail to recommend the reappointment of any Member, he/she will include a specific statement to that effect.

G. The Staff Privileges and Credentials Committee will make a recommendation to the MEC, which will in turn make a recommendation to the Board of Directors.

H. Each recommendation concerning the reappointment of a Medical Staff Member and the delineated clinical privileges to be granted upon reappointment will be based upon the Member's current professional performance and clinical judgment in the treatment of patients, as determined by patient care evaluation studies and other monitoring and performance improvement activities of the Medical Staff. The factors to be evaluated include: (i) technical skill and health factors that could affect performance; (ii) ethics and conduct; (iii) participation in Medical Staff affairs; (iv) compliance with Hospital policies, Medical Staff Bylaws and Rules and Regulations, and Departmental policies and rules and regulations; (v) participation in continuing medical education programs; (vi) malpractice experience; and (vii) other sanctions, if applicable. Malpractice experience will include whether or not the practitioner has maintained continuous malpractice coverage since his/her initial appointment or most recent reappointment.

9. Delegated Approval Process

A. To expedite appointment, reappointment, or renewal or modification of clinical privileges, the Board may delegate the authority to render appointment and reappointment and renewal or modification of privileges decisions to a Board committee of at least two voting members of the Board, in accordance with the Hospital bylaws. A positive decision by the committee results in the status or privileges requested. If the committee's decision is averse to an applicant, the matter will be referred back to the MEC for further evaluation.

B. Applications are not eligible for this expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred:

1. The applicant submits an incomplete application
2. The MEC makes a final recommendation that is adverse or with limitation
3. There is a current challenge or a previously successful challenge to licensure or registration
4. The applicant has received an involuntary termination of medical staff membership at another organization
5. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges
6. The chief of service in conjunction with the credentialing committee 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.

10. Delineated Clinical Privileges

A. A practitioner appointed to the Medical Staff, or the Adjunct Staff may only practice within the delineated clinical privileges recommended by the Medical Staff and approved by the Board of Directors in accordance with these Bylaws.

B. The clinical privileges of a practitioner will be based on the practitioner's current licensure, relevant training and experience, current competence, ability to perform the privileges requested, ability to satisfy the criteria developed by the Medical Staff and Department, and

1. medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team, and peer evaluations relating to these criteria
2. information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable
3. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration
4. practitioner-specific data as compared to aggregate data, when available; and
5. morbidity and mortality data, when available.

C. Each application for appointment and reappointment to the Active Medical Staff or Adjunct Staff must be accompanied by a request for specific clinical privileges. The clinical privileges delineation will be an integral part of the application for appointment or reappointment.

D. Requests for any addition, reduction or revision to a member's delineated clinical privileges that are not made during the reappointment process will be made in writing and submitted to the Credentialing Office. Upon receipt of a request for revision of delineated clinical privileges, queries shall be made to the National Practitioner Data Bank, Office of Inspector General and current State licensing body. The Credentialing Office will then forward the request to the appropriate Chief (and Division Director, if applicable) for consideration and recommendation. The Chief's (and Division Director's, if applicable) recommendation will be based on the professional criteria developed by the Medical Staff and the Department, including the effect of any reductions in privileges on the Hospital's ability to comply with the on-call requirements of the Emergency Medical Treatment and Active Labor Act. Relevant practitioner-specific information from organization performance improvement activities will be considered and compared to aggregate information when these measurements are appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. The recommendation of the Chief (and Division Director, if applicable) will be forwarded to the Staff Privileges and Credentials Committee which will make a recommendation to the MEC, which will in turn make a recommendation to the Board of Directors.

11. Time-Limited and Specialized Privileges

For the purposes of this Section 11, the Chief will be the designee of the President of the Medical Staff.

A. Special Patient/Procedure-Specific Privileges.

1. Upon the recommendation of the President of the Medical Staff or his/her designee, the President of the Hospital or his/her designee may grant Special Patient and/or Procedure-Specific Privileges to a practitioner who is not a Member for the care of a specific patient during a specific hospitalization and/or for a specific procedure or procedures. Special Patient and/or Procedure-Specific Privileges shall be limited in duration and shall continue only so long as is necessary to provide appropriate care, including follow-up care, to a specific patient during a specific hospitalization and/or for a specific procedure or procedures. In any case, such privileges shall not exceed 45 days.

2. A written request for Special Patient / Procedure-Specific Privileges will be submitted on the prescribed form by the requestor to the Credentialing Office and will include: the practitioner's name; an explanation of the need for the privileges and the qualifications of the practitioner; evidence of the practitioner's demonstrated current competence relating to the specific privileges sought; the date(s) for which the Patient or Procedure Specific Privileges are requested; the practitioner's professional liability insurance carrier, the amounts of coverage, and the policy expiration date; and the practitioner's Maryland license number and expiration date, birth date, and social security number. At a minimum, primary source verification of the practitioner's State licensure, National Practitioner Data Bank, Office of the Inspector General query, demonstrated current competence, and current malpractice insurance data will be verified by the Credentialing Office.

3. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and the Hospital.

B. Temporary Privileges for New Applicants.

1. Upon the recommendation of the President of the Medical Staff or his/her designee, a new applicant for Medical Staff membership may be granted temporary privileges by the President of the Hospital or his/her designee for a period not to exceed 120 days if the application is complete and the following information has been verified:

a. current licensure in the State of Maryland

b. relevant training or experience via verified medical degree and graduate medical education

c. proof of current competence and ability to exercise the privileges requested via evaluation from most recent Department Chief, Program Director or direct supervisor

d. results of National Practitioner Data Bank and OIG queries

e. criminal background check

f. completed and approved privilege form in appropriate specialty; and

g. verification of board certification (if applicable).

2. To be eligible for temporary privileges, the applicant must demonstrate that there are no current or previously successful challenges to his or her licensure or registration in any state and that he or she has not been subject to involuntary termination of medical staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

3. A final decision regarding the application of a practitioner granted temporary privileges will be made by the Board of Directors at its next regular meeting following completion of the review process. Temporary privileges will terminate automatically in the event the application is denied by the Board of Directors.

C. Supervision

A Chief may impose special supervision and reporting requirements for any practitioner granted time-limited privileges in that Department.

D. Emergency Privileges

In case of an emergency, any Member of the Medical Staff or a properly supervised member of the House Staff, to the degree permitted by his/her license and regardless of Department or staff status or lack thereof, will be permitted and assisted to do everything possible to save the life of a patient or to prevent the patient from suffering serious harm, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Member must request the privileges necessary to continue to treat the patient. If such privileges are denied or if the practitioner does not want to request them, the patient will be assigned to an appropriate Member of the Medical Staff. For the purpose of this section, an "emergency" is defined as any condition in which serious permanent harm or aggravation of injury or disease could result to a patient or in which the life of a patient is in immediate danger and any delay in treatment would add to that danger.

E. Disaster Privileges

1. In the event of a disaster when the emergency management plan has been activated, and the Hospital is unable to meet immediate patient needs, the President of the Hospital or the President of the Medical Staff is authorized to grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state.

2. Prior to granting disaster privileges, the Hospital will obtain for each practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:

a. verification of the volunteer's identity by a current member of the Medical Staff or Hospital employee who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster

b. current license to practice

c. primary source verification of the license

d. current photo identification from another hospital that clearly identifies professional designation

e. identification indicating the individual is a member of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals program, or other recognized state or federal organization or group

f. identification indicating the individual has been granted authority by a federal, state or municipal entity to render patient care services in a disaster.

3. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

4. 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. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and the Hospital.

6. Notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster, current members of the Medical Staff, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health.

7. Telemedicine Privileges

F. Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate department chairperson(s), the Staff Privileges and Credentials Committee and the Medical Executive Committee.

1. Individuals providing telemedicine services will be credentialed and privileged in accordance with the Medical Staff criteria.

12. Leave of Absence

A. A request for a leave of absence must be made in writing to the Chief of the Department to which the Member is appointed. The leave must be approved by the Chief and the MEC. The Member must complete all medical records prior to approval of the leave.

B. While on a leave of absence, a member is excused from the duties assigned to him/her by virtue of appointment to the Medical Staff, including the obligation to pay dues. In addition, a member on a leave of absence is not permitted to vote, attend and/or admit patients to the Hospital, or provide consultations.

C. A leave of absence may be granted for no more than two years. Reinstatement after a leave of absence without the requirement to reapply is subject to the approval of the appropriate Chief. Notwithstanding the foregoing, any Member who has been granted a leave of absence in order to serve on active duty in the military service and who is eligible for reappointment will be reappointed and granted a leave of absence for each year he/she continues to serve on active duty.

D. If at the end of a leave of absence, the Member does not wish to resume active membership, the Member shall submit a letter of resignation to the Credentialing Office.

13. Termination of Temporary Privileges

The President of the Hospital may terminate a practitioner's time-limited and/or specialized privileges, without right of appeal, at any time or effective as of the discharge from the Hospital of the practitioner's patient. If, however, it is determined that continued treatment by the practitioner would endanger patients, the termination may be imposed by the appropriate Chief, and the termination will be effective immediately. The appropriate Chief or his/her designee will assign a Member of the Medical Staff to assume responsibility for the care of the terminated practitioner's patients.

ARTICLE IV – ADJUNCT STAFF

1. Qualified advanced practice providers may become members of the Adjunct Staff. Special qualifications for becoming a member of the Adjunct Staff may be established by the MEC. Clinical privileges granted to members of the Adjunct Staff will be specifically delineated and granted in the same manner as clinical privileges for Members of the Medical Staff and as provided for in these Bylaws. Members of the Adjunct Staff will be assigned to specific Departments and supervised, if so required, by the Chief or his/her designee.

2. Members of the Adjunct Staff may include, as determined by the MEC, the following advanced practice providers:

A. Nurse Practitioners

B. Nurse Midwives

C. Clinical Psychologists

D. Physician Assistants

E. Nurse Anesthetists

F. Radiology Assistant

G. other licensed independent practitioners.

3. Members of the Adjunct Staff may engage in acts only within the scope of their practice and their delineated clinical privileges. Members of the Adjunct Staff

A. may not attend; may admit patients as determined by the relevant Department in its Departmental criteria

B. may not vote at general Medical Staff meetings

C. May hold the elected position of Adjunct Staff Representative to the Medical Staff, but not hold any other elected positions of the Medical Staff office.

D. Must pay dues as set by the Medical Staff.

E. Individuals on the Adjunct staff are credentialed by the same medical staff standards and processes at initial and reappointment.

4. The Adjunct Affiliate Medical Staff shall consist of advanced practice providers who do not wish to provide direct care to patients in the Hospital or conduct any other clinical activity in the Hospital, but who wish to have ties to the Hospital and its Medical Staff. Qualified Advanced Practice Providers may become members of the Adjunct Affiliate Staff. Special qualifications for becoming a member of the Adjunct Affiliate Staff may be established by the MEC. Clinical privileges granted to members of the Adjunct Affiliated Staff will be specifically delineated and granted in the same manner as clinical privileges for Members of the Medical Staff and as provided for in these Bylaws. Members of the Adjunct Affiliate Staff will be assigned to specific Departments and supervised, if so required, by the Chief or his/her designee. Adjunct Affiliate Staff may attend Medical Staff and Department meetings, participate in continuing medical education functions and may be granted electronic access to laboratory and other diagnostic data relevant to their own patients for purposes of continuity of care. They shall not hold clinical privileges, including the ability to write orders or make entries in the medical record. Each Department may specify requirements and privileges for Adjunct Affiliate Staff membership. Adjunct Affiliate Staff may not vote though may serve on committees.

ARTICLE V – OFFICERS

1. Officers

There will be a President, a Vice-President, a Secretary and Treasurer of the Medical Staff. Only members of the Active Staff will be eligible for election or appointment to these offices. There will also be an Adjunct Staff Representative who will serve on the board of directors. Only members of the Adjunct staff will be eligible for election or appointment to this office. With respect to the functions conferred by law upon the board of directors of a corporation, the four (4) officers will constitute the board of directors of the organization.

A. Duties of Officers

1. <u>President</u>

The President will call meetings of the Medical Staff, will preside at all such meetings, will appoint members of all committees of the Medical Staff unless otherwise provided by these Bylaws and will be an ex-officio voting member of all committees and

subcommittees of the Medical Staff. The President of the Medical Staff will receive a stipend, to be determined by the Budget and Finance Committee of the Medical Staff, subject to approval at the annual meeting.

2. Vice President

The Vice-President will, in the absence or incapacity of the President, or if the office of President becomes vacant, assume all duties of the President.

3. Secretary

The Secretary will keep minutes of all meetings of the Medical Staff, attend to all correspondence, maintain a list of Members, preside at all meetings of the Medical Staff in the absence of the President and the Vice-President, and be responsible for all other duties pertaining to that office.

4. Treasurer

The Treasurer will collect and disburse all dues, assessments, and monies, and will prepare and present financial reports at least annually. In the event of the death, incapacity, or resignation of the Treasurer, the President will appoint a Treasurer to serve until the next annual meetings.

5. Adjunct Staff Representative

The Adjunct Staff Representative will serve as a liaison to for the Sinai Hospital Adjunct staff to the Medical Staff Board, Leadership Council, and the Medical Executive Committee.

6. If there is limited interest from the Active Medical Staff or, if there is a vacancy in one of the positions, the Secretary and Treasurer positions may be combined as the Secretary-Treasurer. The Secretary-Treasurer will be responsible for the roles of the Secretary and Treasurer.

2. Nominations

A. The Leadership Council will nominate one candidate for President, Vice President. Secretary, and Treasurer, one Adjunct Staff Representative, and will deliver a list of its candidates to the Secretary at least forty calendar days before the annual meeting. The Secretary will send a list of the Leadership Council's candidates to all voting Members at least thirty calendar days before the annual meeting.

B. Nominations in addition to those made by the Leadership Council may be made if (i) written and signed by at least ten voting Members (adjunct members for the Adjunct Staff Representative), and (ii) delivered to the Secretary at least twenty calendar days prior to the annual meeting. The Secretary will send a list of these candidates, and the names of the Members making each nomination, to all voting Members (adjunct members for the Adjunct Staff Representative) at least ten days before the annual meeting.

3. Elections

A. Annual Elections

An election will be held for each elective office at the annual meeting. When more than one candidate has been nominated for an office, voting will be by secret written or electronic ballot, and will be tabulated by at least two voting Members appointed by the President. The candidate for each office who receives the most votes will be elected. Only active members will vote for the President, Vice President, Secretary and Treasurer. Only adjunct members will vote for the Adjunct Staff Representative.

B. Special Elections

In the event both the office of President and the office of Vice-President become vacant, or the office of the Vice-President becomes vacant, the Secretary will call a special meeting of the

Medical Staff for the purpose of electing a President and/or a Vice-President, as appropriate, to serve until the next annual meeting. Nominations may be received from the floor. When more than one candidate is running for office, voting will be by secret written ballot, and will be tabulated by at least two voting Members appointed by the Secretary. The candidate who receives the most votes will be elected. In the event the office of the Adjunct Staff Representative becomes vacant, the President of the Medical Staff may appoint an adjunct member to the position to complete the term.

4. Removal of Officer or MEC Member

A. On petition of ten voting Members of the Medical Staff, a request may be made for removal of an officer or a member of the MEC. Grounds for removal from office or membership of the MEC on petition of the Medical Staff include, but are not limited to,

1. failure to perform the duties of the office or the position in an appropriate manner

2. failure to comply with applicable policies, Bylaws, or Rules and Regulations

3. conduct detrimental to the interests of the Hospital and/or its Medical Staff

4. an infirmity that renders the individual incapable of fulfilling the duties of that office or position.

B. A ballot for approval or disapproval of this petition will be sent to all voting Members of the Medical Staff within one week of receipt of such petition by the Chair of the MEC. Ballots must be returned within ten days. Two-thirds approval of those counted votes will be required for removal. Failure to maintain Active Staff membership will result in automatic removal from office.

5. Terms of Office

An elected officer will hold his/her office for two years. No elected officer may hold the same office for more than one consecutive term. They may be eligible after the gap of one term.

ARTICLE VI – MEDICAL STAFF COMMITTEES

1. General

Standing Committees of the Medical Staff shall include the MEC, its subcommittees, and the other committees described in this Article. The President of the Medical Staff may appoint such Special Committees as he/she may deem necessary. The President of the Medical Staff will appoint the Chair of all Medical Staff committees with the exception of the MEC and its subcommittees. The President of the Medical Staff will report on the activities of the Medical Staff Committees to the Medical Staff at its regular meetings. The MEC may, by vote, create, eliminate, or rename any MEC committee or change its functions, meeting schedule, or reporting obligations.

2. Budget and Finance Committee

The committee will consist of the immediate past President of the Medical Staff, the Secretary of the Medical Staff, the Treasurer of the Medical Staff, and at least two additional Active Staff Members appointed by the President of the Medical Staff. Its duties will include review of the budgets, expenditures, and accounting procedures of the various programs, projects, or functions sponsored and funded, in whole or in part, by the Medical Staff. The committee will review the Treasurer's report on the financial affairs of the Medical Staff. On or after January 1st of each year, the committee may reallocate any unexpended funds from the preceding year. This committee will meet at least semiannually and submit its written minutes to the President of the Medical Staff. Both the President of the Medical Staff and the Treasurer or the Medical Staff may act as signatories

3. Bylaws Committee

This committee will consist of the Chair of the MEC or his/her designee, the President of the Hospital or his/her designee, and seven or more members of the Active Staff appointed by the President of the Medical Staff. The committee will act upon all proposed amendments to these Bylaws and Rules and

Regulations, in accordance with these Bylaws. This committee will meet at least semiannually and submit its written minutes to the President of the Medical Staff.

4. Memorial Committee

This committee will consist of at least two Members, one of whom will be the President of the Medical Staff. It will establish and implement a uniform memorial procedure for deceased Members. At the annual meeting, the committee will report all deaths of Members during the preceding year. This committee will meet as needed and submit its written minutes to the President of the Medical Staff.

5. Leadership Council

This committee will consist of the President of the Medical Staff, the Vice-President of the Medical Staff, the Secretary and Treasurer of the Medical Staff, the Chair of the MEC, the immediate past President of the Medical Staff, the immediate past Chair of the MEC, at least two Department Chiefs, all Physician members of the Hospital Board (who are Active Staff), the Adjunct Staff Representative, and one other at-large member appointed by the President of the Medical Staff.

This committee will advise the present Medical Staff leadership on all issues pertaining to the Medical Staff. The committee will meet as needed, at least annually.

This committee will make nominations in accordance with these Medical Staff Bylaws and will submit its nominees to the Secretary.

ARTICLE VII – MEDICAL EXECUTIVE COMMITTEE

1. Duties

A. The MEC is responsible for making Medical Staff recommendations directly to the Board of Directors for its approval. Such recommendations will pertain to at least the following:

1. The structure of the Medical Staff; however, final decisions regarding the structure will be made by the Medical Staff through its approval of the Bylaws

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

3. The Medical Staff professional criteria for membership and clinical privileges

4. Individuals for Medical Staff membership

5. Delineated clinical privileges for each eligible individual

6. The participation of the Medical Staff in organizational performance improvement and patient safety activities

7. Measurement and assess appropriateness of medical care and patient safety

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

9. The mechanism for fair hearing procedures.

B. The MEC will act for and on behalf of the Medical Staff during intervals between Medical Staff meetings, within the scope of its responsibilities as defined by the Medical Staff.

C. The MEC will receive and act on reports and recommendations from Medical Staff committees, the MEC subcommittees, clinical Departments, and assigned activity groups.

D. The MEC will document its actions and activities and submit minutes and recommendations to the Staff Privileges and Credentialing Committee and the Performance Oversight Committee. Members of the Medical Staff will be informed of MEC actions and activities by the Chiefs and at meetings of the Department.

E. Unless otherwise specified by the Board of Directors, the Chair of the MEC, the President of the Medical Staff, the Chair of the Credentials Committee, and other designees will represent the Medical Staff on the Performance Oversight Committee.

F. The MEC will request evaluations of practitioners privileged through the medical staff process where there is doubt about an applicant's ability to perform the privileges requested.

2. Composition

A. Members

The majority of the voting members of the MEC will be licensed physicians who are members of the Active Staff. The following individuals will be voting members:

1. The Chief of each Department, or the Acting Chief in the event of a vacancy in a Chief position, or, if no Acting Chief has been appointed, an attending physician or dentist from the Department, as appointed by the MEC.
2. Director of the Cancer Institute.
3. Representatives from the Active Staff who are elected by the Medical Staff. The number of elected representatives will be equal to two less than the number of Chiefs (or Acting Chiefs) and Cancer Institute Director on the MEC, as provided for in this section. At least one of the MEC elected representatives should have performed clinical work at least once at Grace Medical Center in the previous 12 months.
4. The President of the Medical Staff
5. The Vice-President of the Medical Staff
6. The immediate past President of the Medical Staff
7. The immediate past Chair of the MEC.

B. Nonvoting Members

The following individuals will be nonvoting members of the MEC:

1. The President of the Hospital or his/her designee
2. At least one representative from the Hospital selected by the President of the Hospital
3. VP Quality
4. The Chief Medical Information Officer
5. The Chief Clinical Officer – Physician
6. The Chief Nursing Officer, and
7. The Chair of the Staff Privileges and Credentials Committee.
8. The Chief Medical Officer of Sinai Hospital and Grace Medical Center
9. The Vice President Graduate Medical Education
10. The Chief Diversity Officer
11. The Adjunct Staff Representative

C. Election of Medical Staff Representatives

Members of the Active Staff are qualified to serve as an elected representative to the MEC, regardless of their specialty or professional discipline.

1. Term: Elected representatives will serve for a one 3-year term.

2. Nominations

The Leadership Council will deliver a list of candidates for elected representatives to the Secretary at least forty calendar days before the annual meeting. The Secretary will send a list of these candidates to all voting members at least thirty calendar days before the annual meeting. Nominations in addition to those made by the Leadership Council may

be made if (i) in writing and signed by at least ten Members eligible to vote, and (ii) delivered to the Secretary at least twenty calendar days before the annual meeting.

3. Elections

The Secretary will send a ballot containing the names of all candidates for elected representative to all voting Members via email or regular mail not less than ten calendar days prior to the annual meeting. The candidates' names will be arranged alphabetically, and the ballot will clearly indicate the number of candidates to be elected and voted for. All ballots must be returned to the Secretary for tabulation.

4. Tabulation

The outgoing President, Vice-President, Secretary and Treasurer of the Medical Staff will tabulate the ballots before the annual meeting. Ballots containing more votes than the total number of representatives to be elected will not be counted. Those candidates who receive the greatest number of votes will be elected. The candidates, equal in number to the remaining vacancies, who receive the greatest number of votes will be elected. All Members will be notified of the election results.

5. Vacancies: In the event of a vacancy, the President of the Medical Staff will appoint a replacement to serve for the remainder of that term.

3. Officers

There will be a Chair and Vice-Chair of the MEC nominated by the Leadership Council. An officer of the MEC who has served two consecutive terms in the same office is not eligible to hold that office during the two years immediately following the end of his/her second term. An officer of the MEC may be removed for cause by a vote of two-thirds of that body. Failure of an MEC officer to maintain Active Staff membership will result in automatic removal from office. The Chair of the MEC will receive a stipend, to be determined by the Budget and Finance Committee of the Medical Staff, subject to approval at the annual meeting.

4. Meetings

Regular meetings of the MEC are to be held monthly unless cancellation is recommended by the Chair of the MEC and agreed upon by the membership. Special meetings may be convened by the Chair (a) on his/her own motion, or (b) within seven days after a written request by three members of the Committee. All members of the committee will be notified of the special meeting, either by telephone or in writing, as determined by the Chair. Ten voting members of the MEC will constitute a quorum at any meeting.

5. Subcommittees of the Medical Executive Committee

A. General

The Subcommittees (referred to in this section as Committees) of the MEC will include Standing Committees and Special Committees. The Chair of the MEC will be a member of all Committees. Each Committee will carry out its duties in accordance with the policies established by the MEC. All members of the Committees who are appointed by the Chair of the MEC will serve at the pleasure of the Chair of the MEC. All Committees will keep minutes of their meetings, which will be forwarded to the MEC through the Vice-Chair of the MEC. The MEC may, by vote, create, eliminate, or rename any MEC subcommittee.

B. Special Committees

The Chair of the MEC may appoint such Special Committees as he/she may deem necessary.

C. Standing Committees

Unless otherwise specified in these Bylaws or in the Rules and Regulations of the Medical Staff, all Committee members will be appointed by the Chair of the MEC in collaboration with the Committee Chair, if one has been designated. If the Chair of the MEC does not designate a Chair, the Committee may elect its own Chair.

1. Blood and Tissue Management Committee

   a. Purpose: To review and evaluate the appropriate use of blood components and tissue and all adverse reactions to transfusion/transplantation; the appropriateness of proper documentation including informed consent; and the presence of signed physician orders for all transfusions and transplantations. The committee also will monitor the efficient and effective use of personnel and tests in maintaining the blood inventories.

   b. Membership: Will consist of the Director of the Hospital Transfusion Service, who will act as Chair, two leadership technical/administrative Transfusion Service personnel, and five or more Members from the Active Staff, including an Anesthesiologist, a General Surgeon, two Internists (at least one of whom has a subspecialty interest in hematology), and a pediatrician.

   c. Required Meetings and Reports: Will meet at least quarterly and submit its written minutes to MEC.

2. Cancer Committee

   a. Purpose: As part of a LifeBridge Health Cancer Committee, to work with the Chiefs of Service on matters of general policy and supervise and conduct regular Tumor Board meetings at which the diagnosis and management of cancer cases are reviewed.

   b. Membership: Membership shall consist of but not be limited to representatives of the medical staff from the disciplines of medical oncology, surgery, diagnostic radiology, radiation oncology, and pathology. Designated cancer liaison physicians will also be included in membership. In addition, representatives from the following areas will also be included: (i) Cancer Registry; (ii) Nursing; (iii) Outpatient Services; (iv) Administration; (v) Social Services; (vi) Performance Improvement; (vii) Community Education; (viii) Pain Control/Palliative; (ix) Dietary; (x) Hospice; (xi) Pharmacy; and (xii) Clinical Research.

   c. Required Meetings and Reports: Will meet at least four times each year and submit its written minutes to the MEC.

3. Continuing Medical Education Committee

   a. Purpose: To supervise the educational activities of the Medical Staff, including continuing medical education and other educational activities, as deemed appropriate.

   b. Membership: Will consist of representatives of all clinical Departments, at least one representative from Administration, and at least five additional Members of the Medical Staff.

   c. Required Meetings and Reports: Will meet at semi-annually and submit its written minutes to the MEC.

4. Ethics Committee

   a. Purpose: To review and recommend institutional policies and/or procedures on bioethical issues; to provide educational forums; and to provide consultative services concerning clinical bioethical issues as requested by individuals with a clinical interest in a patient's care, including health care providers, patients, and/or their families and significant others as referenced in the Maryland Health Care Decisions Act.

   b. Membership: Will consist of Members of the Active Medical Staff, a registered nurse, a social worker, a member of the Clergy, representatives from Administration, lay representatives (non-LifeBridge employees), resident

physicians, and other members as deemed necessary by the Chair of the Committee.

c. Required Meetings and Reports: Will meet at least monthly and submit its written minutes to the MEC.

5. Practitioner Health

The Practitioner Health Committee is an ad-hoc committee. Membership will consist of five Medical Staff Members, the President of the Hospital or his/her designee, the President of the Medical Staff, and the Chief of the Department of the involved Member (unless the involved Member is the Chief). To the extent possible, at least two of the members of this committee will have expertise in psychiatry, psychology, substance abuse, or human behavior. In addition, to the extent possible, the five Medical Staff Members of this committee will not be members of the committees engaged in peer review activities. This committee will carry out the activities outlined in the Impaired Practitioner Policy to include matters of physical and mental health, and substance abuse of the Medical Staff. It will meet at the call of the Chair.

6. Infection Prevention and Control Committee

a. Purpose: To maintain records of infections within the Hospital and suggest policies for the prevention and control of infections.

b. Membership: Will consist of six or more Members of the Active Staff, the Director of the Division of Infectious Diseases of the Department of Medicine, the Vice President of Patient Care Services (or his/her designee), at least one representative from Administration, infection control personnel, the Director of Infection Prevention, the microbiologist, and such other Hospital personnel as may be desired

c. Required Meetings and Reports: Will meet at least quarterly and submit reports to the MEC and Quality Oversight Committee

7. Lab Stewardship Committee

a. Purpose: To oversee the catalog of laboratory tests, including those sent out to reference laboratories, advise medical staff on best practices and usage guidelines, review and approve requests for new laboratory tests, and monitor the LBH-wide use of common laboratory tests.

b. Membership: Membership shall consist of but not be limited to LBH medical staff representing the disciplines of internal medicine, surgery, emergency, gynecology, and pediatrics; representatives from information services including laboratory IS coordinator(s) and PowerChart IS team members; and laboratory staff to include the Laboratory Medical Director(s) and Administrative Director(s).

c. Required Meetings and Reports: Will meet at least four times each year at Sinai Hospital, with remote participation by representatives from CHC and NWH, and submit its written minutes to the MEC.

8. Nutrition Care Committee

a. Purpose: To assist in the assessment and implementation of nutrition services in regard to parenteral nutrition, enteral nutrition, restricted diets, meal service, and patient education. To monitor nutrition quality indicators and outcomes for parenteral nutrition, enteral nutrition, restricted diets, meal service and patient education.

b. Membership: A multidisciplinary team with representation from the Medical Staff, the Director of Pharmacy, a Clinical Pharmacist, Clinical Dietitians, the Director of Food and Nutrition Services, the Patient Care Services Department (Nursing), Performance Improvement, and Administration.

c. Required Meetings and Reports: Nutrition Care Committee will meet at least quarterly and report to QOC, PIC, Chiefs, MEC, and other committees as per the bylaws and as needed.

9. Perioperative Governance Committee

a. Purpose: To oversee all perioperative services and to ensure the safest, highest quality and efficient performance of all levels of care. To ensure alignment among physicians and administration on key issues within Perioperative Services.

b. Membership: Will consist of, but not be limited to, the Chair of all surgical services, Chair of Anesthesiology, Director of Division of Gastroenterology, and at least one representative of Administration. The Chair of the Committee will appoint select members of the Active Staff.

c. Required meetings and Reports: Will meet at least quarterly and submit its written minutes of the Medical Executive Committee.

10. Quality Oversight Committee

a. Purpose: To coordinate and evaluate the Hospital Patient Safety and Performance Improvement Programs; provides oversight of the Hospital's safety and performance improvement initiatives; to review and evaluate risk management issues and concerns that are interdepartmental in nature, analyze trends of incidents and to recommend policy and procedures changes when necessary; to ensure that services rendered to patients are of the highest quality; and to review performance improvement activities on campus and evaluate their effectiveness in accordance with the Patient Safety and Performance Improvement Plan.

b. Membership: Will consist of a Chair appointed by the Chair of the MEC, the President of the Medical Staff, the Chairmen of the following committees: Formulary Review Committee and Infection Prevention and Control Committee, and key Medical Staff physicians. In addition, Departmental Chiefs and/or their designees, the Quality & Patient Safety Department, Patient Care Services, and other ancillary departments will be represented.

c. Required Meetings and Reports: Will meet at least monthly and submit its written minutes to the MEC.

d. Root Cause Analysis/Administrative Case/Focused Case Review Committee

The Root Cause Analysis/Administrative Case/Focused Case Review Committee is an ad-hoc subcommittee of the Performance Management Committee.

i. Purpose: To provide peer review of medical incidents that involve several departments and to evaluate and make recommendations with regard to the necessary corrective action involving physicians, dentists, podiatrists, Adjunct Staff, hospital personnel, process, plant, equipment, or other aspects of the Hospital's operations. Any corrective action recommended with regard to a physician, dentist, podiatrist or Adjunct Staff Member will be subject to the provisions of Articles XI and XII of these Bylaws.

ii. Procedure: Written or verbal reports concerning incidents involving serious injury and/or a major breach in standards of care will be made immediately to Quality & Patient Safety Department. The Department of Quality & Patient Safety will inform the Chair of the Performance Management Committee and the Vice President for Quality of the nature of the event and the persons involved. The committee will conduct an investigation as it deems necessary and appropriate.

iii. Membership: Will consist of the Departmental Chiefs and/or their designees, at least one representative from Administration, and a representative from

the Quality & Patient Safety Department. The Chair will determine the membership for specific review committees based upon the event. If the Chief of the Department or a partner is involved in the event in question, the Chief will choose a designee and the Chief will become a non-voting participant.

iv. Required Meetings and Reports: Will meet as determined by the Chair of the committee. If the Chief is unable to attend, he/she will send a designee to represent the Department. The reports and recommendations of the committee are reported to the Performance Management Committee, the MEC, and the Board. The Quality & Patient Safety Department will ensure the completion of the recommendations and will retain and trend the minutes of the Root Cause Analysis/Administrative Case/Focused Case Review Committee.

e. The proceedings and documents generated by this committee are pursuant to the to the evaluation and improvement of quality health care functions set forth in section 1-401(c) of the Health Occupations Article of the Annotated Code of Maryland and are intended as records of a Medical Review Committee as defined in that statute.

11. Formulary Committee

a. Purpose: To review the Hospital formulary; to collect data on, study, and evaluate adverse drug events; and to advise on matters concerning the pharmacy, including the procurement, prescribing, dispensing, and education of appropriate use and administration of medications. The committee will suggest regulations for the storage and dispensing of investigational medications.

b. Membership: Will consist of Members of the Active Staff representing a variety of medical Departments and subspecialties, the Director of Pharmacy, the Pharmacy Clinical Coordinator, at least one representative from Administration, the Assistant Vice President of Quality & Patient Safety or designee, and an Advanced Practice Nurse.

c. Required Meetings and Reports: Will meet at least quarterly and submit its written minutes to the MEC. The committee will be responsible for communicating its recommendations to the Medical Staff.

12. Professional Standards and Grievance Committee

a. Purpose: To seek the maintenance of the highest ethical standards in all professional conduct of Members and to act on charges of unprofessional conduct in accordance with the Bylaws.

b. Membership: Will consist of three or more Members of the Active Staff and the President of the Hospital or his/her designee.

c. Required Meetings and Reports: As needed.

13. Radiation Safety Committee

a. Purpose: To supervise and control the use of all radioactive material, whether natural or artificial, and all equipment producing either ionizing or non-ionizing radiation; to recommend rules, regulations, and policies for the use and control of such material and equipment; and to make certain that such rules, regulations, and policies are in conformance with the rules and regulations of appropriate governmental agencies as concern radiation health and safety.

b. Membership: Will consist of the Chief of Radiology; Chief of Radiation Oncology; the Director of the Division of Nuclear Medicine; the Radiation Safety Officer; a representative from Nursing; the Vice President of Patient Care Services or his/her

designee will serve as a representative of Administration; and others as requested by the committee Chair.

c. Required Meetings and Reports: Will meet at least quarterly and submit its written minutes to the MEC.

14. Staff Privileges and Credentials Committee

a. Purpose: To act on applications for appointment or reappointment to the Medical Staff and requests for clinical privileges as provided elsewhere in the Bylaws; and to make recommendations concerning the minimal amount of professional liability insurance required for maintaining privileges on the Medical Staff.

b. Membership: Will consist of five or more Members from the Active Staff, at least one representative from Administration, and at least one member of the Adjunct Staff. The majority of members shall be from the Active Staff.

c. Required Meetings and Reports: Will meet at least monthly and submit its written minutes to the MEC

15. Trauma Committee

a. Purpose: To advise on all policies of trauma care; to review and recommend changes of trauma protocols, including Hospital as well as MIEMSS protocols; to monitor quality and process of patient care and develop/implement improvement initiatives; to monitor patient movement and bed utilization related to trauma care.

b. Membership: Will consist of the Trauma director, Trauma Coordinator and at least two members of the active medical staff involved in providing trauma care, representatives from Administration, social work/case management, and patient care services, representatives from all essential functional areas and Departments, including but limited to Anesthesiology, Emergency Medicine, Neurology, Neurosurgery, Orthopedic Surgery, and Surgery.

c. Required Meetings and Reports: Will meet at least quarterly and submit its written minutes to the MEC.

16. Utilization Review and Resource Management Committee

a. Purpose: To review and recommend institutional procedures on effective utilization processes for both Sinai and Northwest Hospitals. Provide oversight to case management services in all areas of the hospital. Monitor reimbursement and billing of admissions, discharges, and report to clinical department chiefs trending data.

b. Membership: Will consist of the Physician Advisors at both Sinai and Northwest Hospitals, the Directors of Utilization Management (who serve as co-Chairpersons of the Committee), and representatives of the major clinical Departments as requested by the committee Chairpersons.

c. Required Meetings and Reports: Will meet at least quarterly and submit its written minutes to the MEC.

ARTICLE VIII – DOCUMENTATION

1. A medical history and physical examination must be completed, documented, and entered into the medical record for each patient no more than 30 days (may be completed by a practitioner other than a member of the Medical Staff) before or 24 hours after admission, but prior to an operative or invasive procedure except in the case of a life-threatening emergency (in which case it must be completed within 24 hours). The history and physical examination must be completed by a qualified physician, oral and maxillofacial surgeon, or other qualified licensed individual in accordance with Maryland law and the Medical Staff Rules and Regulations and the policies identified therein. If the

history and physical examination is completed by a practitioner who is not a Member, it shall be updated as described in paragraph 2 below.

2. An updated examination of the patient, including any changes in the patient's condition, shall be completed within 24 hours after admission, but prior to an operative or invasive procedure, when the medical history and physical examination are completed within 30 days before admission. The updated examination of the patient, including any changes in the patient's condition, must be completed by a physician, oral and maxillofacial surgeon, or other qualified licensed individual in accordance with Maryland law and the Medical Staff Rules and Regulations and the policies identified therein.

ARTICLE IX – DEPARTMENTS

1. The President of the Hospital, upon the recommendation of the MEC, will establish the various medical and surgical Departments within the Hospital. The Hospital currently has the following Departments:

- Anesthesiology
- Emergency Medicine
- Medicine
- Neurology
- Neurosurgery
- Obstetrics-Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry
- Radiation Oncology
- Radiology
- Surgery

2. Each Department will be directed by a Chief who is appointed by the President of the Hospital with the recommendation of Medical Staff leadership. Each Chief will have the authority and responsibilities set forth in these Bylaws, as well as such other responsibilities as may be assigned by the President of the Hospital or the MEC. The Chief will be certified by an appropriate specialty board or will affirmatively establish comparable competence by meeting the criteria developed for that Chief position through the Credentialing process.

3. Each Chief will be responsible for the clinical and administrative operation of his/her department, including all Divisions thereof. Each Chief is responsible for, among other things:

A. Assuring that the quality and appropriateness of patient care provided within the Department are monitored and evaluated

B. All clinical activities of the Department

C. All administrative activities of the Department unless otherwise provided for by the Hospital

D. Maintaining professional conduct of all Medical Staff members and practitioners with clinical privileges within the Department, and for implementation of the Professional Conduct Complaint Policy of the Medical Staff

E. The Department's performance improvement activities and programs

F. The integration of the Department into the primary functions of the Hospital

G. The coordination and integration of interdepartmental and intradepartmental services

H. The development and implementation of policies and procedures that guide and support the provision of services

I. Making recommendations regarding the number of qualified and competent persons necessary to provide care or service

J. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department

K. Developing and recommending to the Medical Staff the criteria for clinical privileges in the Department

L. Recommending clinical privileges for each member of the department

M. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services through the establishment of specific guidelines for the evaluation of clinical competence and participation in Hospital and Department activities

N. The continuous assessment and improvement of the quality of care, treatment, and services provided

O. The maintenance of quality control programs, as appropriate

P. Assessing and recommending to the Hospital off-site sources for needed patient care services not provided by the Department or otherwise at the Hospital

Q. The orientation and continuing education of all persons in the Department; and

R. Recommendations for space and other resources needed by the Department.

3. The Chief, subject to the approval of the MEC, may appoint a director to head any Division. The Director of each Division will be responsible to the Chief for the functioning of his/her division and will have general supervision of the work of the Members of his/her division.

4. Members of the Medical Staff are responsible to the Director of their Division and through him/her to the Chief. Members not assigned to a division, or where no Division Director has been appointed, will be directly responsible to the Chief.

ARTICLE X – THE HOUSE STAFF

There will be a House Staff. Members of the House Staff will function pursuant to a job description approved by the Hospital and a contract. To perform services within the scope of their job description, members of the House Staff need not be Members of the Medical Staff. Except as provided in this Article, members of the House Staff will be bound by the provisions of these Bylaws, as well as the Medical Staff Rules and Regulations and policies. The House Staff is not governed by the appointment, credentialing, corrective action, and hearing and appeal provisions of these Bylaws. The House Staff Manual will contain the policies governing the conduct and practice of the House Staff including, appointment, credentialing, corrective action, hearing and appeal procedures, and the supervision of House Staff by Members. The policies contained in the House Staff Manual will be approved by the Graduate Medical Education Committee of the Hospital.

In certain circumstances, a member of the House Staff may wish to perform services for which he/she is appropriately licensed and trained, but which are beyond the scope of his/her job description. To perform such services, the physician must apply for medical staff privileges and become a Member of the Medical Staff.

ARTICLE XI – CORRECTIVE ACTION

1. Board of Directors

The Board of Directors has the authority to suspend, expel, limit, or take other corrective action with regard to a practitioner's clinical privileges or Medical Staff membership at any time. The Board may, in its discretion, delegate its authority under these Bylaws to a subcommittee of the Board.

2. Suspensions

A. Automatic Suspension

1. A practitioner's clinical privileges will be automatically suspended on the occurrence of any of the following events:

a. revocation or suspension of a practitioner's license

b. revocation or suspension of a practitioner's state or federal registration to administer drugs, unless such registration is not required by the appropriate Department or otherwise approved by the MEC

c. a practitioner fails to maintain professional liability insurance in the amounts required by the Hospital

d. misrepresentation or misstatement in, or omission from, the application for Medical Staff membership as set forth in Article III, Paragraph 5F; or

e. a conviction, guilty plea, or plea of nolo contendre with respect to a crime involving moral turpitude or a felony.

2. Upon learning that a practitioner's license or drug registration has been suspended or that the practitioner has failed to maintain professional liability insurance as required above, the President of the Hospital or his/her designee will immediately notify the practitioner in writing that his/her clinical privileges are suspended.

3. If the practitioner's professional license, drug registration, or insurance coverage is restored, the Board of Directors may, upon the recommendation of the MEC, reinstate a practitioner whose privileges have been suspended pursuant to this Section.

4. A practitioner automatically suspended under this Section is not entitled to a Fair Hearing under Article XII.

5. Any practitioner whose clinical privileges are suspended pursuant to this Section for greater than 90 days will be referred to the MEC for appropriate action, which may include deeming the Member to have voluntarily resigned from the Medical Staff.

a. Medical Records Suspension

i. A practitioner's clinical privileges may be suspended temporarily pursuant to these Bylaws when the practitioner fails to complete his/her medical records without good cause within the time frame specified in the Medical Staff Rules and Regulations and the Hospital Medical Record Completion Process policy. The Medical Record Completion policy will be an administrative policy of the Hospital, approved by the MEC.

ii. A practitioner's Medical Staff membership may be revoked by the MEC after he/she has been on medical records suspension for eight consecutive weeks. The Board may, upon the recommendation of the MEC, reinstate a practitioner whose Medical Staff membership has been revoked for failure to complete delinquent medical records. Revoked privileges will require the physician to re-apply for privileges.

iii. A practitioner whose clinical privileges are suspended, or Medical Staff membership revoked or has been deemed to have voluntarily resigned from the Medical Staff for failure to complete medical records is not entitled to a Fair Hearing under Article XII.

B. Summary Action

1. Whenever extraordinary circumstances suggest that summary action is in the best interest of patients and the Hospital, the following persons or entities may summarily suspend or limit a practitioner's clinical privileges:

a. the Board of Directors

b. the President of the Hospital; or

c. with the concurrence of the President of the Hospital, any one of the following: The President of the Medical Staff, the Chair of the MEC, or the Chief of the Department to which the practitioner is assigned.

2. The suspension or limitation will be effective immediately upon either written or verbal notice to the involved practitioner. In the event verbal notice is given, a written notice will be sent immediately to the practitioner. A copy of any summary action notice will be sent to the Chair of the MEC unless he/she initiated the action.

3. The MEC may, in its discretion, order an investigation of the matter. The MEC may designate an individual affiliated with the Hospital, a Medical Staff or Hospital committee or subcommittee, or an ad hoc committee to conduct the investigation. The designated party will investigate the matter and, within five calendar days of receiving the request from the MEC, make a written report to the MEC. The report of the investigating party will be reviewed by the MEC as soon as possible after receipt.

4. In its discretion, the MEC may request that the involved practitioner submit a written statement concerning the matter. At the request of the MEC, the individual who initiated the suspension or conducted any investigation will appear before the MEC to answer questions about the matter. In its discretion, the MEC may consider any evidence it deems relevant to the matter, including, but not limited to the summary suspension notice; any investigation report; any comments of the Chief; medical records; any Medical Staff and Departmental files; and any written statement of the practitioner.

5. The MEC will then make a recommendation to the President of the Hospital regarding whether0 the suspension should continue or under what circumstances or with what limitations it should be terminated. The MEC will make its recommendation regarding the suspension within thirty calendar days from the date of the suspension.

6. The President of the Hospital shall accept, reject, or modify the recommendation of the MEC within five business days of receiving the MEC's recommendation. The decision of the President of the Hospital will be forwarded to the involved practitioner with a copy to the MEC. If action taken constitutes an Adverse Action as defined in Article XII, Paragraph 1D, this notice shall set forth a description of the action taken, the reason for the action and a copy of the procedural rights set forth in Article XII if the practitioner is so entitled.

7. The Board of Directors or the President of the Hospital will have the authority to revoke or modify the terms of any summary action at any time.

3. Corrective Action

A. When the clinical activities or professional conduct/behavior of a practitioner is considered below the standards of the Medical Staff and the Hospital, a recommendation for corrective action, suspension, expulsion, or limitation of a practitioner's clinical privileges and/or Medical Staff membership may be made to the Board of Directors through the MEC. A recommendation for corrective action may be initiated by the MEC or made to the MEC by any of the following:

- the President of the Hospital
- the Chief Quality Officer
- the Chief Medical Officer
- the Chief of a Department
- any Medical Staff or Hospital committee or subcommittee involved in performance improvement or peer review activities; or
- the Professional Standards and Grievance Committee.

B. The written recommendation for corrective action is to be forwarded to the Chair of the MEC, with copies to the President of the Medical Staff and the President of the Hospital. The recommendation will include a description of and the basis for the recommendation.

C. The Chair of the MEC will send the involved practitioner written notification of the recommendation for corrective action within forty-eight hours of the recommendation being forwarded to the MEC. The notice will include a description of and the basis for the recommendation.

D. The MEC will consider the recommendation for corrective action at its next regular meeting, but no later than thirty calendar days after the receipt of the recommendation. The MEC will review the recommendation to determine what action, if any, is necessary.

E. The MEC may, at its discretion, order a further investigation of the matter. The MEC may designate an individual affiliated with the Hospital, a Medical Staff or Hospital committee or subcommittee, or an ad hoc committee to conduct the investigation. The designated party will investigate the matter and, within thirty calendar days of receiving the request from the MEC, make a written report on the matter to the MEC. The report of the investigating individual or entity will be reviewed by the MEC as soon as possible after receipt, but no later than its next regular meeting.

F. An outside consultant or agency may be used whenever a determination is made by the hospital and investigating committee that:

1. the clinical expertise needed to conduct the review is not available on the Medical Staff; or

2. the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

3. the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

G. If the involved practitioner wishes, he/she may appear before the MEC and make an oral statement. The practitioner may not be represented by counsel, must limit his/her statements to the matter at issue before the MEC, and must answer any questions asked of him/her by the MEC. Alternatively, the practitioner may submit a written statement on the matter.

H. At the request of the MEC, the individual who recommended corrective action or conducted any investigation will appear before the MEC to answer questions about the matter. In its discretion, the MEC may consider any evidence it deems relevant to the matter, including, but not limited to: medical records; peer review documents; any committee reports; any investigation report; any Medical Staff or Department files; any comments of the Chief; and any written statement of the practitioner.

I. If the MEC determines that corrective action is necessary or desirable, it will make a recommendation to the Board of Directors. The MEC may recommend any action it deems appropriate, including but not limited to the following: no action; limitation, reduction, suspension, or termination of the practitioner's clinical privileges and/or Medical Staff membership; issuance of a warning letter, a letter of admonition, or a letter of reprimand; or imposition of probation, supervision, educational programs, health care counseling, a requirement for consultation, review, or any other action appropriately designed to educate the practitioner or protect patients and the Hospital.

J. When a final decision is made by the Board of Directors, the President of the Hospital shall notify the involved practitioner of the action of the Board of Directors. If the action is considered an Adverse Action under Article XII, Section 1, and the practitioner is so entitled, the President of the Hospital will also inform him/her of his/her right to request a fair hearing as provided in Article XII. If the practitioner fails to request a hearing under Article XII, the action of the Board of Directors will be final.

K. The MEC may suspend or limit a practitioner's clinical privileges, without approval of the Board of Directors, at any time from the filing of a recommendation for corrective action until final action, if in the opinion of the MEC the safety of patients is at risk. In the event the MEC does

suspend a practitioner pursuant to this paragraph, the MEC will meet as soon as is reasonably possible to consider the matter in accordance with the procedures contained in this section and make a recommendation for final action to the Board of Directors. The Credentialing Department will report suspension of clinical privileges to appropriate state and federal agencies after the final determination has been made and agreed upon by the Board of Directors.

L. This Section does not apply when a recommendation for limitation or modification of a practitioner's clinical privileges occurs during the reappointment process. In those situations, the normal reappointment process provided for in Article III and the LBH Credentialing Procedures Manual is to be followed.

4. Alternative Coverage

Except as provided otherwise in Section 2.B. of this Article (Medical Records Suspension), the President of the Medical Staff in conjunction with the appropriate Chief will arrange to transfer all patients of a suspended practitioner in the Hospital at the time of the suspension to the care of another appropriate practitioner. To the extent possible, the wishes of the patients will control in the selection of such alternative practitioner.

ARTICLE XII – HEARING AND APPEAL PROCEDURE

1. Hearing Procedures

A. When the Board of Directors takes Adverse Action (as defined below) with respect to the requested or existing clinical privileges and/or Medical Staff membership of a physician, dentist, or podiatrist, the President of the Hospital shall give prompt written notice of the decision to the involved practitioner. This notice shall set forth a description of the action taken by the Board, the reason(s) therefor, and a copy of the procedural rights set forth in this Article, if the practitioner is so entitled. The notice shall also specify that a practitioner requesting a Fair Hearing will have the burden of showing that the Board's decision was not supported by substantial evidence.

B. Notwithstanding anything to the contrary contained in this Article, the following suspensions, if greater than fourteen calendar days, will be considered an Adverse Action for purposes of this Article XII: suspension by the MEC pursuant to Article XI, Section 3.K.; or summary suspension pursuant to Article XI, Section 2.C.

C. Members of the House Staff are not entitled to the procedural rights contained in this Article. Procedural rights for members of the House Staff are contained in the House Staff Manual. Members of the Adjunct Staff who are granted clinical privileges and who are not employed by the Hospital are contained in this Article. Procedural rights for members of the Adjunct Staff who are employed by the Hospital are set forth in the applicable Hospital employment policy.

D. The following shall be considered Adverse Action:

1. Denial of initial Medical Staff appointment

2. Denial of Medical Staff reappointment or reinstatement after a leave of absence

3. Denial of requested clinical privileges for reasons other than failure to meet eligibility criteria (e.g., quality of care concerns);

4. Denial of requested department affiliation

5. Suspension or revocation of Medical Staff appointment

6. Suspension or revocation of clinical privileges

7. Involuntary limitation or reduction of clinical privileges; and

8. Involuntary imposition of a consultation requirement, co-admission requirement, or monitoring requirement.

E. Notwithstanding the above, Adverse Action shall not include:

1. any action based on a practitioner's failure to meet the eligibility criteria for the requested privileges or appointment, as established in these Bylaws or in the appropriate Departmental criteria. (For example, a denial of an initial staff appointment because the individual does not possess the requisite educational requirements; or failure to meet the criteria for locum tenens privileges)
2. denial, limitation, or revocation of temporary privileges
3. suspension for failure to timely complete medical records under Article XI, Section 2.B.
4. an automatic suspension under Article XI, Section 2.A.
5. failure to be appointed as a Special Consultant
6. a decision by the Hospital not to employ or hire as an independent contractor
7. denial or revocation of clinical privileges or Medical Staff membership based on an exclusivity policy of the Hospital
8. removal of the practitioner from the Emergency Department call schedule
9. termination of a practitioner employed by the Hospital if the practitioner's contract so states.

F. Within thirty days from the date of the notice set forth in paragraph A of this Section, the affected practitioner may exercise his/her rights under this Article by submitting a written request for a Fair Hearing to the President of the Medical Staff, who shall notify the President of the Hospital of the request. Failure of the practitioner to timely request a Fair Hearing will be deemed a waiver of his/her right to such hearing and to any appellate review.

G. The practitioner's request for a Fair Hearing will not delay imposition of the action taken by the Board of Directors or any action taken pursuant to Article XI.

H. The President of the Medical Staff will appoint, at his/her discretion, either an impartial Hearing Officer or a Hearing Committee of at least three Members, one of whom will be designated as chair. The Hearing Committee may include any combination of: (1) any member of the Medical Staff (as further described below), and/or (2) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital). No Member of the Medical Staff who actively participated in the decision being challenged or is in direct economic competition with the affected practitioner, will be a member of the Hearing Committee or may be appointed as the Hearing Officer. When the hearing is to be heard by a Hearing Officer, "Hearing Officer" will be substituted for all references to "Hearing Committee" in these Bylaws, unless the context clearly indicates otherwise.

B. At the request of the Hearing Committee, a Hearing Advisor may be appointed whose role shall be advisory and who will provide guidance regarding procedural issues. The Hearing Advisor will not be a member of the Hearing Committee and will not have a vote.

C. At the request of the Hearing Committee, a Medical Advisor may be appointed whose role will be advisory and who will provide guidance regarding medical issues. The Medical Advisor will not be a member of the Hearing Committee and will not have a vote. This Medical Advisor may be a Member of the Medical Staff.

D. The decision of the Board of Directors and the bases therefor will be presented to the Hearing Committee by a representative of the Hospital selected by the President of the Hospital. This individual may be a physician, an attorney, or any other person. The Hearing Committee and the involved practitioner will be notified of the identity of the individual representing the Hospital at least thirty calendar days before the Fair Hearing.

E. The practitioner may be represented at the Fair Hearing by legal counsel, by a member of the Medical Staff, by a member of his/her local professional society, or by any other person of his/her choice. At least thirty calendar days before the Fair Hearing, the practitioner must

advise the Hearing Committee as well as the Hospital whether he/she will be represented and by whom.

F. The Hearing Committee will notify the involved practitioner of the date, time, and place of the hearing. Except in unusual circumstances, a hearing date will be set not less than thirty nor more than sixty calendar days after receipt of a hearing request. Notice by the Hearing Committee will include the agenda for the Fair Hearing. If so requested by the involved practitioner, a hearing for a practitioner who is under suspension will be held as soon as the arrangements for it can reasonably be made. At least 30 calendar days before the Fair Hearing, the Hospital and the involved practitioner shall send to the Hearing Committee and to the opposing party a list of witnesses expected to testify at the hearing on their behalf.

G. The Fair Hearing will be conducted in accordance with the following procedures:

1. The involved practitioner and the Hospital will have the right:

a. to call witnesses and to introduce evidence

b. to cross-examine adverse witnesses

c. to review all documents and recommendations upon which the decision was based

d. to submit a written statement at the conclusion of the hearing

2. All testimony will be under oath or affirmation.

3. A record of the hearing is to be made either by a recording device or a court reporter, as determined by the Hearing Committee. The cost of any court reporter and transcript is to be paid equally by the Hospital and the involved practitioner.

4. Formal rules of evidence will not apply, and the Hearing Committee may consider any material it deems relevant to or bearing on the issues involved. The Hearing Committee is also entitled to consider any pertinent material on file in the Hospital, and all other information which may be considered in connection with applications for appointment to the Medical Staff and the granting of clinical privileges. All such material will be deemed part of the record before the Hearing Committee without the need for any further authentication or formal introduction into the record.

5. The Hearing Committee may question any witness on any matter it deems relevant.

6. The practitioner involved may be called as a witness by the Hospital even if he/she chooses not to testify in his/her own behalf.

7. Rebuttal evidence may be accepted at the discretion of the Hearing Committee.

8. The Hearing Committee may call its own substantive witnesses as it deems necessary.

9. Failure of the practitioner to appear at the Fair Hearing without good cause shall be deemed a waiver of all rights and a voluntary acceptance of the Board's action.

10. A continuance of the hearing may be made only for good cause and at the sole discretion of the Hearing Committee.

11. The practitioner has the burden of establishing that the action of the Board of Directors was not supported by substantial evidence.

12. The Hearing Committee may, without special notice, recess the Fair Hearing and reconvene it at a later date for the convenience of the participants or for the purpose of obtaining new or additional information or consultation. Upon conclusion of the presentation of oral and written evidence, the Fair Hearing will be closed, and the Hearing Committee will, at a time convenient to itself, conduct its deliberations in private.

13. All members of the Hearing Committee must be present for all sessions of the Fair Hearing, including the deliberations.

N. Within fifteen business days after final adjournment of the hearing, the Hearing Committee will submit a written report, including recommendations and a statement of the reasons in support of the recommendation, to the Board of Directors. A copy of the report will also be sent to the involved practitioner.

O. If the Hearing Committee's report and recommendations are inconsistent with the action taken by the Board of Directors, the Board may affirm, modify or reverse its prior action, or, in its discretion, it may refer the matter back to the Hearing Committee for further review and recommendations in accordance with the Board's instructions. If the report reflects that the Hearing Committee determined that the action of the Board was supported by substantial evidence, the Board action will be upheld, and the President of the Hospital shall provide notice to the involved practitioner which shall include the right to appellate review.

2. Appellate Review

A. Within ten business days from the date the report of the Hearing Committee is forwarded to the Board of Directors and the affected practitioner, the practitioner may request appellate review by the Board of Directors by delivering a written request for such review to the President of the Hospital. If appellate review is not requested within this period, the practitioner will have waived any right to such review.

B. Upon receipt of a timely request for appellate review, the President of the Hospital will deliver the request to the Chair of the Board of Directors. The Chair or his/her designee will promptly schedule and arrange for an appellate review. The Chair of the Board of Directors will appoint an appellate review committee of at least three members of the Board of Directors, one of whom will be appointed as the Chair.

C. An appellate review for a physician who is under suspension and who so requests will be held as soon as the arrangements for it can reasonably be made. At least fifteen calendar days before the appellate review, the President of the Hospital, on behalf of the Board, will send the affected practitioner notice of the date, time and place of review.

D. Appellate Review Procedure

1. The proceedings by the appellate review committee will be in the nature of a review based on the record of the hearing before the Fair Hearing Committee and that Committee's report.

2. The practitioner seeking appellate review must submit a written statement to the appellate review committee of the Board, with a copy to the Hospital, detailing the findings of facts, conclusions, and/or procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. A written statement in reply may be submitted to the appellate review committee of the Board, with a copy to the involved practitioner, by the Hospital, and legal counsel may assist in its preparation.

3. The appellate review committee, in its sole discretion, may allow the practitioner and a representative of the Hospital to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the appellate review committee.

4. The practitioner has the burden of establishing that the recommendation of the Hearing Committee was incorrect, i.e., that the Adverse Action of the Board of Directors was not supported by substantial evidence.

5. New or additional matters or evidence not raised or presented during the original hearing or in the report of the Hearing Committee and not otherwise reflected in the record may only be introduced at the discretion of the appellate review committee. The party requesting introduction of such information or evidence must explain why it was not presented earlier.

6. All members of the appellate review committee must be present for any meetings of the appellate review committee, including the deliberations.

7. The appellate review committee will make a recommendation to the Board of Directors within fifteen business days of completion of the appellate review process.

8. The appellate review committee may recommend that the Board of Directors affirm, modify, or reverse the adverse action of the Board, or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendations to be returned to the appellate review committee in accordance with its instructions.

3. Final Decision of the Board of Directors

The appellate review committee will forward its written report and recommendations to the Board of Directors for final action. The Board of Directors will consider the recommendations of the appellate review committee and take whatever action it deems necessary. Any inconsistencies between the recommendations of the appellate review committee and the Board's prior action will be resolved by the Board of Directors. If the recommendation of the appellate review committee is consistent with the Board's previous action, the Board will take final action on the matter at its next regular meeting. If the recommendation of the appellate review committee is inconsistent with the Board's prior action, the Board will act on the matter within thirty days of the committee's recommendations being forwarded to the Board. The involved practitioner will be immediately notified of the final decision of the Board of Directors. The Credentialing Department will report suspension of clinical privileges to appropriate state and federal agencies after the final determination has been made and agreed upon by the Board of Directors.

ARTICLE XIII – MEETINGS

1. Annual Meeting

The annual meeting of the Medical Staff will be held in December.

2. Additional Meeting

In addition to the annual meeting, there will be at least one additional meeting of the Medical Staff each year.

3. Special Meetings

Special meetings of the Medical Staff may be called by the President of the Medical Staff if at least fifteen voting Members or the MEC submit a written request for a special meeting to the President. If the President fails to call a special meeting as requested, the Vice-President, and upon his/her failure, the Secretary or Treasurer will call such a meeting as provided by these Bylaws. Notices of special meetings are to be sent to all Members at least five days before the meeting and will state the nature of the business to be transacted. No other business may be considered or transacted at the meeting. Meetings may be conducted electronically.

4. Schedule

The meeting of the Medical Staff will take place at an appropriate time and place set by the President of the Medical Staff.

5. Quorum

Twenty-five voting Members will constitute a quorum to conduct business at a meeting of the Medical Staff.

ARTICLE XIV – DUES AND ASSESSMENTS

On an annual basis, the Medical Staff Budget and Finance Committee will evaluate the schedule of dues and fines and will submit any recommended changes for approval by the membership at the annual meeting. Dues are payable upon request and billed with the medical staff member’s initial and any reappointment application. Fines are payable when imposed, unless specified otherwise. The Treasurer will send a notice to Members whose payment of dues or fines is more than sixty days in arrears. Any Member who continues to

be delinquent 10 days after that notice will be referred to the Chair of the MEC for appropriate action. Any practitioner who reapplies for membership must pay all dues, fines, and assessments prior to rejoining the Medical Staff.

ARTICLE XV – AMENDMENTS

1. Proposed amendments are to be originated by the MEC, another standing committee, or a member and submitted in writing to the Bylaws Committee. The Bylaws Committee will review the proposed amendment and prepare a written report and recommendation regarding the proposal. A copy of the proposed amendment, the recommendation of the committee, and a notice of the date, time and place of the Medical Staff meeting at which a vote will be taken on the proposed amendment will be sent electronically to each voting Member, at least ten days prior to the meeting. Floor amendments that do not substantively change the proposed amendment may be made at the Medical Staff meeting. Approval by (i) two-thirds of the voting Members at a meeting where a quorum exists or (ii) by electronic approval from the number of Members needed to constitute a quorum is required for the amendment to be approved. The proposed amendment and the recommendation of the Bylaws Committee are then sent to the Board of Directors for action. Neither the Medical Staff nor the Board of Directors may unilaterally change these Bylaws.

2. Copies of any significant amendments to these Bylaws will be sent to all Members of the Medical Staff and others with clinical privileges as soon as reasonably possible after adoption by the Board of Directors.

3. These Bylaws will be reviewed on an ongoing basis by the Bylaws Committee and amendments made as necessary. The Bylaws Committee will make a report regarding its ongoing review to the Medical Staff at the annual meeting.

4. The Medical Staff may propose amendments to the Bylaws directly to the Board of Directors. Should the Medical Staff desire to propose an amendment to these Bylaws to the Board, the Members proposing the amendment shall send a letter to the Chair of the Board that describes the amendment and, at the same time, send a copy of the letter to the Chair of the MEC. The Chair of the Board shall consult other members of the Board, and the Board, or a committee designated by the Board, will consult with such physicians or other individuals as deemed necessary to be informed on the issue. If the Board, or a committee thereof, deems it advisable to meet to discuss the proposed amendments, a meeting will be set with some or all (depending on various factors, including the number of Members proposing the amendment) of the Members proposing the amendment.

5. Notwithstanding the procedures set forth above, both the MEC and the Board shall have the power to adopt, without following those procedures, such amendments to these Bylaws as are technical or legal modifications or clarifications, reorganization, or renumbering, or amendments needed because of punctuation, spelling, or other errors of grammar or expression.

ARTICLE XVI – ADOPTION

These Bylaws will become effective upon adoption by the Board of Directors. They will be binding upon all members. Bylaws are available on the LBH Intranet, Physicians Portal website and from the LBH Credentialing Department as soon as reasonably possible after adoption by the Board of Directors.

ARTICLE XVII – RULES AND REGULATIONS

Subject to the approval of the Board, the Medical Staff will adopt such Rules and Regulations as may be necessary for operation of the Medical Staff and to affect the purposes for which the Medical Staff is organized. Rules and Regulations, and any amendments thereto, will become effective upon approval of 2/3 of the voting members at a meeting of the Medical Staff where a quorum exists, and after approval by the Board. Neither the Medical Staff nor the Board may unilaterally change the Rules and Regulations. The Medical Staff may propose additions or amendments to the Rules and Regulations directly to the Board (in the manner described above in Article XV, Section 4); however, the Medical Staff must first communicate the proposal to the MEC and should attempt to resolve any differences with the MEC. In cases of documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve an urgent amendment without prior notification to the Medical Staff. When an urgent amendment is made, the MEC will immediately notify the

Medical Staff and the Medical Staff will have the opportunity to review and comment on the amendment. If the Medical Staff does not object, the provisional amendment will be approved. If there is a conflict between the Medical Staff and the MEC, the conflict resolution procedures will be implemented. If necessary, a revised amendment will then be submitted to the Board for action. The Rules and Regulations will be set out immediately following the Bylaws.

ARTICLE XVIII – POLICIES AND PROCEDURES

Policies and Procedures as may be necessary for operation of the Medical Staff and to affect the purposes for which the Medical Staff is organized will be adopted. The Medical Staff may propose additions or amendments to the Policies and Procedures directly to the Board (in the manner described above in Article XV, Section 4); however, the Medical Staff must first communicate the proposal to the MEC and should attempt to resolve any differences with the MEC. Policies and Procedures, and any amendments thereto, will become effective upon approval of the MEC, and the MEC will communicate any policies or procedures that are adopted or amended to the Medical Staff.

ARTICLE XIX – CONFLICT RESOLUTION

The Medical Staff and the MEC desire to ensure timely and objective resolution of conflicts that may arise between them on issues including, but not limited to, proposals to adopt a rule, regulation or policy, or an amendment thereto. When conflicts arise, the relevant parties are encouraged to attempt to resolve the conflicts through one-on-one discussions. If the conflict cannot be resolved between the parties, it shall be resolved in accordance with the Conflict Management Between Medical Staff and Medical Executive Committee policy.