**BYLAWS OF THE MEDICAL STAFF FOR**

**LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

**December 2023**

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# BYLAWS OF THE MEDICAL STAFF FOR

**LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

***2023***

Recognizing that the best interests of the patients are served by concerted effort, the Medical Staff of Levindale Hebrew Geriatric Center and Hospital hereby organizes in conformity with the Bylaws hereinafter stated.

# PREAMBLE

Whereas, Levindale Hebrew Geriatric Center and Hospital, Inc. (“Levindale” or the “Hospital”) is a nonprofit corporation organized under the laws of the State of Maryland, and

Whereas, its purpose is to serve as a long-term care institution, hospital, and rehabilitation center providing patient care, education, and research, and

Whereas it is recognized that the Medical Staff is responsible for the safety and quality of medical care in the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Governing Body, with the support of a well-functioning positive relationship between the medical staff and governing body to fulfill Levindale’s obligations to its patients.

Therefore, the physicians, dentists, podiatrists, and other medical personnel practicing in the Hospital hereby organize themselves into a Medical Staff.

These Bylaws are intended to create a binding contractual relationship between Levindale and the Governing Body and the Medical Staff and its individual Members.

# ARTICLE I NAME

The name of this organization shall be the “Medical Staff of Levindale.”

# ARTICLE II DEFINITIONS

As used in these Bylaws, the following terms shall have the meanings set forth below:

1. “Advanced Practice Professional” (APP) means a non-physician healthcare Practitioner, including certified physician assistants, certified nurse practitioners, and psychologists. The Board may designate additional categories of Practitioners who may be included as APPs. APPs may be granted specific clinical privileges at the Hospital but are not members of the Medical Staff. APPs may be employees of Levindale. APPs are subject to the Allied Health Practitioner Policy.
2. “Clinical privileges” or “privileges” means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services.
3. “Governing Body” or “Board” means the Board of Directors of Levindale. If the Board has delegated any of its duties or functions to a person or committee in accordance with the Levindale bylaws, a

reference to the Board or Governing Body shall mean that person or committee to which the function has been delegated.

1. “Division Head” shall be the Medical Staff Member duly appointed in accordance with these Bylaws as the head of a Division.
2. “Resident/Training Staff” shall refer to graduates of approved medical, osteopathic, dental, or podiatric schools that participate in graduate medical education training programs at the Hospital.
3. “Medical Director” is that individual who is appointed by Hospital leadership to head of the medical services provided at the Hospital and to whom the Medical Staff Members are responsible.
4. “Medical Executive Committee” (“MEC”) means the executive committee of the Medical Staff as described in Article XII of these Bylaws.
5. “Medical Staff” mean fully licensed medical personnel who have been appointed pursuant to these Bylaws as an Active Member, or as a Consultant as set forth in Article V of these Bylaws.
6. “Practitioner” means an appropriately licensed health professional, privileged to practice in the Hospital including but not limited to a medical or osteopathy physician, dentist, podiatrist, or any APP.
7. “President” means the chief administrative officer, or his/her designee, charged with responsibility for the overall administration and management of Levindale.
8. “Mail” shall be interpreted to mean communication by “United States Postal Service, email and/or posting to a website accessible to Medical Staff Members.

# ARTICLE III PURPOSES

The purposes of the Medical Staff are:

1. To provide all patients admitted to, or treated at, Levindale with medical care and other related services;
2. To strive for a high level of professional performance by all Practitioners at the Hospital by granting appropriate delineation of clinical privileges as well as by a periodic evaluation of each Practitioner’s performance;
3. To provide an educational setting that will maintain scientific standards that will enable continuous advancement in professional knowledge and skill for the Practitioners and caregivers;
4. To maintain self-governance of Medical Staff activities;
5. To provide a means whereby general issues concerning the Medical Staff and Levindale may be discussed by the Medical Staff, the Governing Body, and the President;
6. To provide a forum for discussion of medical-administrative problems and issues;
7. To take a leadership role in performance improvement activities;
8. To assume overall responsibility for quality of professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body;
9. To develop policies and procedures pertaining to the medical staff;
10. To assist the governing body in its annual evaluation of Levindale’s performance in relation to its mission, vision, and goals, and to prioritize and implement changes identified by the evaluation; and
11. To engage in other activities related to the above purposes, but not for the pecuniary profit or financial gain of the Medical Staff.

# ARTICLE IV

**MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

**Section 4.1 Nature of Medical Staff Membership**

Membership on the Medical Staff of Levindale is a privilege that shall be extended to qualified and competent professionals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, as well as in the Medical Staff Rules and Regulations and Policies and Procedures.

# Section 4.2 Qualifications for Membership/Clinical Privileges

1. To be a Member of this Medical Staff, individuals at a minimum must be licensed to practice medicine, dentistry, or podiatry in the State of Maryland. To obtain clinical privileges as an APP, a Practitioner must be licensed to practice his/her profession in the State of Maryland. All applicants must document their professional background, including experience, training, and demonstrated competence, in addition, they must provide evidence through references of their adherence to the ethics of their profession, their good reputation, their ability to work cooperatively with others, and their physical and mental status. All new applicants must successfully pass a drug test as part of their application.
2. Decisions regarding Medical Staff membership and clinical privileges shall not be based on age, sex, race, religion, creed, national origin, or any other criterion not related to the delivery of medical services.
3. No applicant for Medical Staff membership shall be entitled to membership or to exercise particular clinical privileges in Levindale merely because he/she is duly licensed to practice medicine, dentistry, podiatry, or other clinical specialties in this or any other state, or because he/she is certified by any clinical examining board, or because he/she is a member of any professional organization, or because he/she has had or now has such privileges at another hospital, or has previously had privileges at the Hospital, or because he/she resides in the geographic area of the Hospital.
4. In accepting membership on the Medical Staff, an individual must agree to abide strictly by the principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, or the Code of Ethics of the professional association to which the Practitioner belongs, as they may be amended from time to time.

# Section 4.3 General Conditions and Duration of Appointments

1. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on such appointments, after there has been a recommendation from the MEC, following the MEC’s review and approval of the Practitioner’s qualifications as provided in these Bylaws. In the event of delay on the part of the MEC, the Governing Body may act without such recommendation based on documented evidence of the applicant, or Staff Member’s, professional and ethical qualifications. Licensure shall be verified with the primary source at times of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration.
2. Effective January 1, 2013, new members of the Medical Staff must be eligible for certification by the appropriate specialty board in the area of their major clinical activities and must become certified by such board within five years after being considered eligible. All members of the Medical Staff must maintain certification in their specialty. In exceptional circumstances, a Division Head or the Medical Director may recommend to the MEC that an exception be made to the board eligibility, certification, or recertification requirement. If the MEC determines that an exception is warranted, the recommendation shall be brought before the Board, which shall have the final decision regarding the matter. Members of the Medical Staff who were credentialed prior to January 1, 2013 are exempt from this provision.
3. Initial appointment shall be for a period no longer than three years. Reappointment shall be for a period of no more than three years.
4. Appointment to the Medical Staff shall confer on the appointee only to the extent such clinical privileges have been granted by the Governing Body in accordance with these Bylaws. After initial appointment, requests for modification of clinical privileges may be made in accordance with these Bylaws.
5. Failure to pay Medical Staff dues within 30 days of the date on which payment is due shall be considered a voluntary resignation from the Medical Staff.

# Section 4.4 Conditions Surrounding Initial Appointments

1. An application for medical staff appointment must be submitted by the applicant in writing or electronically on the form recommended by the Medical Executive Committee and approved by the Board of Directors. The Maryland State Hospital Credentialing Application will be used for all initial appointments. An addendum with hospital-specific information may be collected from the applicant. In addition to the application, the applicant is required to provide the following:
	1. Current Curriculum Vitae indicating month/year of all affiliations;
	2. Delineation of Privileges form;
	3. Consent to Release Information form;
	4. Proof of current Maryland license;
	5. Proof of current Federal Drug Enforcement Agency (DEA) registration indicating a Maryland address; (if applicable) or submission of the Controlled Substance Prescribing Status form (CDS Attestation form);

The Credentialing Department will utilize an attestation form for all new applicants to acknowledge their prescribing status and intentions to prescribe at LifeBridge Health.

The form will be signed by applicants who either do not prescribe controlled substances or whose Maryland CDS and/or Federal DEA registrations are pending at the time of initial appointment. The form may also be used at reappointment and in the case of non-renewal of Maryland CDS or Federal DEA registration.

* 1. Proof of current Maryland Controlled Dangerous Substances (CDS) registration; (if applicable) or submission of the Controlled Substances Prescribing Status form (CDS Attestation form) see above;
	2. Proof of Board certification, if applicable;
	3. Proof of current malpractice insurance coverage in the amount of $1,000,000 per occurrence and

$3,000,000 aggregate as required by the Board of Directors;

(i) Code of Conduct attestation;

1. Written explanation of any gaps in professional career/clinical activity greater than three (3) months which occur after graduation from professional degree until the time of application; and
2. Written explanation of all malpractice actions regardless of payment made on behalf of the applicant.

Incomplete applications or applications that do not meet the minimum qualifications as set forth in Section 4.2(1) will be considered an “Incomplete Application” and will be processed in accordance to Section 4.4

1. herein.
2. The applicant agrees that any misrepresentation, misstatement, or omission from the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application. If an appointment has been granted prior to the discovery of such occurrence, upon the discovery of such occurrence the applicant shall be deemed to have voluntarily relinquished his/her Medical Staff appointment and/or clinical privileges. In such situations, there shall be no entitlement to any hearing or appeal rights as set forth in these Bylaws.
3. By applying for initial appointment to the Medical Staff, the applicant:
	1. Agrees to appear for interviews in regard to his/her application, if requested;
	2. Authorizes Levindale representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;
	3. Consents to the inspection by Levindale representatives of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out requested clinical privileges, and his/her professional and ethical qualifications for staff membership;
	4. Releases Levindale and all of Levindale’s representatives from any liability for their acts performed in good faith and without malice in connection with investigating and evaluating the applicant and his/her credentials;
	5. Releases all individuals and organizations which provide any information to Levindale representatives from any liability provided that they act in good faith and without malice concerning the applicant’s ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;
	6. Authorizes Levindale representatives to provide other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to the issues which concern these parties, and releases Levindale representatives from liability for so doing, provided that they do so in good faith and without malice;
	7. Agrees to produce or authorize the production of adequate information for a proper evaluation of his/her experience, background, training, licensure and registration to practice, liability insurance coverage, adverse professional liability history, professional or specialty disciplinary activity, continuing medical education, demonstrated ability, voluntary or involuntary surrender or limitation of licensure, physical and mental health status, and judgment;
	8. Agrees to review and be bound by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures and the Levindale Bylaws, Rules and Regulations, and Policies and Procedures, and any and all applicable professional codes of ethics, and applicable federal and state laws and regulations;
	9. Acknowledges his/her obligation to provide continuous supervision of his/her patients with care of the generally recognized professional level of quality and efficiency, agrees to accept committee assignments, and to accept consultation and educational assignments in accordance with the responsibilities which pertain to his/her category of the Medical Staff; and
	10. Agrees that, to the extent information is “Protected Health Information” as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under (“HIPAA”), it will comply with the requirements of HIPAA
4. Upon application for initial appointments, the LifeBridge Health Credentialing Department shall collect, primary source verify, review, and document, to the extent reasonably possible, all information received about the applicant. A reliable secondary source may be used in lieu of the primary source if the unsuccessful attempts to contact the primary source are documented in the applicant's file.

A detailed description of the responsibilities of the Credentialing Office is contained in the LBH Credentialing Procedures Manual.

(5) In addition, the Credentialing Department will query the applicable licensing agency in the State of Maryland, the National Practitioner Data Bank, and any 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. The Credentialing Department will query the Office of Inspector General, Medicare and Medicaid Sanctions and perform a criminal background check during the initial appointment process.

Licensure shall be verified at appointment, reappointment, the granting or renewal of clinical privileges, and any time that the license expires during an appointment cycle.

During the credentialing process, the Credentialing staff will contact the applicant in writing to discuss any variances from the information provided on the credentialing application.

The Credentialing Department will allow correction of said information via a letter from the applicant or addendum to the original application. This policy applies to both initial appointment and reappointment of medical staff membership and clinical privileges.

1. If information furnished in the application indicates that the application is an Incomplete Application as defined in Section 4.4, then the MEC shall notify the applicant in writing that the application cannot be considered until all of the information requested has been furnished. If the applicant has submitted an incomplete application, then that applicant shall not be entitled to any hearing or appeal as set forth in these Bylaws. Unless the applicant requests in writing further consideration of his application within 30 days after receipt of such notification, the application need not be considered further.
2. In all other circumstances, after receiving the completed application for Medical Staff membership, the Chief of Department/Division shall recommend the applicant for appointment to the Medical Director. The Medical Director shall present the completed application to the MEC for review. At the next regular meeting, the MEC shall review the application and make a report of its investigation to the Governing Body, including its recommendation that the Practitioner be appointed or rejected for Medical Staff membership or clinical privileges, or that his/her application is deferred for further consideration. Minority opinions shall be included. All recommendations to appoint must also specifically recommend the assigned Division and the tentative clinical privileges to be granted. The maximum period of time for consideration of a completed application for Medical Staff Membership by the MEC shall be 60 days, unless extended for good cause.

 (8) The Governing Board shall consider the MEC recommendation at its next meeting scheduled more than 15 days after receipt of the MEC’s recommendation. The Board shall, in whole or in part, adopt or reject a favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation shall be made. If the Board’s action is adverse to the applicant, the Levindale President shall promptly so inform the applicant by written notice.

1. Any recommendation of the Medical Executive Committee to defer the application for further consideration must be followed within 60 days by a subsequent recommendation for appointment or rejection of the applicant for Medical Staff membership.
2. The Quality Department will assist the Medical Director in development of specific guidelines for the focused professional practice evaluation of Members’ clinical competence and participation in Levindale 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 Levindale employees.

# Section 4.5 Procedures for Reappointment, Demotions and Failure to Reappoint

1. Approximately six months prior to expiration of Medical Staff appointment, the Credentialing Office will initiate the reappointment process.
	1. Those Medical Staff Members who wish to be considered for reappointment shall complete a LifeBridge Health Reappointment Application and return it to the LBH Credentialing Department within five monthsof the notice of reappointment. Applicants for reappointment are required to submit any reasonable evidence of current ability to perform privileges that may be requested. Any Member who does not wish to be considered for reappointment shall notify the MEC accordingly
	2. After receiving the completed application, the Credentialing Office will verify and document the following information about the applicant:

The Credentialing Department verifies the information provided on the reappointment application working with the same authorities and generally in the same manner as provided in Sections 4.4.4 and 4.4.5 for the initial application process. Peer references will be collected for faculty with insufficient activity. Current hospital affiliations, licensure, certification, NPDB, sanctions and malpractice claims history verification will be verified as per the procedure outlined in Sections 4.4.4 and 4.4.5. The Credentialing Department notifies the staff member, with a copy to the Medical Director, of any information, inadequacies or verification issues. This notice must indicate the nature of any additional information the staff member is to provide and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary resignation of appointment and all clinical privileges.

* 1. Appraisal for reappointment to the Medical Staff or renewal of clinical privileges is based on ongoing monitoring of information concerning the Practitioner’s professional performance, judgment, and clinical or technical skills. In conducting such appraisal, the Medical Director review the information listed in subsection (b) above, plus the following: performance improvement data, which shall be compared to aggregate information when appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills; utilization review data; risk management data; information about the Practitioner’s performance at other hospitals where that individual has privileges, from peers; and other pertinent information about the applicant’s performance, skills, adherence to the Medical Staff’s Bylaws, policies and procedures, working relationships with professional staff, completion of continuing medical education requirements prescribed by the State of Maryland, and participation in the Medical Staff’s committees and programs.
1. Based on this review, the Medical Director will recommend to the MEC reappointment as well as specified privileges for the reappointment term. Should the Medical Director decide not to recommend the reappointment of any Member, or to deny clinical privileges, he/she shall present a written statement to that effect, rather than merely omitting the name from his/her recommendations.
2. The MEC shall consider these recommendations. In doing so, the MEC may consider information provided by any source, including the Member under evaluation. Such information-gathering process shall be of an informal nature.
3. After completing its appraisal, the MEC shall make a report of its recommendations. The maximum period of time for consideration of a completed application for reappointment to the Medical Staff shall be 120 days. All recommendations to reappoint must also specifically recommend the assigned Division and the clinical privileges to be granted. These recommendations will be made to the Board at the next Board meeting. The Member may waive any requirement in this Section that the MEC act within a specified time, however in no event shall the acts of the MEC exceed six months even though such a delay may prevent final action on his/her reappointment by the beginning of the following Medical Staff year.
4. The Board shall act upon the recommendation of the MEC at its next scheduled meeting.
5. All Members seeking reappointment and the renewal of clinical privileges shall satisfy the Medical Staff professional criteria and the Division criteria, and the factors listed in Article IV, Section 4.2 (Qualifications for Medical Staff Membership). The following factors shall also be considered:
	1. results of Levindale’s performance improvement, ongoing professional practice evaluations, and other peer review activities;
	2. any focused professional practice evaluations;
	3. verified complaints received form patients and/or staff; and
	4. other reasonable indicators of continuing qualifications.

# Section 4.6 Delineation of Clinical Privileges

1. Every Practitioner at Levindale (by virtue of Medical Staff membership or otherwise) shall be entitled to exercise only those clinical privileges specifically granted to him/her by the MEC and approved by the Governing Body, except as provided in Sections 4.8 and 4.9 below.
2. Privileges shall be granted to APPs in accordance within the appropriate scope of practice.

# Section 4.7 Modification of Privileges

1. At any time after initial appointment a Medical Staff Member may request a modification of privileges. Such requests, which must be made in writing to the MEC, shall specify the scope of privileges requested and shall demonstrate good cause why such privileges should be granted. However, requests made within 120 days of renewal may be deferred and considered together with the renewal application, in the sole discretion of the Medical Director.
2. Appraisal for revision of clinical privileges is based on ongoing monitoring of information concerning the Practitioner’s professional performance, judgment, and clinical or technical skills. In conducting such appraisal, the MEC shall review performance improvement data, which shall be compared to aggregate information when appropriate for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. A modification request must contain all pertinent information supportive of the request and is processed according to the procedures outlined in Section 4.5.

Prior to MEC evaluation, verification with primary sources external to LifeBridge Health and compilation of such internal data as necessary to properly evaluate the request will be collected.

Verifications include:

* 1. State licensure
	2. National Practitioner Data Bank (NPDB)
	3. Medicare/Medicaid Sanctions (OIG)

A staff member who determines to no longer exercise a particular privileges which he has been granted shall send written notice to the Medical Director indicating same and identifying the particular privileges involved and, as applicable, the restriction or limitation. This notice shall be included in the member's credentials file.

1. The MEC shall make a recommendation to the Governing Board concerning such request no later than 45 days after the request is made. The Board shall make a final determination regarding the modification of privileges at is next scheduled meeting.

# Section 4.8 Temporary Privileges

1. Upon written recommendation of the Medical Director, and in accordance with the conditions set forth in this Section 4.8, the President of Levindale (or their Designee) may grant temporary clinical privileges. Temporary clinical privileges shall not exceed 120 days.
2. Conditions:
	1. The process of granting temporary privileges requires completion of the approved credentialing application and Levindale privilege request form. Verification will include:
		1. Maryland license and/or registration, DEA registration, state CDS registration, completion of professional degree (MD/DO/DDS, etc.,) post-graduate education (residency and fellowship), current ability to perform privileges requested (via reference evaluation from primary hospital Department Chair or Medical Director), evidence of malpractice insurance coverage indicating coverage of at least $1 million/$3 million,
	2. Before temporary privileges are granted, the Practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws and Rules and Regulations, and that he/she agrees in writing to be bound by the terms thereof in all matters relating to his/her temporary privileges.
	3. The applicant must not be the subject of a current, or previous challenge that resulted in:
		1. the suspension or loss of his/her licensure or registration;
		2. the involuntary termination of medical staff privileges at another organization; or,
		3. the involuntary limitation, reduction, denial, or other loss of clinical privileges.
	4. Temporary privileges may be granted for limited purposes such as, limiting the treatment to specific patients and/or making the privileges is subject to specific and defined supervision and reporting requirements.
	5. The granting of temporary privileges does not constitute appointment to the Medical Staff a denial of a request for temporary privileges does not entitle a Practitioner to any hearing or appeal procedures.
3. Termination:

The Levindale Medical Director or designee may terminate a Practitioner’s temporary privileges, without right of appeal, at any time. If a patient’s life or wellbeing is determined to be endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose precautionary suspensions under these Bylaws. In the event of any such termination, the Practitioner’s patients who are still at Levindale shall be transferred to another Practitioner by the Medical Director.

# Section 4.9 Emergency/Disaster Privileges

In case of an emergency, any Member of the Medical Staff, volunteer practitioner or a properly supervised APP, to the degree permitted by his/her license, and regardless of staff status, shall be permitted to perform necessary emergency treatment, provided to save the life of a patient or to prevent patient from suffering serious harm, using every facility of the institution necessary, including the calling for any consultation necessary or desirable. The volunteer practitioners addressed by this process only include those that are required by law and regulation to have a license, certification, or registration to practice their profession. The volunteer practitioners at the time of the disaster will be identified by a badge supplied by the facility as Disaster Volunteer.

When such emergency situation ends, such Practitioners must either have or request the privileges necessary to continue to treat the patient. If such privileges are denied or such Practitioner does not desire to request privileges, the patient shall be admitted to an appropriate Member of the Medical Staff. Primary source verification, certification, or registration begins as soon as the immediate situation is under control and completed within 72 hours or in extraordinary circumstances ASAP. In extraordinary circumstances, there must be documentation of the following: why primary source could not be performed in required time frame; evidence of demonstrated ability to continue to provide adequate care, treatment and services, and an attempt to rectify the situation ASAP. The organization will make a decision within 72 hours or as soon as possible relating to continuation of the disaster responsibilities initially assigned**.** For purposes of this section, an “emergency” is defined as a 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.

In the event of a severe disaster (i.e. chemical spill, bioterrorism, flood, etc.) in which the facility’s Disaster Plan has been activated, the President (or their designee), on recommendation of the Levindale Medical Director may grant disaster privileges to the individuals as mentioned above of known reputation and quality who hold medical staff memberships at other fully accredited institutions. This will be granted on a case by case basis and based upon receipt of the following:

* At a minimum a valid government issued photo identification issued by the state or federal government (e.g. Drivers license or passport) and at least one of the following:
* A current healthcare picture ID that clearly identifies professional designation
* A current license, certification, or registration
* Primary source verification of licensure, registration, or registration required to practice a profession
* ID indicating the individual is a member of a Disaster Medical Assistance Team
* ID indicating the individual has been granted authority to render resident care, treatment, and services in disaster circumstances
* ID by current organization(s) who possess personal knowledge regarding the volunteer's qualifications

Even in a disaster, the integrity of two parts of the usual process for determining qualifications and competence must be maintained:

* Verification of licensure, certification, or registration required to practice a profession
* Oversight of the care, treatment, and services provided

# Section 4.10 Telemedicine Privileges

1. 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 MEC will make recommendations to the board for consideration of clinical services to be provided through telemedicine.
2. Individuals providing telemedicine services will be credentialed and privileged in accordance with this Article IV as any other independent licensed practitioner. In addition, the contractual arrangement that authorizes the practitioners to provide services at the hospital will address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

# Section 4.11 Leave of Absence

1. A leave of absence means that a Medical Staff Member is excused from the duties assigned to him/her by virtue of his appointment to the Medical Staff however, status as a Member shall be maintained while on leave. During a leave of absence a Member shall not: a) be permitted to vote; b) be required to pay dues; c) have the right to admit patients; nor d) be called on for consultation.
2. A request for a leave of absence must be in writing and be addressed to the Medical Director.
3. The MEC may grant the leave of absence.
4. A leave of absence shall not extend beyond one year. Any Member who is granted a leave of absence in order to serve on active duty in the military service and is eligible for reappointment shall be duly reappointed and granted a leave of absence for each year he/she continues to serve on active duty. Any other Member who wishes to extend his/her leave of absence beyond one year must be reappointed to the Medical Staff and apply for a new leave of absence.

# ARTICLE V MEMBERSHIP

**Section 5.1 Categories**

The Medical Staff shall be divided into Active, Consulting and Affiliate categories.

# Section 5.2 Active Staff

 The active Medical Staff shall be members of the staff who will consist of healthcare providers licensed to practice under Maryland law. Physicians, Nurse Practitioners and Physician Assistants are eligible for membership on the Active Medical Staff. Members of the active Medical Staff are involved in the care of patients including treating, admitting, or referring. Members of the Medical Staff may vote on all matters presented at general and special meetings of the medical staff and Medical Staff committees of which he/she is a Member.

# Section 5.3 Consulting Staff

The Consulting Staff shall consist of Physicians, Physician Assistants, Nurse Practitioners, Dentists, and Podiatrists, each of whom meet the basic qualifications set forth in Section 4.2 of these Bylaws. Consulting Staff Members are practitioners, who, by experience, reputation or needed specialty, are recognized as experts in their field of specialty. The consulting staff provide services at the request of the active medical staff to render clinical services within their area of competence. Consulting staff may write orders but may not admit patients to the hospital.

Section 5.4 Affiliate Staff

The Affiliate Staff shall consist of licensed professionals who are members of the Medical Staff who do not wish to provide direct care to patients or conduct any other clinical activity in the facility, but who wish to have ties to the facility and its Medical Staff. The Affiliate Staff shall not hold clinical privileges, including the ability to write orders or make entries in the medical record.

# ARTICLE VI RESIDENT/TRAINING STAFF

Members of the Resident/Training Staff will function pursuant to a job description approved by Levindale. To perform services within the scope of their job description, members of the Resident/Training Staff need not be, and will not be eligible to become, Active Members of the Medical Staff. Except as provided in this Article, members of the Resident/Training Staff will be bound by the provisions of these Bylaws, as well as the Medical Staff Rules and Regulations and policies, specifically the House Staff Prerogatives and Responsibilities Policy. The Resident/Training Staff shall be governed by the appointment and credentialing, provisions of these Bylaws and the MEC shall ensure that the credentials of Resident/Training Staff members are verified prior to their performing services at the Hospital. Their privileges will, however, automatically terminate upon termination of their employment or contract, without right of appeal as set forth in these Bylaws but pursuant to the terms set forth within their employment contract.

In certain circumstances, a member of the Resident/Training 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 individual involved must become a Member of the Medical Staff and secure delineated clinical privileges in accordance with these Bylaws.

# ARTICLE VII CORRECTIVE ACTION

**Section 7.1 General**

1. When the activities or professional conduct of a Practitioner are considered to be below the standards of the Medical Staff, a recommendation for corrective action such as suspension, expulsion, or limitation of a Practitioner’s clinical privileges and/or Medical Staff membership may be made to the Board through the recommendation of the MEC. A recommendation for corrective action may be initiated by the MEC or made to the MEC by the Medical Director, by an officer of the Medical Staff, the Chair of any Medical Staff committee, the Levindale President, or the Board.
2. A written recommendation for corrective action is to be forwarded to the Medical Director, and the Levindale President. The recommendation shall include a description of the specific activities or conduct, which constitute the grounds for the request.
3. The Chairman 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.
4. The MEC will consider the recommendation for corrective action at its next regular meeting or at a meeting called for that purpose, but no later than 30 business days after the receipt of the recommendation. The MEC will review the recommendation to determine what action, if any, is necessary.
5. The MEC may, at its discretion, order a further investigation of the matter. The MEC may request the Medical Director, or another individual or committee selected by the MEC to conduct the investigation. The designated party will investigate the matter and, within 15 business days of receiving the request from the MEC, make a written report on the matter to the MEC. The report of the investigating individual will be reviewed by the MEC as soon as possible after receipt, but no later than its next regular meeting or at a meeting called for that purpose, but no later than 30 business days after the MEC received the recommendation for corrective action.
6. If the involved Practitioner wishes, he/she may appear before the MEC and make an oral statement to the MEC. The Practitioner may not be represented by counsel, must limit his/her statement 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.
7. 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 reports, any Medical Staff or Division Head’s files, and any written statement of the Practitioner.
8. If the MEC determines that corrective action is necessary or desirable, it will make a recommendation to the Board. 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 Levindale.
9. When a final decision is made by the Board, the President shall notify the Practitioner, in writing by certified mail, return receipt requested, of the action of the Board.
10. The MEC may suspend or limit a Practitioner’s clinical privileges, without approval of the Board, 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, but in no event longer than 10 working days, to consider the matter in accordance with the procedures contained in this Section, and make a recommendation for final action to the Board.
11. This Section does not apply when a recommendation for limitation or modification of a Practitioner’s clinical privileges occurs during the reappointment process.
12. Except as provided in Section 7.2(2) of this Article (Medical Records Suspension), the Medical Director will plan 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.

# Section 7.2 Suspensions

1. Automatic Suspension
	1. A Practitioner’s clinical privileges will be automatically suspended on the occurrence of any of the following events:
		1. revocation or suspension of a Practitioner’s license;
		2. revocation or suspension of a Practitioner’s state or federal registration to administer drugs, unless such registration is not required by the relevant Division or otherwise approved by the MEC; or
		3. failure of a Practitioner to maintain professional liability insurance in the amounts required by Levindale.
	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 Levindale or his/her designee will immediately notify the Practitioner in writing, by certified mail, return receipt requested, or by hand delivery, that his/her clinical privileges are suspended.
	3. If the Practitioner’s professional license, drug registration, or insurance coverage is restored, the Board may, upon the recommendation of the MEC, reinstate a Practitioner whose privileges have been suspended pursuant to Section 7.2(1)(a).
2. Medical Records Suspension

A Practitioner’s clinical privileges may be temporarily suspended pursuant to these Bylaws when the Practitioner fails to complete his/her medical records in accordance with the Levindale Medical Records Completion Process Policy. If a Practitioner’s clinical privileges are suspended pursuant to this Section 7.2(2), he or she may ~~not~~ continue to treat his or her patients already in the Hospital, but may not admit patients or provide consultation until the suspension has been lifted. If medical records remain incomplete after an extended period determined in the Levindale Medical Records Process, the MEC may consider this a voluntary resignation of privileges.

1. Summary Suspension
	1. Whenever extraordinary circumstances suggest that precautionary action is in the best interest of patients and Levindale, the following persons or entities each may summarily suspend or limit a Practitioner’s clinical privileges:
		1. the Governing Board;
		2. the Levindale President;
		3. the MEC;
	2. The suspension or limitation will be effective immediately upon either written or verbal notice to the involved Practitioner, which will be given by the Levindale President, with a copy to the MEC. In the event verbal notice is given, a written notice by certified mail, return receipt requested, will be sent immediately to the Practitioner, with a copy to the MEC.
	3. The MEC may, in its discretion, order an investigation of the matter. The MEC may designate an individual affiliated with Levindale, 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 working 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 Division Head; medical records; Medical Staff and Division files; and any written statement of the Practitioner.
	5. The MEC will then make a recommendation to the Levindale President regarding whether 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 ten business days from the date of the suspension.
	6. The Levindale President shall accept, reject, or modify the recommendation of the MEC within three business days of receiving the MEC’s recommendation. The decision of the President of Levindale will be forwarded to the involved Practitioner and the Board Chair, in writing by certified mail, return receipt requested with a copy to the MEC.
	7. The Board or the Levindale President will have the authority to revoke or modify the terms of any summary action at any time.
	8. Immediately upon the imposition of a summary suspension, the Medical Director shall have the authority to provide for alternate medical care of the patients formerly under the suspended Practitioner’s care. To the extent possible, the wishes of the patients/residents will control in the selection of such alternative Practitioner.

# Section 7.3 Action Taken Against a Medical-Administrative Officer

1. The clinical privileges and Medical Staff membership of a medical-administrative officer shall be considered separate and distinct from his functions as an administrative official.
2. Any action taken against a medical-administrative officer regarding administrative duties shall follow LifeBridge Health Human Resources policies, and shall be considered separately from any actions regarding clinical privileges or corrective actions concerning those privileges.

# ARTICLE VIII

**HEARING AND APPELLATE REVIEW PROCEDURE**

**Section 8.1 Right to Hearing**

1. When an Adverse Action (as defined below) is taken with respect to the requested or existing clinical privileges and/or Medical Staff membership of a physician, dentist, or podiatrist, the Levindale President 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) therefore, and a copy of the procedural rights set forth in this Article VIII if the Practitioner is so entitled.
2. Notwithstanding anything to the contrary contained in this Section, the following suspensions, if greater than fourteen business days, will be considered an Adverse Action for purposes of this Article VIII: suspension by the MEC pursuant to Section 7.1(10); or summary suspension pursuant to Section 7.2(3).
3. Upon any change in the status of the Member or the Member’s privileges, the right to hearing and appeal shall be as set forth in these Bylaws.
4. The following actions, when taken by the Board, shall be considered Adverse Action:
	1. Denial of initial Medical Staff appointment;
	2. Denial of Medical Staff reappointment, or denial of 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. Suspension or revocation of Medical Staff appointment;
	5. Suspension or revocation of clinical privileges;
	6. Involuntary limitation or reduction of clinical privileges;
	7. Involuntary imposition of a consultation requirement or a transfer of medical care requirement, co-admission requirement, or monitoring requirement; and/or
	8. Involuntary imposition of a counseling requirement or the involuntary transfer of a patient, in the event of a determination of Practitioner impairment.

Notwithstanding the above, Adverse Action shall not include:

1. Any action based on a Practitioner’s submittal of an Incomplete Application;
2. Denial, limitation, or revocation of temporary privileges;
3. Suspension for failure to timely complete medical records under Section 7.2(2);
4. Loss of privileges due to noncompliance with attendance requirements;
5. Denial or revocation of clinical privileges or Medical Staff membership based on the termination of an employment contract;
6. An automatic suspension under Section 7.2(1); and/or, a decision by Levindale not to employ or hire as an independent contractor or Consultant.
7. Any Practitioner for whom this Article may apply shall be required to exhaust all administrative remedies set forth in this Article VIII prior to seeking any legal remedy outside of this organization. Within 30 days from the date of the notice set forth in Section 8.1(1), the affected Practitioner may exercise his/her rights under this Article VIII by submitting a written request for a fair hearing to the Levindale President, who shall notify the Levindale Board Chair of the request. Failure of the Practitioner to timely request a Fair Gearing will be deemed a waiver of his/her right to such hearing and to any Appellate Review and a waiver of his/her right to seek any other legal remedy against Levindale.
8. The Practitioner’s request for a Fair Hearing will not delay imposition of the action taken by the Board or any action taken pursuant to this Section.

# Section 8.2 Appointment of Hearing Officer/Committee

1. Upon receipt of a request for hearing properly made under Section 8.1(5), The Levindale

President 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; (i) members of the Medical Staff (as further next described), and/or (ii) 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 Committee” will be substituted for all references to “Hearing Officer” in these Bylaws, unless the context clearly indicates otherwise.

1. At the request of the Hearing Committee Chair, 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 Ad Hoc Hearing Committee and will not have a vote.
2. 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 Ad Hoc Hearing Committee. This Medical Advisor may be a Member of the Medical Staff.

# Section 8.3 Hearing Procedures

1. The decision of the Board and the bases therefore will be presented to the Hearing Committee by a representative of the Hospital selected by the Levindale President. This individual may not be an attorney but may be a physician, 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 30 business days before the Fair Hearing.
2. The Practitioner may not be represented at the Fair Hearing by legal counsel but may be represented, 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 30 business 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.
3. 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 30 or more than 60 business 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 business 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.
4. The Fair Hearing will be conducted in accordance with the following procedures:
	1. The involved Practitioner and the Hospital will have the right:
		* to call witnesses and to introduce evidence;
		* to cross-examine adverse witnesses;
		* to review all documents and recommendations upon which the decision was based; and
		* 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 Governing Board 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.
5. Within 15 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. A copy of the report will also be sent to the involved Practitioner.
6. If the Hearing Committee’s report and recommendations are inconsistent with the action taken by the Governing Board then 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 Levindale President shall provide notice to the involved Practitioner, which shall include the right to Appellate review.

# Section 8.4 Appellate Review

1. Within 10 business days from the date the report of the Fair Hearing Committee is forwarded to the Board and the affected Practitioner, the Practitioner may request Appellate Review by the Board by delivering a written request for such review to the Levindale President. If Appellate Review is not requested within this period, the Practitioner will have waived any right to such review.
2. Upon receipt of a timely request for appellate review, the Levindale President will deliver the request to the Chair of the Board. The Chair or his/her designee will promptly schedule and arrange for an Appellate Review. The Chair of the Board will appoint an Appellate Review committee of at least three members of the Governing Board, one of who will be appointed as the Chair.
3. An Appellate Review for a Staff Member who is under suspension and who so requests will be held as soon as the arrangements for it can reasonably be made. At least 15 working days before the appellate review, the Levindale President, on behalf of the Board, will send the affected Practitioner notice of the date, time and place of review.
4. Appellate Review Procedure
	1. The proceedings by the Appellate Review Committee will 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 MEC, 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 MEC; 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 Fair Hearing Committee was incorrect (i.e., that the Adverse Action of the Board 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 Fair 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 within 15 business days of completion of the appellate review process. The Appellate Review Committee may recommend that the Board 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.

# Section 8.5 Final Decision of the Governing Board

The Appellate Review Committee will forward its written report and recommendations to the Board for final action. The Board 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. 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 30 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.

# Section 8.6 Limitations on Number of Hearings and Appeals

Regardless of the means by which the action adversely affecting a Practitioner is taken, no individual shall be entitled to more than one Hearing and one Appeal in connection with any particular action or any group of actions based upon a common set of facts. If the Board determines to deny initial Medical Staff appointment or reappointment, or to revoke the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for Medical Staff appointment or for the denied clinical privileges for a period of two years unless the Board provides otherwise.

# ARTICLE IX

**IMPAIRED PRACTITIONER HEALTH**

**Section 9.1 General Policy**

1. An impaired Practitioner is one whose performance, effectiveness and dependability to practice medicine are impaired because of a psychological or emotional crisis, mental illness, behavioral or social adjustment, substance abuse or cognitive deterioration resulting from disease, aging or accident.
2. Whenever a Practitioner is suspected of being impaired, or is suspected of providing unsafe treatment, a confidential report of the facts and Practitioner behavior, which led to such suspicion, shall be made to the Medical Director. A Practitioner may also self-report impairment to the Medical Director.
3. The Medical Director shall report allegations or self-referrals of potential impairment to the MEC, which shall review the complaint and make a determination as to the veracity of the complaint or severity of the behavior within 30 days of receipt of the complaint or self-referral. Upon a determination by the MEC of Practitioner impairment, the MEC shall attempt to intervene with and assist an impaired Practitioner while maintaining the safety and quality of care to all patients. Notwithstanding any legal or administrative requirements to report such findings to applicable regulatory agencies, each individual privy to information about, a Practitioner’s potential impairment shall be made aware of the standard held at Levindale to maintain such information confidential.
4. Within 30 days of receipt of the complaint or self-referral, and upon a determination of Practitioner impairment, the MEC shall recommend to the Board a course of action to be taken with respect to the impaired Practitioner, which may include, but is not limited to the following: taking no action, further investigation, or confronting the Practitioner informally or formally with an offer of assistance and/or a demand for a change of behavior. The MEC may also recommend that the Practitioner seek professional counseling, either through the Employee Assistance Program, the Medical and Chirurgical Faculty of Maryland Physician Rehabilitation Program, or another outside specialist. The MEC shall also make a recommendation to the Board concerning whether the Practitioner may maintain clinical privileges, whether such privileges require modification, or whether such privileges shall be suspended or terminated.
5. Within 30 days of receipt of the recommendation of the MEC, the Board shall make the final determination as to what course of action is appropriate, and whether the Practitioner may maintain clinical privileges, whether such privileges require modification, or whether such privileges shall be suspended or terminated. If counseling is mandated, the Practitioner shall consent to release to the MEC a report of the counselor’s findings and recommendations, as well as the Practitioner’s progress.
6. A copy of the complaint, findings, and recommendations of the MEC, as well as any action taken by the Board, shall be made part of the Practitioner’s permanent credentialing record.

# Section 9.2 Corrective Action

If the MEC determines that corrective action is necessary, such action shall be taken in accordance with the Corrective Action Procedures set forth in these Bylaws.

# Section 9.3 Reappointment

After the conclusion of any mandated counseling and/or treatment, the Practitioner may appeal to the MEC to have his/her original clinical privileges reinstated. If the Practitioner’s privileges were terminated or suspended, he/she may re-apply for initial appointment the Medical Staff. When making a determination regarding reappointment of an impaired Practitioner, the MEC and/or Board shall consider the criteria required for reappointment to the Medical Staff, as well as the safety of Levindale patients and staff, the physician’s progress in any treatment program, and the physician’s success with respect to rehabilitation of the impairment. All recommendations to reappoint shall specifically identify the clinical privileges to be granted, which may be qualified by conditions.

# Section 9.4 Confidentiality

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

# ARTICLE X OFFICERS

**Section 10.1 Officers of the Medical Staff**

The Medical Director shall be appointed by Hospital leadership. The Levindale President shall nominate an individual to serve as the President of the Medical Staff, who shall be confirmed by a majority vote of the Active Staff Members present at a Medical Staff meeting. All nominees for the President of the Medical Staff shall abstain from voting in the election. The President of the Medical Staff is the single officer of the Medical Staff and shall be an Active Staff Member at all times. The President of the Medical Staff and Medical Director are titles that may refer to a single individual.

# Section 10.2 Term of Office

The President of the Medical Staff shall serve for a three-year term, which may be renewed, his/her successor is nominated by the Levindale President.

# Section 10.3 Duties of President of the Medical Staff

The President of the Medical Staff shall:

* 1. help coordinate the activities and concerns of the Levindale administration and of the nursing and other patient care services with those of the Medical Staff;
	2. communicate the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Governing Body, the Levindale President, and other officials of the staff;
	3. attend meetings of the Board and, upon request, may attend meetings of the Board of the parent organization of Levindale to represent the interests of the Medical Staff;
	4. be responsible for enforcing Medical Staff Bylaws and Rules and Regulations, for implementing sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
	5. serve as Chairman of the MEC, with full power to vote on any all matters concerning the Medical staff, except for the election of the President of the Medical Staff;
	6. appoint Medical Staff Members to the various committees, including the MEC, and appoint committee chairmen;
	7. receive and clarify the policies of the Governing Body regarding the performance of the Medical Staff in its exercise of its responsibilities to provide, and maintain the quality of, medical care; and
	8. ensure medical staff participation in performance improvement activities.

# Section 10.4 Removal of Officer or MEC Member

On petition of 1/3 of the Active Staff 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, (a) failure to perform the duties of the office or the position in an appropriate manner (b) failure to comply with applicable policies, Bylaws, or Rules and Regulations; (c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or (d) an infirmity that renders the individual incapable of fulfilling the duties of that office or position. A ballot for approval or disapproval of this petition will be sent to all Active Staff Members within one week of receipt of such petition by the person initiating the petition. 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.

# ARTICLE XI SERVICES

**Section 11.1 Organization of Services**

The medical services and professional staff of Levindale shall be categorized into Clinical Divisions. Divisions shall be established or removed, as needed, by the Medical Director with the approval of the Medical Executive Committee. Divisions shall be as follows: (a) Medicine (b) Psychiatry (c) Physical Medicine & Rehabilitation (d) Podiatry (e) Dentistry (f) Orthopedic (g) Pulmonology, (h) Cardiology (i) Otolaryngology, and (j) Urology.

# Section 11.2 Qualification, Selection, and Tenure of Division Heads

1. Each Division Chief, should one be deemed necessary shall be a Member of the Medical Staff qualified for the position by the standards established by the Medical Director and shall be board certified in their specialty. Board certification by an appropriate specialty board may be waived by the Board upon a determination that the individual possesses comparable competence.

# Section 11.3 Functions of Division Chiefs

Each Head of Division Chief is responsible for the following:

1. all clinically related activities of the Division;
2. all administratively related activities of the Division, including implementation of actions taken by the MEC and/or Board, unless otherwise provided for by Levindale;
3. enforcing Levindale’s bylaws and personnel policies, and the Medical Staff Bylaws and Rules and Regulations within the Division;
4. continuing surveillance of the professional performance of all individuals in the Division who have delineated clinical privileges;
5. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Division;
6. recommending clinical privileges for each Member of the Division;
7. assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the Division or Levindale;
8. the integration of the Division into the primary functions of Levindale;
9. the coordination and integration of interdivisional and intra divisional services;
10. the development and implementation of policies and procedures that guide and support the provision of services;
11. the recommendations for a sufficient number of qualified and competent persons to provide care or service;
12. the determination of the qualifications and competence of Division or service personnel who are not licensed independent Practitioners and who provide patient care services;
13. the continuous assessment and improvement of the quality of care and services provided;
14. the maintenance of quality control programs, as appropriate;
15. the orientation and continuing education of all persons in the Division;
16. recommendations for space and other resources needed by the Division;
17. the teaching, education, and research program in the Division; and
18. assisting in the preparation of such annual reports, including budgetary planning, may be required by the Medical Executive Committee, the Medical Director, the Levindale President, or the Board.

# ARTICLE XII COMMITTEES

**Section 12.1 Medical Executive Committee**

1. The MEC shall be made up of the Medical Director, Medical Director Post-Acute Physician Partners (PAPP), senior leadership, Division Chief(s) and may consist of other licensed independent practitioners of the Medical and Adjunct Staff as shall be appointed by the Medical Director. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee. The Levindale President will regularly attend the MEC as a non-voting member. The majority of voting Medical Executive Committee members are fully licensed physicians actively practicing in the hospital.
2. The MEC shall make recommendations directly to the Governing Body.
3. The duties of the Medical Executive Committee shall be to:
	1. represent and be empowered to act on behalf of the Medical Staff and between meetings for the organized Medical Staff, subject to such powers as may be set forth in these Bylaws;
	2. coordinate the activities and general policies of the medical service;
	3. review, revise and enforce policies of the Medical Staff not otherwise the responsibility of the Divisions;
	4. recommend action to the Levindale President on medical-administrative matters;
	5. enforce the Medical Staff’s responsibility for the medical care rendered to patients in the Hospital, including review of patient medical records and all policies and procedures designed to ensure that such records are maintained in accordance with appropriate industry standards, and utilization review activities;
	6. review the credentials of all applicants and make recommendations relating thereto to the Board for Medical Staff membership, and delineation of clinical privileges;
	7. review periodically all information available regarding the performance and clinical competence of Medical Staff Members, and make recommendations for reappointments and renewal of, or changes in, clinical privileges;
	8. review the mechanism used to review credentials and to delineate clinical privileges;
	9. review the mechanism for terminating Medical Staff privileges, including the mechanism for hearing and appeal procedures;
	10. take all reasonable steps to ensure professional and ethical conduct, and competent clinical performance, on the part of all Members of the Medical Staff, including the initiation of or participation in Medical Staff corrective or review measures when warranted;
	11. approve and then make recommendations to the Board, regarding all performance improvement activities of the Medical Staff, including the conduct, evaluation, and revision of such activities;
	12. appoint special or ad hoc committees for special functions;
	13. receive and act upon Medical Staff committee reports, including the Quality Oversight Committee and
	14. review these Bylaws and the Rules and Regulations at least annually and recommend revisions as necessary.
	15. requests evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.
4. The Medical Executive Committee shall meet at least 10 months per year.
5. The Levindale President shall attend MEC meetings on an ex-officio basis, without vote.

# Section 12.2 Other Committees

The following professional committees shall consist of Members of the Medical Staff appointed by the Medical Director Levindale professionals as appropriate or required by state, federal, or other regulations. The Chair of each committee shall be named by the Medical Director. A non-physician member may co- chair any committee, at the discretion of the Medical Director.

1. LifeBridge FormularyCommittee
	1. The committee shall develop and oversee all drug utilization policies and practices within the Hospital and strive for optimum clinical results and a minimum potential for hazard. The committee shall help formulate broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, and all other matters relating to drugs. It shall also advise Levindale’s Medical Staff and the pharmacist on these matters.
	2. Levindale is represented on the LifeBridge Formulary Committee by the Director of Levindale Pharmacy or Designee
	3. The committee shall meet at least quarterly.
2. Infection Control Committee
	1. The committee shall oversee the surveillance for inadvertent infection potential, review and analyze actual infections, promote a preventive and corrective program designed to minimize infection hazards, and supervise infection control in all phases of the Hospital’s activities.
	2. The committee shall consist of representatives from Levindale’s Medical Staff appointed by the Medical Director and other Levindale professionals as appropriate or required by state, federal, or other regulations.
	3. The committee shall meet at least quarterly.
	4. The committee is intended to be a Medical Review Committee as defined by the Health Occupations Article of the Annotated Code of Maryland, §1-401
3. Quality OversightCommittee
	1. The committee shall function to oversee all professional clinical staff conduct to assure a high standard of care for Levindale patients. The committee shall report to the MEC, Performance Oversight Committee, and to the Board.
	2. The committee shall:
		1. ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the Medical Staff provides leadership for the process measurement, assessment, and improvement with respect to at least: medical assessment and treatment of patients; use of medications; use of blood and blood components; use of operative and other procedures; efficiency of clinical practice patterns; and significant departures from established patterns of clinical practice;
		2. ensure that the Medical Staff participates in the measurement, assessment, and improvement of other patient care processes, including: education of patients and families; coordination of care with other Practitioners and Levindale personnel, as relevant to the care of an individual patient; and accurate, timely, and legible completion of patients/residents medical records;
		3. ensure that when the findings of the assessment process are relevant to an individual’s performance, the Medical Staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent Practitioner’s competence, in accordance with the standards for renewing or revising clinical privileges set forth in these Bylaws;
		4. ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff Members; and
		5. ensure that the Medical Staff, with other appropriate Hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed.
	3. The committee shall consist of representatives of Levindale’s Medical Staff who are appointed by the Medical Director and other Levindale professionals as appropriate or required by state, federal, or other regulations.
	4. The committee shall meet at least monthly.
	5. The committee is intended to be a Medical Review Committee as defined by the Health Occupations Article of the Annotated Code of Maryland, §1-401
4. Special or Ad Hoc Committees. The Medical Director may establish any additional committees, which may be necessary to address issues relevant to the functioning of the Medical Staff or to care of patients of the Hospital.

# ARTICLE XIII MEDICAL STAFF MEETINGS

**Section 13.1 Regular Meetings**

1. Medical Staff meetings shall be held periodically to review, analyze, and evaluate the performance of the Medical Staff, to consider and act upon committee reports, and to consider and act upon such other matters as may be appropriate to a hospital medical staff.
2. The Medical Executive Committee shall, by standing resolution, designate the time and place for all regular Medical Staff meetings. Notice of the original resolution, and any changes thereto, shall be provided to each Member of the Medical Staff.

# Section 13.2 Special Meetings

1. The Chief Medical Officer, or the MEC, or not less than one-fourth of the Members of the Active Medical Staff may, at any time, file a written request with the Chief Medical Officer to call a special meeting of the Medical Staff. The MEC shall designate the time and place of any such special meeting, which shall be held within 14 days of the Medical Director’s receipt of the request for a special meeting.
2. Written notice stating the place, date, and time of any special meeting of the Medical Staff shall be delivered either personally or by mail to each Member of the Active Staff, not less than three days before the date of such meeting, either by or at the direction of the Medical Director or other persons authorized to call the meeting. Notice may also be sent to other Medical Staff Members who have so requested. No business shall be transacted at any special meeting except that described in the notice calling the meeting.

# Section 13.3 Quorum

One third or at least two of the Active Staff Members present at any regular or special meeting to constitute a quorum for all purposes.

# Section 13.4 Special Attendance Requirements

A Practitioner whose patient’s clinical course is scheduled for discussion at a regular Medical Staff meeting shall be so notified and shall be expected to attend such meeting even if such Practitioner is not otherwise required to attend that Medical Staff meeting.

# ARTICLE XIV COMMITTEE AND DIVISION MEETINGS

**Section 14.1 Regular Meetings**

Committees shall designate the time and place for all regular meetings. Notice of the regular meetings shall be provided to each member of the committee.

# Section 14.2 Special Meetings

A special meeting of any committee may be called by, or at the request of, the chair thereof, by the Medical Director or by one-third of the group’s current Members (but not less than two).

# Section 14.3 Notice of Meetings

Written notice stating the place, date, and time of any special meeting or of any regular meeting not held pursuant to resolution shall be provided to pertinent Medical Staff Members.

# Section 14.4 Quorum

One third or at least two of the Active Staff Members of a committee shall constitute a quorum at any meeting, excluding Quality Oversight Committee and Infection Control Committee.

# Section 14.5 Manner of Action

The action of a majority of the Members present at a meeting of a committee at which a quorum is present shall be the action of that committee. Action may be taken without a meeting by unanimous consent in writing setting forth the action so taken, signed by each member of the committee entitled to vote.

# Section 14.6 Rights of Ex-Officio Members

Persons serving under these Bylaws as ex-officio members of a committee shall have all the rights and privileges of regular Members, unless otherwise specified.

# Section 14.7 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members. The minutes shall be signed by the person designated to take such minutes and copies thereof shall be submitted promptly to the committee members and to the Medical Office. The minutes of the meetings of such committee shall be retained in a permanent file.

# ARTICLE XV DOCUMENTATION

A medical history and physical examination must be completed and documented for each patient in the chronic hospital no more than 7 days before or 24 hours after admission or registration. The history and physical examination must be completed by a qualified physician, or other qualified licensed individual in accordance with Maryland law and the Medical Staff Rules and Regulations and the policies identified therein. (For minimum content of medical histories and physical examinations, See Rules and Regulations, Article V, Attending Physician Requirements for New Admissions).

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 7 days before admission. The updated examination of the patient, including any changes in the patient’s condition, must be completed by a physician or other qualified licensed individual in accordance with the Maryland law and the Medical Staff Rules and Regulations and the policies identified therein.

For the nursing home facility, a medical history and physical must be completed and documented for each patient within 48 hours of admission.

Nurse Practitioners and Physician Assistants may pronounce death and record the death certificate. All deaths must be documented in the Medical Record by the pronouncing practitioner.

# ARTICLE XVI IMMUNITY FROM LIABILITY

The following shall be express conditions of any application for, or exercise of, clinical privileges at Levindale:

1. Any act, communication, report, recommendation, or disclosure with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility or any professional medical facility or governmental agency or organization, shall be privileged fully permitted by law;
2. Such privilege shall extend to Members of Levindale’s Medical Staff and of Levindale’s Governing Body, its President and his/her representatives, and to parties who supply information to any person or body authorized to receive, release, or act upon same. For this Article XV, the term “parties” means both individuals and organizations from whom or from which information has been requested by an authorized representative of Levindale or its Governing Body, or of the Medical Staff;
3. There shall be fully permitted by law absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even if the information involved would otherwise be deemed privileged;
4. Immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to, the following areas: (1) applications for appointment of clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) medical care evaluation; (6) utilization reviews; and (7) other patient care and professional conduct;
5. The acts, communications, reports, recommendations, and disclosures referred to in this Article may relate to a Practitioner’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care; and
6. Any Practitioner, by accepting these Bylaws and agreeing to abide thereby, agrees that he/she shall promptly, upon request of Levindale, execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in the second paragraph, subject to the requirements of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness.

# ARTICLE XVII RULES AND REGULATIONS

The Medical Staff, subject to the approval of the Governing Body, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular or special meeting of the Medical Staff at which a quorum is present by a simple majority vote of those voting Members present. Such changes shall become effective when approved by the Governing Body.

The Medical Staff may propose additions or amendments to the Rules and Regulations directly to the Governing Body; 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 Governing Body 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 Governing Body for action.

# ARTICLE XVIII POLICIES AND PROCEDURES

Policies and Procedures as may be necessary for operation of the Medical Staff and to the effect 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 Governing Body; 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. The Medical Director or the MEC shall adopt such policies and procedures as may be necessary to implement more specifically the general principles found within these Bylaws and the Rules and Regulations.

# Annual Review

**ARTICLE XIX AMENDMENTS**

The Medical Director shall, in consultation with Hospital counsel and the MEC, review these Bylaws at least annually, and recommend revisions as necessary.

# Amendments

All proposed amendments, whether originated by the MEC, another standing committee, or by a Member of the Active Medical Staff, must be reviewed and discussed by the MEC prior to an MEC vote. The Medical Staff may propose amendments to the Bylaws directly to the Board by written request to the Board Chair; however, the Medical Staff must first communicate the proposal to the Medical Director. Amendments may be recommended to the Board by the MEC after a majority vote, provided that the proposed amendments were first distributed to the Active Staff Members at least 21 days prior to the MEC vote.

The MEC’s recommendation may be acted upon by the Board unless more than 10 Members of the Active Staff object within 15 days after the MEC action. If more than 10 Members of the Active Staff object to a proposed amendment, the Chair of the MEC will schedule and hold a meeting of the Active Staff at which the proposed amendment will be presented, discussed, and voted upon. The affirmative vote of a majority of those Active Staff members present and voting is required for passage. Absentee ballots, properly dated and signed, will be permitted.

In cases of documented need for an urgent amendment to the Medical Staff Bylaws 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 so provisionally adopted, the MEC will immediately notify the Medical Staff and the Medical Staff will have the opportunity to review and comment upon 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 regarding the amendment, the conflict resolution procedure will be implemented. If necessary, a revised amendment will then be submitted to the Board for final action.

# Technical or Clarifying Amendments

Notwithstanding the procedures set out in Section 19.2, the MEC shall have the power to adopt, without following those procedures, such amendments to the Bylaws as are, in the MEC’s judgment, technical or legal modifications or clarifications, reorganization, or renumbering, or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective when approved by the Board of Trustees.

# Board Approval

All amendments must be approved by the Board or its authorized agent prior to becoming effective.

# ARTICLE XX MISCELLANEOUS

For purposes hereof, the singular shall include the plural, and vice-versa, and use of either gender encompasses both genders.

# ARTICLE XXI LEGAL REQUIREMENTS

These Bylaws shall be interpreted in a manner that renders them consistent with State and Federal laws, guidelines, and regulations, standards of The Joint Commission.

# ARTICLE XXII ADOPTION

These Bylaws shall become effective when approved by the Governing Body, upon recommendation of the Medical Staff.

# ARTICLE XXIII 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 by the Governing Body.

Approved: Medical Executive Committee,

Approved: Performance Oversight Committee

Approved: Medical Executive Committee, 3/21

Approved: Performance Oversight Committee,

Approved: Medical Executive Committee, 12/23

Approved: Performance Oversight Committee, 12/23

Approved:

Approved: