MEDICAL STAFF BYLAWS AND RULES & REGULATIONS

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SECTION 1 - NAME

The name of this organization shall be ***"THE MEDICAL STAFF OF CARROLL HOSPITAL CENTER".***

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SECTION 2 – PREAMBLE

The practitioners of Carroll Hospital Center located in Westminster, Maryland, by this document establish the framework for the organization and functioning of the Medical Staff of Carroll Hospital Center, under the auspices of the hospital's Board of Directors. The Medical Staff is a self-governing and collegial body accountable to the Board of Directors for the oversight of the quality of care, treatments and services delivered by credentialed and privileged practitioners at the hospital. Within this framework, it is our goal to provide a culture of excellence and to serve our community by providing the highest quality of care consistent with the values of service, performance, innovation, respect, integrity, and teamwork.

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SECTION 3 - DEFINITIONS

3.1 President

Whenever the term "President" appears, it shall be interpreted to mean the President of the hospital or his representative.

3.2 Chief of Staff

Whenever the term "Chief of Staff" appears, it shall be interpreted to mean the President of the Medical Staff or his representative.

3.3 Day

Any reference to "day" for a time period equal to or less than seven days shall be interpreted to mean business weekdays (i.e. Monday through Friday) excluding nationally observed holidays. Any reference to "day" for a time period equal to or greater than eight days shall be interpreted to mean a calendar day.

3.4 Gender

Whenever the terms "he" or "she" or the terms "his" or "hers" appear, they shall be interpreted to be gender neutral.

3.5 Governing Body

Whenever the term "Governing Body" appears, it shall be interpreted to refer to the Board of Directors of the hospital.

3.6 Hospital

Whenever the term "hospital" appears, it shall be interpreted to mean Carroll Hospital Center, a not-for-profit corporation organized under the laws of the state of Maryland and under whose articles of incorporation and bylaws these Medical Staff bylaws operate.

3.7 Mail

Whenever the term "mail" appears, it shall be interpreted to mean communication by United States Postal Service, email and/or posting to a website accessible to all members of the Medical Staff.

3.8 Practitioner

Whenever the term "practitioner" appears, it shall be interpreted to mean an individual licensed by the Maryland Department of Health and Mental Hygiene.

3.9 Physician

Whenever the term "physician" appears, it shall be interpreted to mean Medical Doctors (M.D.) and Doctors of Osteopathy (D.O.) licensed to practice medicine/surgery in the state of Maryland. Only M.D.s and D.O.s will be allowed to wear a hospital badge identifying themselves as Doctor.

3.10 Medical Staff

For the purpose of these Bylaws and the words "Medical Staff" or "medical staff" shall be limited to include all physicians, dentists, maxillofacial surgeons, podiatrists, advanced practice providers and other practitioners to include physician assistants, nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists approved by the Board of Directors who are privileged to attend patients in the Carroll Hospital Center.

3.11 Meeting or Hearing

Whenever the term "meeting" or "hearing" appears, it should be interpreted to mean an assembly or conference of persons for a specific purpose. Such meeting or hearing may be held in-person or electronically upon approval of the chair.

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SECTION 4 - ETHICS AND ETHICAL RELATIONSHIPS

The Principles of Medical Ethics adopted by the American Medical Association, the Principles of Medical Ethics adopted by the American Osteopathic Association, the ethical standards adopted by the Council on Dental Education of the American Dental Association, the Code of Ethics of the American Podiatric Medical Association, the ethical standards adopted by other disciplines, wherever applicable, the ethical standards adopted by the various licensing boards of the state of Maryland, as applicable, Code of Conduct for Carroll Hospital Center and Affiliates, Medical Staff Code of Conduct Policy and C.H.C. Compliance Program will govern the professional conduct of Members and others with clinical privileges.

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SECTION 5 – RIGHTS, RESPONSIBILITIES AND CATEGORIES OF MEMBERSHIP

This Section delineates the rights and responsibilities of membership on the Medical Staff of Carroll Hospital Center.

The Medical Staff is comprised of Practitioners (as defined in Section 3.8) in good standing, appointed by the Board of Directors, limited to the following: Physicians (M.D. or D.O.), Oral and Maxillofacial Surgeons, Dentists, Podiatrists, and Advanced Practice Providers to include physician assistants, nurse practitioners, certified nurse midwives and certified registered nurse anesthetists.

Membership on the Medical Staff shall not be denied or granted on the basis of race, creed, religion, color, age, sex, national origin, ancestry, economic status, marital status, disability, or sexual orientation.

5.1 All Medical Staff Members must:

- 5.1.1 Be licensed through the applicable Maryland State Licensing Board;
- 5.1.2 Have Medical Malpractice Insurance coverage (subject to the exception set forth under Emeritus Staff) in the amounts specified in the Medical Staff Rules and Regulations;
- 5.1.3 Maintain current federal and state Controlled Dangerous Substance registration except for pathologists or Certified Registered Nurse Anesthetists;
- 5.1.4 Not be excluded from participation in any federal or state funded health care program (e.g. Medicare or Medicaid);
- 5.1.5 Not be convicted of a felony
- 5.1.6 Advise Administration, within thirty (30) days, of any civil judgements or criminal convictions, pleas of guilt or nolo contendere;
- 5.1.7 Abide by the Bylaws, Rules and Regulations, Policies, Procedures and/or Standards of Carroll Hospital Center, its Medical Staff and its Clinical Departments;

5.1.8 Go through the reappointment process every two years;

5.1.9 Advise Administration, within thirty (30) days, of any changes in qualifications or representations related to professional liability claims or actions by any licensing or certification entities which occur between appointment periods;

5.1.10 Advise Administration, within thirty (30) days, of any changes or restrictions of privileges in any other hospital or health care organization;

5.1.11 Be assigned to an appropriate Clinical Department; and

5.1.12 Pay dues as established by resolution of the Medical Staff as defined in the tables below.

5.2. Categories: The Medical Staff shall consist of the following categories: Active, Affiliate, Emeritus, Telemedicine, and Advanced Practice Provider.

Active and Affiliate categories shall have delineated prerogatives for Physicians (M.D. or D.O.), Oral and Maxillofacial Surgeons, Dentists, Podiatrists and Advanced Practice Providers to include physician assistants, nurse practitioners, certified nurse midwives and certified registered nurse anesthetists.

5.3 Qualifications Generally

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned.

5.4 Prerogatives and Responsibilities

5.4.1 The prerogatives available to a Medical Staff member depending upon staff category enjoyed are:

5.4.1.1 Admit patients consistent with approved privileges.

5.4.1.2 Eligible for Clinical Privileges: Exercise those clinical privileges that have been approved.

5.4.1.3 Vote on any Medical Staff matter including, officer selection and other matters presented at department meetings.

5.4.1.4 Hold Office: Hold office in the Medical Staff and in the department to which he or she assigned.

5.4.1.5 Service on Committee: Serve on committees and vote on committee matters.

5.5 Basic Responsibilities of Medical Staff Membership, are to:

5.5.1 Medical Staff Functions: Contribute to and participate equitably in staff function, at the request of a Department Chief or staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management: serving in Medical Staff and department offices and on hospital and Medical Staff committees; participating in and assisting with the hospital's medical education programs; proctoring of other practitioners; and fulfilling such other staff functions as may reasonably be required.

5.5.2 Consulting with other staff members consistent with his or her delineated privileges.

5.5.3 Pay Fees/Dues: Pay staff application fees, dues and assessments in the amounts specified in the rules.

5.6 Obligations of Staff Categories: The prerogatives and obligations of each staff category are described in the tables below.

5.7 Assignment and Transfer in Staff Category

Medical Staff members shall be assigned to the category of staff membership based upon the qualifications identified below. Active staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate the privileges and membership of any staff member who has failed to have any activity. An Affiliate Member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers, which shall then be evaluated in accordance with the bylaws and these rules. The transfers shall be done at the time of reappointment.

5.8 Active Staff

The Active Staff shall consist of the members who:

5.8.1 Are regularly involved in caring for patients. Regular involvement in patient care shall mean treating, admitting, referring, or consulting on at least 25 inpatient or hospital-based outpatient cases each Medical Staff year. Members of the departments of Diagnostic Imaging and Emergency Medicine have the option of Affiliate Staff regardless of the number of encounters.

5.8.2 Summary of Applicable Prerogatives, Responsibilities, etc., and additional particular qualifications of the Active Staff:

Prerogatives		
	Physicians, Dentists, Maxillofacial Surgeons, Podiatrists	**Advanced Practice Providers: Nurse Practitioners, Nurse Midwives, Physician Assistants, Certified Registered Nurse Anesthetists**
Admits, consults and refers patients (inpatients and outpatients)	Yes	Yes (In accordance with 5.4.1.1)
Eligible for clinical privileges	Yes	Yes
Vote at medical staff elections	Yes	Yes
Vote for Bylaws changes	Yes	Yes
Hold office as MEC Member at large	Yes (once successfully completed initial FPPE)	Yes (once successfully completed initial FPPE)
Hold office as President or Vice President	Yes (once successfully completed initial FPPE)	No
Hold office as Secretary/Treasurer	Yes (once successfully completed initial FPPE)	Yes (once successfully completed initial FPPE)
Serve as a Committee Chair	Yes	Yes
Serve as Department Chief	Yes	No
Serve on Committee	Yes	Yes
Responsibilities		
Consulting	Yes	Yes
Emergency room call (in accordance with Departmental Rules and Regulations)	Yes	Yes
Pay application fee	Yes	Yes
Pay dues (members with 25 years of continuous service on Active Staff are exempt for paying dues)	Yes	Yes
Additional Particular Qualifications		
Must successfully complete initial FPPE	Yes	Yes
Malpractice insurance	Yes	Yes
File application and apply for reappointment	Yes	Yes
Need Immunizations (e.g.) Flu shot and PPD as required	Yes	Yes

5.8.3.1 Active Staff members shall not be allowed to vote in general medical staff elections, be elected to medical staff office, or be appointed as a committee chair if, and as long as they have been determined to be delinquent in medical staff dues or have been suspended from the medical staff for a total of at least 30 days in the previous 12 months.

5.9 Affiliate Staff

The Affiliate Medical Staff shall consist of the members who:

5.9.1 Admit, treat, refer or otherwise provide services for no more than 25 patient encounters during each Medical Staff year, except for the departments of Diagnostic Imaging and Emergency Medicine, where members may see 25 or more patients per year as designated as Affiliate Staff at the discretion of the Chiefs of Diagnostic Imaging and Emergency Medicine.

5.9.2 Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the member's department or the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested clinical privileges.

5.9.3 Affiliate Staff will be automatically transferred to the Active Staff if they complete 25 patient encounters per year. Exceptions for Diagnostic Imaging and Emergency Medicine as defined above.

5.9.4 Summary of Applicable Prerogatives, Responsibilities, etc., and additional particular qualifications:

Prerogatives		
	Physicians, Dentists, Maxillofacial Surgeons, Podiatrists	Advanced Practice Providers: Nurse Practitioners, Nurse Midwives, Physician Assistants, Certified Registered Nurse Anesthetists
Admits, consults and refers patients (inpatients and outpatients)	Yes	Yes (In accordance with 5.4.1.1)
Eligible for clinical privileges	Yes	Yes
Vote at Medical Staff elections or for Bylaws Changes	No	No
Hold office as President, Vice President, Secretary/Treasurer or Member at Large	No	No
Serve as Committee Chair	No	No
Serve as Department Chief	No (unless previously Active Staff in good standing, and waiver granted by Board of Directors	No
Responsibilities		
Consulting	Yes	Yes
Emergency Room call	No	No
Pay application and reappointment fees	Yes	Yes
Pay dues	No	No
Additional Particular Qualifications		
Must successfully complete initial FPPE	Yes	Yes
Malpractice insurance	Yes	Yes
File application and apply for reappointment	Yes	Yes
Need immunizations (e.g. Flu shot and PPD as required)	Yes	Yes

5.10 Emeritus Staff

The Emeritus Staff shall consist of practitioners who are deemed deserving of membership by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and members who were in good standing when they retired. Emeritus Staff, unlike the other categories, do not have an OPPE since they have no clinical activity. Emeritus Staff may become Chiefs of Departments with Board of Directors approval. They must have served at least two years active staff in good standing. If serving as a chief of a department, they may vote in departmental, committee, and MEC meetings as specified.

5.11 Telemedicine Staff

Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. A Telemedicine provider is responsible for the care, treatment and services of the patient via a telemedicine link. The Telemedicine provider is generally a physician, but other licensed independent practitioners may also be involved as Telemedicine providers. The Telemedicine Provider would generally contract with (or in the case of non-physicians, be employed by) the entity that serves as the Distant Site. There are two main modalities of telemedicine- clinical video telemedicine (real time two-way audiovisual communication) and store and forward telemedicine (sending images or videos to be read asynchronously).

5.11.1 Practitioners who are responsible for a patient's care, treatment and services via telemedicine link will be credentialed and privileged at this Hospital (the originating site) upon review and approval of the credentialing decision of the distant Joint Commission-accredited site upon verification of the following:

5.11.1.1 The practitioner is licensed by the state of Maryland;
5.11.1.2 The practitioner is privileged at the distant site for those services to be provided at this Hospital;
5.11.1.3 Current list of the practitioner's privileges at the distant site; and,
5.11.1.4 An internal review of the practitioner's performance of these privileges at the distant site.

5.11.2 A practitioner who holds privileges to provide care, treatment and services via telemedicine link shall cooperate fully with, and provide such materials which, the Administration requires under the Carroll Hospital Center Medical Staff Quality Policy for the performance of an Ongoing Professional Practice Evaluation which shall be sent to the distant site for use in privileging and performance improvement.

5.11.3 Summary of Applicable Prerogatives, Responsibilities, etc., and additional particular qualification:

Prerogatives	
Consult and refers patients (in patients and outpatients)	Yes, with limitations
Eligible for clinical privileges	Yes, with limitations
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee	No
Responsibilities	
Consulting	Yes
Emergency room call	No
Attend meetings	No
Pay application and reappointment fees	No
Need Immunizations (e.g. Flu shot) and PPD as required	No
Pay dues	No
Additional Particular Qualifications	
Subject to focused professional practice evaluation	Yes
Malpractice insurance	Yes
File application and apply for reappointment	No
Complete a drug screening	No

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SECTION 6 - MEMBERSHIP AND CLINICAL PRIVILEGES

6.1 General Provisions

Unless otherwise specified in these Bylaws, appointment and reappointment of Medical Staff Membership and granting of Clinical Privileges are governed by the same provisions and shall be collectively referred to as "appointment."

The General Provisions apply to:

- Initial applications for appointment; and
- Applications for reappointment.

The General Provisions do not apply to:

- Temporary Privileges; and
- Telemedicine

6.1.1 Duration

Appointment to the Medical Staff shall be made by the Board of Directors of the Hospital and shall be for a period not to exceed two years.

6.1.2 Qualifications

All applicants shall:

6.1.2.1 Have a current, unrestricted license through the applicable Maryland State Licensing Board;

6.1.2.2 Have Medical Malpractice Insurance coverage (subject to the exception set forth under Emeritus Medical Staff) in the amounts specified in the Medical Staff Rules and Regulations;

6.1.2.3 Maintain current federal and state Controlled Dangerous Substance registration;

6.1.2.4 Not be excluded from participation in any federal or state funded health care program (e.g. Medicare or Medicaid); and

6.1.2.5 Not be convicted of a felony.

Each applicant shall include in his application identification of the category of membership to which he desires appointment and a request for the specific clinical privileges he seeks and comply with any additional requirements for that membership category.

6.2 Active or Affiliate Medical Staff

In addition to the general requirements for all applicants for membership, each applicant for membership on the Active or Affiliate Medial Staff and for privileges to practice as a Physician, Dentist, Oral and Maxillofacial Surgeon or Podiatrist at Carroll Hospital Center, shall:

6.2.1 Be a graduate of:

6.2.1.1 A medical, osteopathic, dental or podiatric school which has been approved by the American Medical Association, American Osteopathic Association, American Dental Association, or American Podiatric Association, respectively; or

6.2.1.2 A foreign medical school and have successfully completed the E.C.F.M.G. (Educational Commission for Foreign Medical Graduates) certification; and

6.2.1.3 Subject to any Departmental Rules and Regulations for Board Certification, all new applicants shall, at a minimum:

6.2.1.3.1 Be a graduate of a training program approved by the supervisory board for that specialty in the United States; and

6.2.1.3.2 Be Board Certified [Board Certification shall be through one of the constituent boards of ABMS (American Board of Medical Specialties) or AOAB (American Osteopathic Association Board), ABOMS (American Board of Oral &

Maxillofacial Surgery), ABPS (American Board of Podiatric Surgery) or equivalent Advanced Practice Provider Professional board] in the specialty of medicine, dentistry or podiatry for which application is made or become Board Certified in that specialty within the board eligible period of time that may elapse between a provider's completion of training and achievement of initial certification as specified by the applicable constituent boards as noted above;

6.2.1.3.3 Maintain Board Certification once attained. Board recertification shall be through the constituent boards as in 6.2.1.3.2

6.2.1.3.4 Waiver of Board Recertification. Insofar as is consistent with applicable law, rule or regulation, the Board of Directors, upon recommendation of the Medical Executive Committee, has discretion to waive the requirement of maintenance of board certification set forth in the subtitle, upon such terms and conditions as it deems advisable and in the best interests to patients and of the Hospital. The Board is not obligated to grant such a waiver under any circumstances and initial Board Certification may not be waived.

6.3 Advanced Practice Provider Staff

In addition to the general requirements for all applicants for membership, each applicant for membership on the Advanced Practice Provider Staff and for privileges as an Advanced Practice Provider shall:

6.3.1 Be certified by the appropriate certifying body.

6.4 Application

6.4.1 Form

Each applicant shall submit an application which shall conform to the requirements of policies duly adopted by Carroll Hospital Center. Each submitted application shall be processed by the Medical Affairs Office of Carroll Hospital Center and, once complete, will be presented for review, recommendation and determination as provided by policies duly adopted by Carroll Hospital Center.

All applications to the Medical Staff shall be in writing, shall be signed by the applicant and shall be submitted on a prescribed form to the President of the Hospital.

The information provided shall include but not be limited to that appearing in the Maryland Uniform Credentialing Application, the CHC Supplement form and the Credentialing Procedures for Applicants to the Medical Staff of Carroll Hospital Center.

6.4.2 Substance

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications and for resolution of any doubts about such qualifications.

By applying for Medical Staff membership and privileges, the applicant authorizes the Medical Staff to consult with members of the Medical Staffs of other Hospitals with which the applicant has been associated and with others who may have information bearing on competence, character and ethical qualifications. The applicant further consents to the Hospital's inspection of all records and documents that may contain material pertinent to an evaluation of his professional qualifications as well as his character.

Each applicant consents to appear for interviews regarding the application if requested.

6.4.3 Cooperation

An applicant for initial appointment shall cooperate fully with, and provide such materials which, the Administration requires under the Carroll Hospital Center Medical Staff Quality Policy for the performance of a Focused Professional Practice Evaluation.

An applicant for re-appointment shall cooperate fully with, and provide such materials which, the Administration requires under the Carroll Hospital Center Medical Staff Quality Policy for the performance of an Ongoing Professional Practice Evaluation.

By applying for appointment or reappointment to the Medical Staff, the applicant agrees to provide, upon request, copies of the practitioner's office charts and records relating to the treatment of patients who have received treatment at the Hospital if deemed necessary for the review of the practitioner's professional activities and current competence.

If such information is not provided or is deemed insufficient as provided by the applicant, the application or reappointment will be deemed incomplete and will not be processed.

6.4.4 Immunity

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this Hospital:

6.4.4.1 That 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 for the purpose of achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

6.4.4.2 That such privilege shall extend to members of the Hospital's Administration, Medical Staff and Board of Directors, its other practitioners, and to third parties who supply information to any of the forgoing authorized to receive, release, or act upon the same. For the purpose of this section, the term "third parties" means both organizations and individuals from whom information has been requested by an authorized representative of the Board of Directors or of the Medical Staff.

6.4.4.3 That there shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure even when the information involved would otherwise be deemed privileged.

6.4.4.4 That such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institutions' activities related, but not limited to:

6.4.4.4.1 Applications for appointment or clinical privileges; periodic appraisals for re-appointment, advancement or clinical privileges;

6.4.4.4.2 Corrective action including summary suspension;

6.4.4.4.3 Hearings and appellate reviews;

6.4.4.4.4 Medical care evaluations;

6.4.4.4.5 Utilizations reviews, and;

6.4.4.4.6 Other Hospital departmental service or committee activities related to quality patient care and professional conduct.

6.4.4.5 That the acts, communications, reports, recommendations and disclosures referred to in this section 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.

6.4.4.6 That in furtherance of the foregoing, each practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this section in favor of the individuals and organizations entitled to immunity under these Bylaws and applicable provisions of state and federal law subject to the requirements of state and federal laws including those of good faith, absence of malice and the exercise of reasonable effort to ascertain truthfulness.

6.4.4.7 That the consents, authorizations, releases, rights, privileges, and immunities provided by these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment shall also be fully applicable to reappointment, advancement and all activities and procedures covered by this section.

6.4.5 Review and Consideration

6.4.5.1 The completed application shall be submitted to Administration.

6.4.5.2 The National Practitioner Data Bank shall be queried.

6.4.5.3 After collecting the references and other materials deemed pertinent, Administration shall transmit the application and all supporting materials to the Chief of the clinical department in which privileges are being sought for departmental review.

6.4.5.4 Within 30 days of receipt of the completed application, the Chief or his designee shall review the application, may interview the applicant, and shall submit specific written recommendation to the Credentials Committee. The written recommendation shall include a documented peer recommendation, a delineation of clinical privileges and an assignment of Medical Staff category of membership.

6.4.5.5 In the event that the Chief fails to act within 30 days, the President of the Medical Staff shall assign another member of the department to review the application and to submit written recommendation within 15 days.

6.4.5.6 Within 90 days of receipt of the recommendation, the Credentials Committee shall review the recommendation, the completed application, and may interview the applicant. The Credentials Committee shall transmit its recommendation, including a delineation of clinical privileges and an assignment of Medical Staff category of membership, to the Medical Executive Committee. A recommendation to deny membership, limit or reduce privileges or to defer or reject the application shall state the reasons for the recommendation.

6.4.5.7 Following receipt of the recommendation of the Credentials Committee and at its next regular meeting, the Medical Executive Committee shall consider the application and determine its recommendation whether to approve, with or without modifications, or to reject the application. The

Medical Executive Committee may defer the application for further consideration but at its next regular meeting shall determine its recommendation.

6.4.5.8 A determination to recommend approval of the application, in whole or in part, shall be transmitted to the Board of Directors for final decision.

6.4.5.9 A determination to recommend denial of membership and/or to limit or reduce privileges shall entitle the applicant to due process as provided in these Bylaws and he shall be so notified by certified mail, return receipt requested. At its next regular meeting after receipt of the Medical Executive Committee's recommendation to approve an application for appointment or reappointment, the Board of Directors shall consider the application and determine whether to grant membership and/or clinical privileges. The Board of Directors may defer the application for further consideration but its next regular meeting shall reach its decision.

6.4.5.10 A determination to grant membership and clinical privileges, in whole or in part, shall be final and the applicant shall be notified by Administration.

6.4.5.11 A determination to deny membership and/or to limit or reduce privileges shall entitle the applicant to due process as provided in these Bylaws and he shall be so notified by certified mail, return receipt requested. The applicant will not have the right to have counsel present until those such conditions exist which entitle the right of due process.

6.4.5.12 Following an adverse recommendation by the Medical Executive Committee and/or an adverse decision of the Board of Directors and the exhaustion or waiver of all due process rights as provided in these Bylaws, the Board of Directors shall reach a final decision on the application which shall be conclusive.

6.4.5.13 The Board of Director's final decision shall be sent to Administration, to the President of the Medical Staff, and Chief of the clinical department and to the practitioner within 14 days of the decision.

6.4.5.14 The privileges of a medical staff member will not expire for any reason if the member is under investigation or suspension. if such member fails to take action to renew privileges, the member's privileges will be automatically renewed, in a state of suspension, for a period until termination of the suspension or investigation or until the completion of "due process" or until the member resigns. A suspension greater than 30 days and/or resignation while under suspension or investigation are reported to the Maryland Board of Physicians and National Practitioner Data Bank (NPDB). If a member under investigation or suspension chooses not to respond or participate in the due process, then after 60 days the MEC may recommend to the Board of Directors that the member's privileges be revoked.

6.4.6 Additional Clinical Privileges

Additional clinical privileges will be reviewed in the same manner as an application for appointment as provided by the Carroll Hospital Center Medical Staff Quality Policy and the Carroll Hospital Center Protocol for Additional Privileges and New Procedures.

6.4.7 Temporary Privileges

Temporary Privileges may be granted under the following circumstances:

- When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Board of Directors; or

- To fulfill an important patient care, treatment or service need.

  All temporary privileges are granted by the CEO or designee following recommendation of the President of the Medical Staff or his designee and may be terminated at any time by the CEO after conferring with the Chief of Department and the President of the Medical Staff.

There are no rights to appeal a decision not to approve, not to extend or to terminate Temporary Privileges.

Health Care Providers who are granted Temporary Privileges are subject to the authority of the respective Chief of Department.

The granting of Temporary Privileges does not confer membership on the Medical Staff.

6.4.7.1 New Applicant

Temporary privileges may be granted to allow an applicant whose application is otherwise complete and has been reviewed and approved by the Chief of Department and the Credentials Committee to start practicing while his application is being further reviewed by the Medical Executive Committee and the Board of Directors upon verification of the following:

6.4.7.1.1 A complete application;
6.4.7.1.2 Current licensure through the applicable Maryland State Licensing Board;
6.4.7.1.3 No current or previously successful challenge to licensure;

6.4.7.1.4 Relevant training or experience;

6.4.7.1.5 Current competence and ability to perform the privileges requested;

6.4.7.1.6 No subjection to involuntary limitation, reduction, denial or loss of clinical privileges;

6.4.7.1.7 No subjection to involuntary termination of Medical Staff membership at another organization;

6.4.7.1.8 A query and evaluation of the National Practitioner Data Bank information;

6.4.7.1.9 Malpractice insurance at a level of coverage not less than the amount specified in the Rules and Regulations of the Medical Staff of Carroll Hospital Center;

6.4.7.1.10 Current federal and state Controlled Dangerous Substance registration;

6.4.7.1.11 No exclusion from participation in any federal or state funded health care program (e.g. Medicare or Medicaid); and

6.4.7.1.12 No conviction of a felony.

Temporary Privileges may be granted to a new applicant for no more than 120 days but shall automatically terminate in the event the application is rejected by either the Medical Executive Committee or the Board of Directors.

6.4.7.2 Important Patient Care, Treatment or Service Need

Upon verification of current licensure and current competence, temporary privileges may be granted to a Health Care Provider who is not on the Medical Staff at Carroll Hospital Center to meet an important patient care need for the following purposes only:

6.4.7.2.1 For care, treatment or service for a single patient; or

6.4.7.2.2 In the event that an emergency situation arises wherein a critical Medial Staff function cannot be provided by available members of the Medical Staff; or

6.4.7.2.3 To teach, supervise, perform or assist in the performance of a procedure so that a member of the Medical Staff may gain Clinical Privileges to perform a procedure not presently in his delineation of privileges; or

6.4.7.2.4 To monitor, mentor, precept, counsel or supervise a Member of the Medical Staff in connection with Corrective Action taken by the Board of Directors.

Temporary Privileges to provide care, treatment or service to a single patient shall expire upon discharge of the patient from Carroll Hospital Center.

Temporary Privileges granted because a critical Medical Staff function cannot be provided by available members of the Medical Staff shall expire when a member of the Medical Staff is able to assume responsibility for the function in question.

All other Temporary Privileges granted for an important patient care, treatment or service need may be granted for a period of time up to 120 days and may be extended for additional time periods at the request of the Chief of Department and/or President of the Medical Staff and upon approval by the CEO.

6.4.7.3 Locum Tenens

Temporary privileges may be granted to a practitioner in a Locum Tenens position who is either employed directly by an absent Member or by an outside agency following submission of an application which has been reviewed and approved by the Chief of the involved Department, the Chairman of the Credentials Committee and the Medical Staff President with a recommendation to the CEO.

Temporary Privileges granted to a practitioner to serve in a Locum Tenens position will expire upon the earlier of the return of the practitioner being replaced or 120 days from the time the privileges were granted. Such privileges may be extended for additional time periods at the request of the Chief of Department and/or President of the Medical Staff and upon approval by the CEO.

6.4.7.4 Privileges in Event of Disaster

In the event of any governmentally declared emergency, the CEO, CMO, or Medical Staff President or their designee shall have the authority to grant temporary privileges to a Health Care Provider who is not a Member of the Medical Staff in accordance with the "Credentialing Licensed Independent Practitioners (LIP) in the Event of Disaster" Policy of the Carroll Hospital Center, which is incorporated into these Bylaws by this reference.

6.4.8 Provision of Coverage

6.4.8.1 Each member of the Medical Staff shall be responsible for providing

appropriate coverage for patients admitted to his inpatient or outpatient service when he is not available or not on call. The member, or his coverage who must also be a member of this Medical Staff, shall be responsible for responding to the needs of his patients in an appropriate and timely fashion.

6.4.8.2 Coverage of the Emergency Department and Inpatient Consultation Service

6.4.8.2.1 The Medical Staff, through each clinical department, shall maintain an on-call system to serve as a medical resource to the Emergency Department of Carroll Hospital Center and to the inpatient service, in accordance with the Medical Staff Bylaws and departmental Rules and Regulations, and to comply with federal statutes. The Hospital bears the responsibility to ensure adequate resources for specialty coverage for the ED and in-house patients and the service and department chiefs are thus empowered to make necessary arrangements.

6.4.8.2.2 Medical Staff members on-call must come into the Hospital if requested to do so by the Emergency Department physician or inpatient attending when the requesting physician deems it to be clinically indicated. When called, the on-call doctor must respond to the Hospital within 30 minutes with a verbal response, and if the situation warrants, one hour for physical response.

6.4.8.2.3 For consultations requested by the Emergency Department, the on-call physician is obligated for a follow-up outpatient visit or appropriate disposition for the current episode that required Emergency Department care, if requested by the Emergency Department physician.

6.4.8.3 Failure or Refusal to Provide Coverage

If an on-call member fails or refuses to come to the Hospital, such failure or refusal may result in corrective action against the member as set forth in these Bylaws.

6.4.9 Leave of Absence

6.4.9.1 A member who anticipates being unable or unavailable to discharge the member's scope of privileges for a period of time exceeding 30 days shall notify the Credentials Committee and the relevant Department Chief for a determination whether a leave of absence will be required. A

leave of absence can be for personal, educational, medical, psychological, behavioral or legal reasons.

A member who is so unable or unavailable for a period of less than 30 days and has any physical or mental condition (including drug or alcohol abuse) that will limit or adversely affect their ability to fully participate in the care of their patients, shall notify the Credentials Committee and the relevant Department Chief for a determination whether a leave of absence will be required. The provisions of this paragraph shall not apply to maternity leave.

6.4.9.2 A leave of absence shall not exceed two years.

6.4.9.3 The leave of absence should be requested in writing, stating the reasons, to the Credentials Committee through the department chief. The member or department chief must take necessary steps to cover the member's in-patients, call schedule obligations and other patient-care responsibilities involving Carroll Hospital Center. The Administration must be notified of any member on leave of absence status.

6.4.9.4 While on a leave of absence, the member cannot admit, attend or consult on patients in the hospital. The member's obligations to attend meetings and serve on committees is waived during the leave of absence.

6.4.9.5 A request to return from leave of absence to prior status shall be made in writing at least 10 days before the anticipated return to the Credentials Committee through the department chief. Such a request shall include certification that the member is in compliance with the conditions of the application for reappointment which relate to licensure, qualifications and fitness to practice medicine. If pertinent, the request to return must include separate documentary evidence that proper rehabilitation has occurred. When the leave of absence is due to illness or temporary physical disability, the request to return must include a letter from the member's attending/treating physician authorizing the member to return to his hospital duties and must include any restrictions or limitations caused by the illness or physical disability. A current Maryland medical license and evidence of continuing medical education must be submitted with the member's request to return to prior status. If such information is not provided or is deemed insufficient as provided by the member, the request for return from leave of absence will be deemed incomplete and will not be processed.

If the duration of the leave of absence extends beyond the member's reappointment date, reinstatement without the requirement to reapply is subject to the review and approval of the appropriate Chief and the Chairman of the Credentials Committee.

6.4.9.6 The Credentials Committee, with the advice of the department chief, may grant or deny a request to return from leave of absence to prior status. If granted, the Administration must be notified, in writing, of the date of return and any medical restrictions or limitations. If the request to return to prior status is denied, it shall be treated as though reappointment was not recommended under these by-laws at the applicable level, with all rights under these by-laws applying.

6.4.9.7 Failure to request to return from leave of absence to prior status after 2 years shall be considered a voluntary resignation of privileges.

6.4.9.8 Nothing in this section shall be construed to prevent, delay or reverse any corrective action, summary suspension or automatic suspension instituted, or to be instituted, under these Bylaws.

6.4.10 Resignation

Letters of resignation shall be in writing and presented to the President and CEO of the Hospital, or his designee, who shall acknowledge receipt of the resignation and advice the Chief of Department, Credentials Committee, Medical Executive Committee and Board of Directors of the resignation.

6.4.11 Medical Records Documentation

A medical history and physical (H&P) examination shall be completed and documented in the medical record for each patient no more than thirty (30) days before registration, or within twenty-four (24) hours after admission, but prior to any procedure requiring anesthesia services or any surgery. The medical history and physical examination must be completed and documented by a physician, dentist, maxillofacial surgeon, podiatrist or other qualified licensed individual in accordance with the laws of the state of Maryland and Hospital policy.

When the medical history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff. If, upon examination, the practitioner finds no change in the patient's condition since the prior medical history and physical examination was conducted, he may indicate in the patient's medical record that the prior medical history and physical examination was reviewed, the patient was examined

and that "no change" has occurred, however, any changes in the patient's condition must be documented in the update note and placed in the patient's medical record within twenty-four (24) hours of admission or registration but prior to any procedure requiring anesthesia services or any surgery.

Required elements of a complete H&P are: chief complaint, details of present illness, relevant past history appropriate to the patient's age, drugs, allergies, assessment of body system (including heart and lungs), conclusion/impression, and plan of care. (If drug and allergy documentation is provided elsewhere in the medical record, they do not need to be documented in the H&P.)

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SECTION 7 - CLINICAL DEPARTMENTS

7.1 The clinical departments and divisions thereof shall include, but not be limited to:

7.1.1 Anesthesiology

7.1.2 Diagnostic Imaging:
Computed Axial Tomography
Diagnostic
Nuclear Medicine
Radiation Therapy
Sonography

7.1.3 Emergency Medical Services:
Emergency Medicine
Pediatric Emergency Medicine

7.1.4 Medicine:
Allergy
Cardiology
Critical Care
Dermatology
Family Practice
Gastroenterology
Gerontology
Hematology
Infectious Disease
Internal Medicine
Medical/Surgical House Officers
Nephrology
Neurology
Oncology
Physical Medicine/Rehabilitation
Pulmonary Medicine
Rheumatology
Sleep Medicine

7.1.5 Obstetrics & Gynecology:
Gynecology
Gynecologic Oncology
Obstetrics
Maternal Fetal Medicine

7.1.6 Department of Pathology:
Anatomic Pathology
Clinical Pathology

7.1.7 Department of Pediatrics:
Cardiology
Infectious Disease
Pediatrics
Neonatology
Nephrology

7.1.8 Psychiatry

7.1.9 Department of Surgery:
Colorectal Surgery
Dental and Maxillo-Facial Surgery
General Surgery
Neurosurgery
Ophthalmology
Orthopedic Surgery
Otolaryngology
Plastic and Reconstructive Surgery
Podiatry
Thoracic Surgery
Urologic Surgery
Vascular Surgery

7.2 Organization of Departments

7.2.1 Department Chief

Each department shall have a departmental chief who shall be responsible to the President of the Medical Staff and the Medical Executive Committee for the functioning of the work falling within the department.

The chief of each department shall be a member of the department who is Board certified by the American Board of Medical Specialties, or American Osteopathic Association Boards of Certification, or American Board of Oral and Maxillofacial Surgery, or American Board of Podiatric Surgery in a medical specialty, that falls within that department's area of practice.

Each department chief shall be elected by members of the department except for the Departments of Anesthesiology, Emergency Medicine, Pathology, Pediatrics, Psychiatry and Diagnostic Imaging in which the department chief is specified by

contract with the hospital. However, the Medical Executive Committee shall appoint the chief of any department having three or less members, unless the department chief is specified by contract as above.

The responsibilities of a department chief shall include, but not be limited to, the following:

7.2.1.1 Performing oversight on all clinically related departmental activities;
7.2.1.2 Performing oversight on all administratively related departmental activities, unless otherwise provided for by the hospital;
7.2.1.3 Making recommendations to the President of the hospital regarding administrative matters concerning patient care;
7.2.1.4 Performing continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
7.2.1.5 Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
7.2.1.6 Recommending clinical privileges for each member of the department;
7.2.1.7 Assessing and recommending to the relevant hospital authority, off-site sources for needed patient care, treatment and services not provided by the department or hospital;
7.2.1.8 Integrating the department or its services into the primary functions of the hospital;
7.2.1.9 Coordinating and integrating interdepartmental and intradepartmental services;
7.2.1.10 Developing and implementing policies and procedures that guide and support the provision of care, treatment and services;
7.2.1.11 Recommending the number of qualified and competent persons sufficient to provide care, treatment and services;
7.2.1.12 Determining the qualifications and competence of department or service personnel who provide patient care, treatment and services and are not licensed independent practitioners;
7.2.1.13 Assessing and improving, on a continuing basis, the quality of care, treatment and services provided;
7.2.1.14 Maintaining quality control programs, as appropriate;
7.2.1.15 Providing for the orientation and continuing education of all persons in the department;
7.2.1.16 Recommending space and other resources needed by the department;
7.2.1.17 Fostering a spirit of good collegial relations within the department and hospital in general.

7.3 Departmental Subdivisions

A department may provide for additional departmental subdivisions directed by other individuals who are responsible to the chief of the department and to whom specific responsibilities of the chief may be delegated as provided by the departmental Rules and Regulations.

7.4 Rules and Regulations

Each department shall meet in accordance with its rules and regulations.

Each department shall submit a copy of its departmental rules/regulations under which the department functions to the Medical Executive Committee for approval, with a copy to the Bylaws Committee. These shall be appended to the Bylaws of the Medical Staff. Each chief shall be responsible for keeping the departmental rules and regulations current. The chief shall report the status of the rules and regulations including any changes to the Medical Executive Committee with a copy to the Bylaws annually by its February meeting.

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SECTION 8 - OFFICERS AND COMMITTEES

8.1 Officers

8.1.1 The officers of the Medical Staff shall be the President, Vice President, and the Secretary/Treasurer. These shall be elected at the annual meeting of the Medical Staff in the even number years and shall hold office until July 1 of the next biannual election year, or removal from office by the process described in Section 8.4, of these bylaws, or until a successor is elected.

8.1.2 The President of the Medical Staff shall call and preside at the Quarterly Medical Staff meetings and the Medical Executive Committee meetings and shall be a member ex-officio of all committees.

8.1.3 The Vice-President of the staff, in the absence of the President of the Medical Staff, shall assume all his duties and have all his authority. He shall also be expected to perform such duties of supervision as may be assigned to him by the President.

8.1.4 The Secretary/Treasurer shall supervise the keeping of accurate and complete minutes of all medical staff meetings, calling meetings on order of the President, attending to all correspondence and performing such other duties as ordinarily pertain to his office. He shall act as Treasurer for the Medical Staff.

8.1.5 The officers of the Medical Staff may succeed themselves by election.

8.2 Chief Medical Officer (CMO)

The CMO shall be a physician appointed by the President of the Hospital, following consultation with a committee appointed by the President of the Hospital, such committee to include but not be limited to members of the Medical Staff, Administration and the Board of Directors. The committee will identify individuals who possess the abilities and interests required to discharge successfully the responsibilities of this office. Suitable candidates will be those who have demonstrated outstanding clinical skills, exceptional administrative performance, and an ability to work successfully with members of the Medical Staff, Board of Directors and administrators.

8.2.1 Reporting:

8.2.1.1 The CMO reports to the President of the Hospital and has responsibility to report to the Board of Directors and Medical Staff regarding medical practice. The President of the Hospital will review the CMO's performance annually.

8.2.2 The CMO will be the Chief Administrative Officer of the Medical Staff and shall be an ex-officio voting member of all Medical Staff and Department committees.

8.2.3 Responsibilities include:

8.2.3.1 To work with the President relative to all matters of mutual concern between the Medical Staff and the Hospital;

8.2.3.2 To represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and the President;

8.2.3.3 May serve as the public spokesperson for the Medical Staff;

8.2.3.4 To report at the annual Medical Staff meeting regarding Medical Staff affairs;

8.2.3.5 To enforce the Bylaws of the Medical Staff, the Rules and Regulations of the Medical Staff and related policies and manuals and implement and monitor sanctions or corrective action taken pursuant to these Bylaws;

8.2.3.6 Supervising the physician operated hospital-based programs (adult hospitalist, pediatric hospitalist, intensivist, OB hospitalist and other future hospital-based programs), case management, medical library and CME; and informing others as to whether these programs are clinically sound, accomplishing stated objectives and enhancing patient care;

8.2.3.7 Assisting Medical Staff officers and Department Chiefs in establishing and maintaining systems and processes designed to monitor and favorably impact quality, safety and clinical outcomes;

8.2.3.8 Supporting Medical Staff officers and Department Chiefs with duties and responsibilities as related in these Bylaws and helping resolve problematic administrative issues;

8.2.3.9 Assessing compliance issues relating to relevant Medical Staff Bylaws, Rules & Regulations and policies as well as assuring that applicable accreditation standards and/or regulations are met; and

8.2.3.10 Directing the Medical Affairs Office especially with regard to its requisite credentialing and privileging function.

8.3 Committees

Committees shall be either standing or special. Except as indicated, all committees and committee chairmen other than the Medical Executive Committee shall be appointed by the President of the Medical Staff with advice from the Chief Medical Officer. The term of office for each member is for two years. Any vacancy which arises shall be filled by appointment by the President of the medical staff. All committees mandated by the Joint Commission shall meet at least quarterly. All other standing committees shall meet as specified or at the call of the Chairman, but not less than once a year. All committees shall report to the Medical Executive Committee.

8.3.1 Standing committees shall be:

8.3.1.1 Medical Executive Committee (MEC)

Shall consist of members of the Medical Staff, as outlined below, the CMO, and up to three (3) representatives from the Board of Directors. The Medical Staff members of the Medical Executive Committee shall be physicians, dentists, maxillofacial surgeons and/or podiatrists and an advanced practice provider member at large shall include the immediate Past President, the three current officers of the Medical Staff, the chief of each of the nine (9) clinical departments, (or in the absence of the chief, the vice chief), and three members of the Medical Staff at - large elected on even years for a two year term, one and only one of whom must be an advanced practice provider (PA, NP, CRNA, or CNM).

The President of the hospital, chief hospitalist, Chief Nursing Officer and Quality Officer (senior chair of MSQC) shall be non-voting ex-officio members.

Title	How a member of MEC	Voting?
President of the Medical Staff	Medical Staff election	Yes, only in the event of a tie
Vice President of the Medical Staff	Medical Staff election	Yes
Secretary/Treasurer of the Medical Staff	Medical Staff election	Yes
Physician Member at Large	Medical Staff election	Yes
Physician Member at Large	Medical Staff election	Yes
Advanced Practice Provider Member at Large	Medical Staff election	Yes
Immediate Past President	Per Bylaws	Yes
Member, Board of Directors	Per Board Bylaws	Yes
Member, Board of Directors	Per Board Bylaws	Yes
Member, Board of Directors	Per Board Bylaws	Yes
CMO	Ex-officio	Yes
Chief of Medicine	Per Department Rules and Regulations	Yes
Chief of Surgery	Per Department Rules and Regulations	Yes
Chief of OB/Gyn	Per Department Rules and Regulations	Yes
Chief of Pediatrics	Per Department Rules and Regulations	Yes
Chief of Psychiatry	Per Department Rules and Regulations	Yes
Chief of Anesthesiology	Per Department Rules and Regulations	Yes
Chief of Diagnostic Imaging	Per Department Rules and Regulations	Yes
Chief of Pathology	Per Department Rules and Regulations	Yes
Chief of Emergency Medicine	Per Department Rules and Regulations	Yes
Hospital President	Ex-officio	No
Chief Nursing Officer	Ex-officio	No
Quality Officer	Ex-officio	No
Chief Adult Hospitalist	Ex-officio	No

Nothing shall prohibit an immediate past president, Vice President, Secretary/Treasurer or MEC or member at large from assuming the office of chief of a department per the rules and regulations of that department. However, no person shall have more than one vote at the MEC meeting.

If the President of the Medical Staff is also a Chief of a Department, the Department which the President is from, will lose a vote since each member of the MEC gets only one vote and the President only votes if there is a tie. To regain the lost vote, the Department which has lost this vote due to their Chief being appointed President may elect a new Chief and the current Chief will have to resign.

Shall meet at least once a month, unless cancelled by the Chair of the MEC and agreed upon by a majority of the members and maintain a permanent record of its proceedings and actions. It shall report at each general staff meeting with the exception of confidential, privileged and/or peer review information. The President of the Medical Staff shall serve as its chairman. The Chair may close all or part of a meeting for the discussion of matters recognized by law to be confidential, privileged, and/or peer review information.

Subject to a vote of the majority of the members of the Medical Staff at the Annual Meeting or any special meeting of the Medical Staff, the Medical Staff delegates to the Medical Executive Committee the authority to act on its behalf as follows:

8.3.1.1.1 Coordinate the activities and general policies of the various departments;

8.3.1.1.2 Act on behalf of the medical staff between meetings of the medical staff;

8.3.1.1.3 Receive and act upon the reports of all medical staff committees and the clinical departments;

8.3.1.1.4 Initiate and implement Medical Staff policies and procedures consistent with these Bylaws which carry out the provisions, effectuate the purposes, and further define the processes described in these Bylaws;

8.3.1.1.5 Be responsible to the Board of Directors for the quality of patient care;

8.3.1.1.6 Assist in the promotion and maintenance of quality care through the analysis, review and evaluation of clinical practices in accordance with the Organizational Performance Improvement Plan and the Medical Staff Quality Policy and Procedure.

8.3.1.1.7 To encourage effective and efficient utilization of hospital facilities and services.

8.3.1.1.8 Be responsible for medical staff compliance with accreditation standards.

8.3.1.1.9 Make recommendations to the Board of Directors concerning medical staff appointments and reappointments, department assignments, initial and renewed clinical privileges, and corrective action.

8.3.1.1.10 Represent the medical staff to the administration and to the Board of Directors.

8.3.1.1.11 Disburse Medical Staff funds on behalf of Medical Staff.

8.3.1.2 Credentials Committee

Shall consist of members of the Active, Affiliate and Advanced Practice Provider Staff so selected as to insure representation of the major specialties. A member of the Board of Directors, or their designee, may serve as a voting member. Its duties shall be to investigate the credentials of all applicants for membership and to make recommendations in conformity with Section 6.4.5 of these Bylaws; to evaluate the qualifications, competence, and performance of current or prospective members of the Medical Staff; to investigate any breach of ethics that may be referred to the committee as part of the process set forth in Section 10 of these Bylaws; to review all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of members of the various divisions and departments as provided in Section 7 of the Bylaws; and investigate alleged incidents of failure to provide coverage as stated in Section 6.4.8 of these Bylaws.

The CEO, and/or his designee, as well as department chiefs, shall serve as agents of the Credentials Committee for purposes of its ongoing activities as herein specified in the Bylaws.

8.3.1.3 Infection Control Committee

Shall maintain an ongoing program of surveillance, prevention, investigation, education and control of infections. The membership shall include representatives from the Medical Staff, Administration, Nursing Staff, Operating Room, Lab, Infection Control Practitioner, Sterile Processing and Distribution, Central Supply, Pharmacy, General Environmental Services, Dietary and Facilities, and other departments and resources, as needed.

8.3.1.4 Bylaws Committee

Shall plan, integrate and prepare changes to the medical staff bylaws and rules and regulations and present them, with recommendations, to the Medical Executive Committee. The Committee shall also evaluate changes to the Bylaws and Rules and Regulations proposed by any concerned party and report on the proposed changes, with recommendations, to the Medical Executive Committee. A member of the Board of Directors, or their designee, may serve as a voting member. At least every two years, or as necessary, it shall perform a complete review of the current Bylaws and Rules and Regulations and report to the Medical Executive Committee by its January meeting with a recommendation for any or no changes. The Committee shall also review each clinical department's rules and regulations to ensure that they do not conflict with the medical staff Bylaws and Rules and Regulations and report that evaluation to the Medical Executive Committee before the Medical Executive Committee forwards the departmental rules and regulations to the Board of Directors for approval.

8.3.1.5 Radiation Safety Committee

Shall consist of a radiologist, a radiation oncologist, a senior member of Administration, a registered nurse, the Director of Diagnostic Imaging Services, and other members as appropriate. A radiologist shall serve as its chairman. Its duties shall be to monitor and supervise the appropriate and safe use of radioisotopes and the associated equipment used in the hospital and to fulfill the requirements of statutory agencies regulating same. The committee shall meet at least quarterly.

8.3.1.6 Medical Staff Quality Committee (MSQC)

Shall consist of at least ten members of the Active Medical Staff, with membership generally representing the disciplines actively practicing at the hospital. Members will be appointed by the President of the Medical Staff, with advice from the Chief Medical Officer, for a two-year term with no limit on succession. The hospital's Director of Quality Outcomes Management along with the Peer Review Coordinator will serve as staff support. Its duties shall be to advise and monitor each department on their Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) processes, monitor trends in individual provider and system-

derived care and perform peer review for all events identified by quality monitoring and review programs. Additional information is described in the Medical Staff Quality Policy. The Committee shall meet at least eight times yearly and report to the Medical Executive Committee.

8.3.1.7 Special Committees

Shall be appointed from time to time as may be required to carry out properly the duties of the Medical Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Medical Executive Committee. They shall not have power of action unless such is specifically granted by the motion which created the committee.

8.4 Removal of an Elected Officer or Member of the Medical Executive Committee

The reasons for which an elected officer of the medical staff or member-at-large of the Medical Executive Committee may be removed from office are:

8.4.1 Suspension of privileges;

8.4.2 Unethical or immoral behavior; or

8.4.3 Failure to fulfill the duties of his office.

On recommendation of the Medical Executive Committee or presentation of a petition signed by 33% of the voting members of the Medical Staff, any elected officer or member-at-large of the Medical Executive Committee may be removed from office at a special meeting of the medical staff called for the sole purpose of evaluating and acting upon the Medical Executive Committee's recommendation or the petition. At this special meeting there must be a quorum of voting members present and a majority vote is required to act. Proxy votes will not be accepted.

A chief of a clinical department serving on the Medical Executive Committee shall be removed from the Medical Executive Committee in accordance with the Department's Rules and Regulations or in accordance with a contract with the hospital.

A representative of the Board of Directors serving on the Medical Executive Committee shall be removed from the Medical Executive Committee upon a majority vote of the Board of Directors.

8.5 Vacancy of Office

8.5.1 When the office of president becomes vacant, it shall be assumed by the Vice-President and a new vice-president elected at a special meeting of the medical staff called for that purpose.

8.5.2 When the office of vice-president becomes vacant, it shall be filled by election by the medical staff at a special meeting called for that purpose.

8.5.3 A vacancy in any other office shall be filled for the remainder of the original term by appointment by the President of the Medical Staff with the approval of the Medical Executive Committee.

8.5.4 Any election to fill a vacant office shall follow the normal election procedures described in these Bylaws.

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SECTION 9 - MEETINGS

9.1 The Annual Meeting

The annual meeting of the staff shall be held on the second Tuesday in June. At this meeting the officers and committees shall make such reports as may be desirable.

The members of the Medical Staff who are present at the Annual Meeting shall constitute a quorum.

9.1.1. Officers of the Medical Staff and members-at-large of the MEC for the ensuing term shall be elected in even number years.

During an election year, the office of medical affairs will compose a roll of eligible voting members of the medical staff. The officers of the MEC shall review and certify this roll no less than 14 days before the annual meeting.

Candidates may nominate themselves or be nominated by another member of the medical staff. Nominations shall be sent to the incumbent president of the medical staff and to the office of medical affairs. The office of medical affairs will confirm that the nominee is eligible for the office they were nominated and are willing to stand for election. A list of nominees will be drawn up and disseminated to the voting members of the medical staff 14 days before the annual meeting. During the annual meeting, the incumbent president will present the list of nominees. Nominations may also be accepted up until the nominations are duly closed at the annual meeting. Any new names will be added to the ballot by the office of medical affairs.

When the nominations have been closed, unopposed nominees shall be deemed to have been elected by acclamation. For all contested offices, voting shall take place by electronic ballot. The voting will be open for 72 hours after the meeting.

Election of officers is by an affirmative vote of the majority of those casting ballots. In the case of no majority, there will be a 48-hour run-off election of the top two candidates by electronic ballot.

In the event of a tie, for the election of an officer or a member-at-large, the President shall perform a coin flip.

Administrative powers of the staff officers shall be transferred to the newly elected as of July 1.

Proxy votes shall not be accepted in the elections of officers and MEC members at large.

9.2 Regular Meetings

The objective of staff meetings is to promote quality care of patients and disseminate information to the Medical Staff. Executive sessions of the staff may be conducted at the discretion of the President of the Medical Staff during which guests and non-voting categories of the staff may be excluded.

The President of the Medical Staff will conduct a business meeting at least two (2) times per year (one of which may be the Annual Meeting) and report on medical staff issues. Staff meetings may be held exclusively for the purpose of continuing medical education.

9.3 Special Meetings

Special meetings of the Medical Staff may be called at any time by the President and shall be called at the request of the Board of Directors, the Medical Executive Committee, or any five members of the active Medical Staff. At any special meeting no business shall be transacted except that stated in the notice of any meeting at least 48 hours prior to the meeting.

9.4 Quorum

The number of members eligible to vote excused from any particular meeting shall be used to reduce the total membership from which the quorum is calculated.

9.4.1 Regular and Special Meetings of the Medical Staff: No less than fifteen (15) members of the Active Medical Staff members in attendance at regular or special meetings shall constitute a quorum.

9.4.2 Departmental and Committee Meetings: One fifth (20%) of the Active and Affiliate Medical Staff members shall constitute a quorum.

9.5 Majority

At any meeting of the Medical Staff or at any Departmental or Committee meeting, over fifty percent of the members eligible to vote shall constitute a majority. In the case of a tie, the member presiding over the meeting shall cast the deciding vote.

9.6 Distribution of Minutes

A copy of the approved minutes of all staff meetings shall be made available at all times to the Board of Directors.

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SECTION 10 - CORRECTIVE ACTION

Types of Corrective Action

- Automatic Suspension
- Summary Suspension
- Corrective Action for Sexual Harassment
- Ordinary Corrective Action

10.1 Automatic Suspension Categories

- Temporary
- Limited
- Complete

10.1.1 Temporary Automatic Suspension

10.1.1.1 Indications for Temporary Automatic Suspension
A temporary automatic suspension will be imposed by the Health Information Management (HIM), Credentialing Office (CO), or the Medical Staff Office (MSO) for the failure(s) to maintain:

10.1.1.1.1 Malpractice insurance coverage in the amount specified in the Rules and Regulations of the Medical Staff.
10.1.1.1.2 Complete medical records.
10.1.1.1.3 Current license to practice in Maryland, state (CDC), and/or federal (DEA) Controlled Substance registration.
10.1.1.1.4. Board certification in accordance with the departmental rules and regulations unless granted a waiver of the maintenance of board certification.
10.1.1.1.5. Current influenza vaccination and/or verification of tuberculosis status according to the Hospital's Tuberculosis Control Program.

10.1.1.2 Process for Termination of Temporary Automatic Suspension

Following imposition of a temporary automatic suspension, the suspension shall be automatically terminated upon receipt by the Medical Staff Office of proof of:

10.1.1.2.1 Required malpractice insurance and/or malpractice to cover the procedure.
10.1.1.2.2 Certification by the Director of HIM that the member has satisfactorily completed their medical records and corrected any medical record deficiencies.
10.1.1.2.3 Required Maryland state license, state (CDC) and/or federal (DEA) Controlled Substance registrations.
10.1.1.2.4 Current board certification in accordance with the departmental rules and regulations unless granted a waiver of the maintenance of board certification.
10.1.1.2.5 Current influenza vaccination or demonstration of medical or religious exemption from vaccination and/or verification of tuberculosis status.

10.1.2 Limited Automatic Suspension

10.1.2.1 Indications for Limited Automatic Suspension

10.1.2.1.1 Limitations or Restrictions of Licensure or Certification
- License and/or other legal credentials are limited or restricted by licensing and/or credentialing committee
- Duration of restriction will parallel that dictated by licensing and/or credentialing committee.

10.1.2.1.2 Malpractice Insurance Coverage
- Procedure performed is not covered by malpractice insurance coverage.

10.1.2.1.3 Performance of Procedure Beyond Scope of Privileges
- Procedure performed for which the operator does not have clinical privileges.

10.1.2.2 Process of Termination of Limited Automatic Suspension

10.1.2.2.1 Malpractice Insurance Coverage
- Providing proof of malpractice coverage for the procedure

10.1.2.2.2 Performance of Procedure Beyond the Scope of Privileges
- Obtains privileges to perform the procedure

- Complete counseling in accordance with the Medical Staff Code of Conduct Policy
- Compliance with other sanctions that may result according to the Bylaws.

10.2. Summary Suspension

10.2.1 Indications for Summary Suspension

10.2.1.1 When the continuation of practice by the Member presents an immediate threat to a patient's health and wellbeing; or

10.2.1.2 When the conduct or condition of the Member presents an immediate threat of danger to any patient, other practitioner, Hospital personnel or visitor or;

10.2.1.3 When an on-call member refuses to provide on-call coverage as described in Section 6.4.8.3 of these Bylaws.

10.2.2 Initiation of Summary Suspension

10.2.2.1 Summary Suspension can be imposed by:

- Chief of the Department to which the member belongs, CEO or CMO
- President of the Medical Staff after notificaton to the CEO or CMO or;
- Medical Executive Committee
- CEO or CMO
- Chairman of the Board of Directors
- Board of Directors

10.2.3 Process Following Summary Suspension

10.2.3.1 Within four (4) business days: Review by Medical Executive Committee with recommendation of suspension as Continue, Modified or Terminated

10.2.3.2 Continued or Modifed Summary suspension

- Within four (4) business days: Suspended member notified in writing for their right to review by the Board of Directors
- Notice may be handed in person or sent to the professional address of the suspended members maintained by the hospital via USPS by certified mail and return receipt requested. After three (3) business days following mailing, notice will be deemed received by the suspended member.
- Within seven (7) business days: Notification to review by the Board of Directors must be submitted in writing to the CEO by the suspended member or right to review will be deemed to have been waived.

- Waived right to review will default to indefinite suspension until the next regular appointment.
- At reappointment the Department Chief to which the suspended member belongs may recommend:
  1. Full reappointment
  2. Reappoinment with conditions
  3. Reappointment not recommended

10.2.2.3 Termination of Summary Suspension

- Decision is made by MEC
- Within four (4) business days after decision has been made: CEO will forward a report of the summary suspension and the deliberation of the MEC to Board of Directors.
- Within four (4) business days after receipt of the report and deliberatons, the Board of Directors will decide if summary suspension shall be terminated or remain, pending results of the investigation and Fair Hearing pursuant to these Bylaws regarding the matter leading to suspension.

10.3 Corrective Action for Sexual Harassment

10.3.1 Conduct Constituting Sexual Harassment

- Unwelcomed sexual advances, requests for sexual favors, and other verbal or physicial conduct of sexual nature
- Defined in the Medical Code of Conduct Policy
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals
- Such conduct has the purpose of effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment

10.3.2. When probable cause exists that conduct constituted sexual harassment and there has been no Administrative Resolution, the CEO shall:

- Forward the Probable Cause Determination to the Medical Executive Committee with request for corrective action (Section G of Medical Code of Conduct Policy)
- Impose summary suspension if conduct meets summary suspension criteria (Section 10.2.2 Bylaws) forward the summary suspension to the MEC for review, request for initiation of corrective action.

10.3.2.1 Within four (4) business days: MEC shall review the request for corrective action and/or the summary suspension and decide to:

- Approve CEO's action with notice of hearing right to the Member
- Request of corrective action approved, but the summary suspension terminated with notice of hearing rights provided to the CEO and Member
- Request of corrective action denied and the summary suspension terminated with notice of hearing rights provided to the CEO
- If a hearing is requested by either the CEO or the Member: proceed as a hearing on the merits with respect to the Probable Cause Determination

10.3.2.2 Following review by MEC

- Notice of hearing on merits of corrective action and/or summary suspension shall be provided to the accused Member and CEO

10.3.2.3 Within one (1) business day: CEO will forward a notice of hearing to the President of the Medical Staff and the Board of Directors

10.3.2.4 Notice of hearing shall advise the accused Member of the opportunity to:

- Be present at the hearing
- Be represented by counsel
- Testify and present witnesses
- Confront witnesses against him
- Examine witnesses under oath
- Cross examine opposing witnesses
- Impeach the credibility of any witness
- Offer and refute any relevant evidence
- Present oral and written arguments

10.3.3 Hearing on the Merits for Corrective Action and/or Summary Suspension for Sexual Harassment

10.3.3.1 Within three (3) days after receiving notice of a hearing the President of the Medical Staff shall:

- Appoint a Hearing Panel consisting of three (3) members of the Medical Staff
- Designate one member of the Hearing Panel to be Panel Chairman
- Schedule hearing to be held within fifteen (15) days
- Provide accused member and CEO at least ten (10) days advanced notice

10.3.3.2 Before five (5) days from the date of the scheduled hearing, the CEO and the accused Member shall notify the others in writing of the

witnesses they expect to testify at the hearing.

10.3.3.3 The Hearing Panel shall conduct the hearing according to the following:

- The accused Member and the Hospital each have the opportunities as outlined in Section 10.3.2.5 of the Bylaws
- Shall determine the admissibility of evidence and other procedural matter for which their decisions will be final
- The proceedings will be recorded so there will be a written transcipt, the cost for which will be borne by the hospital and a copy of which will be supplied to the accused Member
- The meeting shall be conducted in two (2) phases which may occur in one (1) day or two (2) separate days are outlined below:

10.3.3.3.1 Phase I

- Decide whether the accused Member engaged in sexual harassment as outlined in the Probable Cause Determination and was in violation of the Medical Staff Code of Conduct Policy and Medical Staff Bylaws
- If allerged sexual harassment consisted of a single incident, then only evidence relating to that evidence will be permissible
- If alleged sexual harassment consisted of a series of incidents, then only evidence relating to each of those incidents will be permissible
- After the close of evidence, the Hearing Panel will decide if the accused Member was guilty of engaging in sexual harassment

10.3.3.3.2 Phase II

- Hearing panel will consider and recommend disciplinary action, including disposition of the summary suspension
- May consider any information deemed relevant to deterime the appropriateness of the discipline and may include: prior Code of Conduct investigations, informal resolutions, Early Resolution Agreements, remedial actions, or formal Corrective Action proceedings
- Evidence regarding prior complaints that were never investigated under the Code of Conduct Policy or investigated and deemed not to have merit will be dismissed

10.3.4 Appeal of Decision of the Hearing Panel

10.3.4.1 May be made to the Board of Directors by the accused Member or by the CEO by written notice of appeal within five (5) business days after receipt of the hearing decision.

10.3.4.2 In the absence of a timely appeal the decision and recommendation of the Hearing Panel will be considered final.

10.3.4.3 Upon receipt of a timely appeal
- Board of Directors shall schedule and hold an oral argument within seven (7) business days
- The accused member and CEO will be given five (5) days advance notice of the date of the oral argument

10.3.4.4 Oral argument
- Accused Member, CEO, and respective counsel shall appear and present arguments relevant to the issue(s).
- Shall be limited to the arguments based upon the record of the hearing and the decision and recommendations of the Hearing Panel
- Any other evidence presented will not be accepted by the Board of Directors
- Either before or at the oral argument: written arguments may be submitted by the parties in support or in opposition to the whole or any part of the decision and recommendations of the Hearing Panel

10.3.4.5 Within five (5) business days after the oral argument, the Board of Directors:
- Will issue a written decision on the merits of the complaint, including findings of fact and determination of actions to be taken
- Shall send copies of the decision to the accused Member, President of the Medical Staff and the CEO
- The decision of the Board of Directors shall be FINAL.

10.4 Ordinary Corrective Action

10.4.1 Indications for Ordinary Corrective Action

10.4.1.1 Non-compliance with the Bylaws and Rules and Regulations of the Medical Staff which includes, but not limited to failure to:
- Disclose information pertinent to and necessary in the evaluation of a Member's qualification for (re)appointment to the Medical Staff
- Discharge responsibilities of membership

- Provide coverage as specified in the Bylaws

10.4.1.2 Care Below Applicable Standards which includes, but not limited to:
- Non-compliance with the Medical Staff Quality Policy and Procedures
- Lack of clinical competence
- Failure to adhere to standards of practice or patient care policies established by the Member's clinical department

10.4.1.3 Improper use of Carroll Hospital Center resources

10.4.1.4 Misconduct which has not been satisfactorily resolved in accordance with the Medical Staff Code of Conduct Policy

10.4.2 Initiation of Ordinary Corrective Action

10.4.2.1 Requests for ordinary corrective action may be initiated by:
- Any officer of the Medical Staff
- Chief of any Clinical Department
- Chairman of any standing committee
- CMO or CEO
- Board of Directors

10.4.2.2 Request for ordinary corrective action must be made in writing to the Medical Executive Committee and must include specific references to actions that constitute the basis for initiating corrective action proceedings

10.4.2.3 After reviewing the request for ordinary corrective action, the MEC may take the following actions:
- Acceptance of request: follow procedure described in the Fair Hearing and Appellate Process provisions from the Bylaws (Section 10.5)
- Reject the request: President of MEC shall inform the Board of Directors of the decision and the Board of Directors may accept the MEC's decision or initiate its own investigation and, if warranted, may impose actions in accordance with the Fair Hearing and Appellate Process (Section 10.5)

10.5 Fair Hearing and Appellate Process

All hearings shall be conducted as provided for by The Health Care Quality Improvement Act of 1986 and/or other applicable state or federal law.

10.5.1 Right to Hearing

10.5.1.1 Hearing may be requested for any adverse recommendation. An adverse recommendation is one which has a materially adverse effect on an Applicant's or Member's Medical Staff membership and/or clinical privileges and shall include, but not limited to, a recommendation of:

- Termination of Medical Staff Membership or clinical privileges
- Suspension of clinical privileges
- Denial of appointment of any requested clinical privileges
- Denial of reappointment
- Imposition of conditions or restrictions on privileges, other than ones imposed automatically, that limit the Member's ability to exercise clinical privileges

10.5.1.2 There shall be no entitlement to a hearing for any action that is recommended or taken which does not place conditions on, limit or restricts the Applicant's or Members' Medical Staff membership and/or clinical privileges including, but not limited to, the following actions:

- An agreed upon resolution
- Automatic suspension
- Letters of reprimand, censure or admonition
- Imposition of monitoring, proctoring, consultation or review requirements
- Imposition of educational or training requirements
- (Re)appointment for less than two (2) years
- A decision not to grant, not to extend or to terminate temporary privileges

10.5.2 Notice of Hearing

10.5.2.1. Within eight (8) days after receipt of an adverse recommendation from the MEC or Board of Directors, the CEO shall forward a copy of the Bylaws and a written notice of hearing that states reasons for the action and which shall advise:

- Of the right to a hearing
- That a request for hearing shall be made in writing and shall be sent to the President of the MEC within fifteen (15) days of receipt of the notice or the right to the hearing shall be waived
- Of the opportunity to be present at the hearing
- The rights given to any defendant as outlined in these Bylaws in Section 10.3.2.4

10.5.3 Scheduling of Hearing

10.5.3.1 Within eight (8) days of receipt of a request for a hearing, the President of the Medical Staff shall:
- Appoint a Hearing Subcommittee
- Thirty (30) days after issuance of notice: Issue notice to the Applicant or Member of the date, time and place of the hearing

10.5.4 Composition of the Panel

10.5.4.1 Hearing committee shall be composed of:
- Five (5) members of the Medical Staff: who are impartial and not in direct economic competition with the Applicant or Member who requested the hearing.
- One of the members of the subcommittee shall serve as the chairman as designated by the President of the Medical Staff
- The chairman shall serve as the subcommittee's presiding officer.

10.5.5 The Hearing

10.5.5.1 The Hearing will be conducted by the Hearing Subcommittee in accordance to the following rules:
- Each party has the opportunities as outlined in Section 10.3.2.4 of the Bylaws.
- Admissibility of evidence shall not be governed by the rules of the evidence applicable in court.
- Any relevant evidence may be admitted if it is the type of evidence upon which responsible persons would rely in the conduct of serious affairs.
- The presiding officer shall determine the admissibility of evidence and other procedural matters for which their decisions will be final, unless overruled by a majority of the committee
- The proceedings will be recorded so there will be a written transcript, the cost for which will be borne by the hospital and a copy of which will be supplied to the accused Member
- May have its own counsel present for procedural advice
- Each party shall bear any expense it incurs in connection with the hearing.

10.5.6 Decision of the Hearing Subcommittee

10.5.6.1 Within eight (8) days after final adjournment: Hearing Subcommittee shall render a decision if the decision pertains to a Member currently under suspension.

10.5.6.2 Within fifteen (15) days after final adjournment: Hearing Subcommittee shall render a decision for all other instances.

10.5.6.3 The decision of the Hearing Subcommittee shall:

- Be based upon the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony.
- Be accompanied by a written report stating the basis of the decision and any recommendations of the Hearing Subcommittee for further action.
- Be put into a written report stating that the basis of recommendations shall accompany the documentation provided to the Board of Directors
- All documentations will be delivered to the Applicant or Member and the Board of Directors with copies to the CEO and Medical Executive Committee.

10.5.7 Decision by the Board of Directors and Appellate Review

10.5.7.1 Board of Directors:

- Shall consider the disputed issue based upon the record and recommendation of the Hearing Subcommittee.
- Within fifteen (15) days: forward a written decision to the Applicant or Member, CEO and Medical Executive Committee.

10.5.7.2 CEO

- Within eight (8) days: Notify the parties of its decision, reasons for the decisions, and any right to and procedure for obtaining appellate review by the Board of Directors. Applicants are not entitled to appellate review.
- If appellate review is requested, notify the parties of the date, time, and place, which shall be no more than thirty days (30) from the date of the receipt of request for appellate review.

10.5.7.3 The Member:

- May submit written argument in support or opposition to the whole or any part of the findings and recommendations of the Hearing Subcommittee.
- Within fifteen (15) days of receipt of the Board of Directors decision: file a written request to the CEO for appellate review or the right to appeal shall be waived. The request shall state whether the Member or their attorneys wish to submit written arguments, appear before the Board of Directors to deliver oral arguments, or both.

- If the parties appear before the Board of Directors, the Chairman of the Board of Directors shall act as presiding officer and may limit the presentation to those matters raised before the Hearing Subcommittee.

10.5.7.4 Appellate Review: Board of Directors:
- Shall decide the disputed issue upon the recommendations of the Hearing Subcommittee and the written and/or oral arguments presented to it on appeal.
- Decision is final
- Within eight (8) days of its decision: shall notify in writing of its decision to the Member, the President of the Medical Staff and the CEO.
- In case of adverse decision against the Member of the Medical Staff, shall impose sanctions upon that person.

10.5.8 Sanctions:
- A formal letter of reprimand
- Probation upon conditions and with such consequences as the Board of Directors may determine
- The imposition of monitoring, mentoring, preceptoring, counseling or supervision pertaining to the exercise of staff privileges.
- Imposition of costs of sanctions and fines.
- Suspension of privileges for a period not to exceed one (1) year.
- Limitations of staff privileges.
- Revocation of staff privileges.
- Denial of new applicant's request for privileges.
- Other sanction(s) as deemed appropriate under the circumstances by the Board of Directors.

10.5.9 Other Provisions

10.5.9.1 Records and Recommendations Under this section:
- Treated as privileged communication
- Distribution limited to fulfilling the purpose of resolving disputes involving the Medical Staff at Carroll Hospital Center.
- Actions shall be reported to the appropriate regulatory body if required by law.

10.5.9.2 Duty of the CEO:
Notification by the CEO of the decision of the Board of Directors does not accrue until all rights to hearing and appellate review have been exhausted and that action is deemed final pusuant to the provisions of these Bylaws.

10.5.9.3 Rights of Applicant and Members

- One (1) Hearing Subcommittee for applicant
- One (1) Hearing Subcommittee and one (1) appellate review for Members
- For each particular and discrete application for reappointment, expansion of privileges or request for corrective action.

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SECTION 11 – ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS

11.1 Adoption

Adoption of the Medical Staff Bylaws shall be effective upon an affirmative two-thirds vote of the returned ballots of the voting members of the Medical Staff and upon approval by the Board of Directors.

11.2 Amendment

Amendments to the Medical Staff Bylaws may be proposed by any member of the Medical Staff, Administration or Board of Directors and must be directed to the Bylaws Committee. The Bylaws Committee will evaluate the proposed amendment and report on same, with recommendations, to the Medical Executive Committee. The M.E.C. will then review the proposed amendment and reject, modify, approve or recommit to the Bylaws Committee for further consideration. When the M.E.C. has approved the proposed amendment, it will be submitted to the members of the Medical Staff entitled to vote thereon.

If the Medical Executive Committee rejects a proposed amendment to the Bylaws, the Medical Staff may propose the amendment directly to the Board of Directors upon presentation of a petition signed by 33% of the voting members of the Medical Staff. Upon acceptance of any petitioned amendment to the Bylaws, the Board of Directors shall direct the President of the Medical Staff to submit the petitioned amendment to the members of the Medical Staff entitled to vote thereon.

Any amendment of the Medical Staff Bylaws must be approved by an affirmative two-thirds vote of the returned ballots of voting members of the Medical Staff and shall become effective upon approval by the Board of Directors.

11.3 Mechanism of Voting

Any proposed amendments to the Medical Staff Bylaws must be mailed to the Active Medical Staff along with an explanation of the rationale for the changes and a ballot for voting by return mail.

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SECTION 12 – MEDICAL STAFF RULES, REGULATIONS AND POLICIES

12.1 Rules and Regulations

The Medical Staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these Bylaws and shall be adopted and amended by the same procedure for adopting and amending the Bylaws as described in Section 11. Any adoption or amendment of the Rules and Regulations shall become effective when approved by the Board of Directors.

12.2 Urgent Amendment of Rules and Regulations

In cases of documented need for an urgent amendment to the rules and regulations in order to comply with changes in the law, regulations or requirements of The Joint Commission, the Medical Executive Committee may provisionally adopt and the Board of Directors may provisionally approve an urgent amendment to the Rules and Regulations without prior notification to the medical staff. Upon provisional approval of the amendment, the Medical Executive Committee shall present the amendment to the Medical Staff, within 30 days, for ratification. The provisional amendment shall become permanent if approved by two-thirds vote of the returned ballots of the voting members of the Medical Staff. If the amendment fails to be ratified, a revised amendment shall be prepared by the Medical Executive Committee and submitted to the voting members of the Medical Staff for ratification within 60 days. Upon ratification by the Medical Staff, the revised amendment shall be submitted to the Board of Directors for action. To comply with changes in the law, regulations or requirements of the Joint Commission, the provisional amendment shall be in effect until a revised amendment is approved by the Medical Staff and Board of Directors.

12.3 Policies

The authority to adopt and amend Medical Staff Policies consistent with the Medical Staff Bylaws is delegated to the Medical Executive Committee. Medical Staff Policies shall be adopted and amended upon a two-thirds vote of the voting members of the Medical Executive Committee and shall become effective when approved by the Board of Directors.

If the voting members of the Medical Staff propose to adopt a policy or an amendment thereto, the proposal must first be communicated to the Medical Executive Committee. If the Medical Executive Committee declines to adopt the proposed policy, upon presentation of a petition signed by 33% of the voting members of the Medical Staff, the Medical Staff may propose the policy directly to the Board of Directors. Upon acceptance of any petitioned policy, the Board of Directors shall direct the President of the Medical Staff to submit the petitioned policy to the members of the Medical Staff for a vote. Any petitioned policy must be approved by an affirmative two-thirds vote of the returned

ballots of members of the Medical Staff and shall become effective upon approval by the Board of Directors.

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SECTION 13 - PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Medical Staff in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and any special rules of order the Medical Staff may adopt.

Adopted by the voting members of the Medical Staff of Carroll Hospital Center:

MARK GOLDSTEIN, M.D.
President, Medical Staff

Date: ______________________

WILLIAM McNALLY, C.R.N.A.
Secretary/Treasurer, Medical Staff

Date: ______________________

Approved by the Board of Directors of Carroll Hospital Center:

ALEC YEO
Chair, Board of Directors

Date: ______________________

MARTIN K.P. HILL
Secretary, Board of Directors

Date: ______________________

RULES AND REGULATIONS
THE MEDICAL STAFF OF CARROLL HOSPITAL CENTER

1. In an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm - regardless of his or her medical staff status or clinical privileges - provided that the care, treatment and services are provided within the scope of the individual's license.

2. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper written consent unless it is a Medical Examiner's case. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility.

3. Patients requiring admission who have no personal physician nor have expressed preference for any physician shall be attended by members of the medical staff on duty in the appropriate department.

4. Each member of the medical staff actively practicing his profession must carry a minimum of $1,000,000. per occurrence/$3,000,000. per annum aggregate professional liability insurance or equivalent protection against professional liability (medical malpractice) exposure acceptable to the hospital. In the event that any member's professional liability protection excludes specific procedures from coverage, that member or the association which employs or contracts with that member, shall notify the Credentials Committee of same within 10 business days of his receipt of such exclusion(s). Failure of notification will result in automatic suspension of the affected member's hospital privileges. Each member, or the association which employs or contracts with the member, shall submit documentation of professional liability protection on an annual basis, prior to the end of the fiscal year of the hospital.

5. Mass Casualty Assignments - All physicians shall agree to fulfill their mass casualty assignments as described in the Hospital disaster plan.

6. No patient shall be discharged except by order of the medical staff member attending him or his designee.

7. The attending physician shall be responsible for medical records documentation consistent with medical records policies which includes but not limited to documentation of history and physical examination, verbal orders and incomplete and delinquent records; and departmental rules and regulations.

8. Any patient that presents for emergency treatment receives a medical screening by a physician or Advanced Practice Provider. Patients are not denied care for any reason, i.e. religious, financial or ethnic reasons.

9. All records are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except on a court order or subpoena. In case of readmission of a patient, all previous records shall be available for the use of the medical staff member attending the patient.

10. Free access to all medical records of all patients shall be afforded to staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the President of the hospital, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

11. All members required to pay dues shall remit same within 30 days of the initial written notification. Any member failing to remit such sums within 30 days of a designated "final notice" shall automatically forfeit their privileges and medical staff membership.

12. All members required to pay fines shall remit same within 30 days of completion of any appeals process. Any member failing to remit such sums within the specified 30 days shall automatically forfeit their privileges and medical staff membership as of the end of the 30-day period.

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Adopted by the voting members of the Medical Staff of Carroll Hospital Center:

____________________________	____________________________
MARK GOLDSTEIN, M.D. President, Medical Staff	WILLIAM McNALLY, C.R.N.A. Secretary/Treasurer, Medical Staff
Date: ________________________	Date: ________________________

Approved by the Board of Directors of Carroll Hospital Center:

____________________________	____________________________
ALEC YEO Chair, Board of Directors	MARTIN K.P. HILL Secretary, Board of Directors
Date: ________________________	Date: __________________