BYLAWS

MEDICAL STAFF

INOVA LOUDOUN HOSPITAL

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Medical Staff Rules and Regulations
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CONFIDENTIAL

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MEDICAL STAFF BYLAWS
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PREAMBLE

WHEREAS, INOVA LOUDOUN HOSPITAL is a not-for-profit corporation organized under the laws of the Commonwealth of Virginia; and

WHEREAS, its purpose is to serve as an acute care Hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is delegated responsibility for the quality of care rendered in the Hospital by all individuals with delineated clinical privileges and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Directors, and that the cooperative effort of the Medical Staff, the Chief Executive Office, and the Board of Directors is necessary to fulfill the Hospital’s obligations to its patients.

THEREFORE, the practitioners in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE 1 DEFINITIONS

1. HOSPITAL means INOVA LOUDOUN HOSPITAL, formerly known as Loudoun Hospital Center, at 44045 Riverside Parkway, Leesburg, Virginia, 20176.

2. BYLAWS are the framework for self-governance of the medical staff activities and accountability to the governing body. They create a system of mutual rights and responsibilities between a member of the medical staff and the Hospital. Bylaws are adopted by the medical staff and approved by the governing body.

3. INOVA HEALTH SYSTEM is a corporation with which Loudoun Hospital Center executed a merger in 2004.

4. BOARD OF DIRECTORS OR BOARD means the governing body of the Hospital, with authority to oversee and approve, within any existing Inova policies and procedures, all matters related to quality assurance, patient safety and satisfaction for all service lines, and medical staff credentialing and relations at the Hospital.

5. INOVA HOSPITAL means any other Hospital owned by Inova Health System or any successor corporation.

6. CHIEF EXECUTIVE OFFICER or ADMINISTRATOR means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

7. CHIEF MEDICAL OFFICER means a physician appointed by the Chief Executive Officer and employed by the Hospital who performs assigned administrative duties and who, when so authorized by the Chief Executive Officer, serves as his substitute in roles prescribed by these Bylaws and in subordinate documents.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a health care practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services.

9. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

10. ADVANCED PRACTICE PROVIDER formerly known as Allied Health Professional means an individual, other than an M.D., D.O., D.D.S., D.M.D., or D.P.M., whose patient care activities require that his authority to perform specified patient care services be processed through the usual Medical Staff channels.

11. MEDICAL STAFF or STAFF means the formal organization of practitioners who qualify for membership as specifically defined in these Bylaws.

12. MEDICAL STAFF YEAR means the period from January 1 to December 31.
13. PHYSICIAN means, unless otherwise expressly limited, an appropriately licensed M.D. or D.O.
14. PRACTITIONER means, unless otherwise specified, a member of the Medical Staff, a holder of Clinical Privileges, or an applicant for Medical Staff membership or Clinical Privileges.
15. QUORUM means, unless otherwise specified in these Bylaws, 33 $\frac{1}{3}$% of the members of the Medical Staff with voting eligibility as defined in these Bylaws and who are present in person at a meeting or who have submitted mail or electronic ballots.
16. RESPONSIBLE PRACTITIONER means the practitioner who has primary responsibility for the management of a patient and for the initial management of unexpected events.
17. WRITTEN NOTICE is a written communication delivered by certified mail, registered mail or documented personal delivery to the individual who is to receive the notice.
18. TERMINATION OF MEMBERSHIP is an action taken by the Medical Staff and the Board of Directors against a practitioner that ends both Medical Staff participation and patient care privileges, with rights of appeal for the practitioner as specified in these Bylaws.
19. RELINQUISHMENT is a discontinuation both of medical staff participation and patient care privileges, considered voluntary under circumstances specified in these Bylaws.
20. CHIEF OF STAFF AND VICE CHIEF OF STAFF are equivalent terms for the President of the Medical Staff and the Vice President of the Medical Staff, respectively, used prior to revision of these Bylaws in 2011.

ARTICLE 2 NAME

2.1. The name of this organization shall be the Medical Staff of INOVA LOUDOUN HOSPITAL.

ARTICLE 3 PURPOSES AND RESPONSIBILITIES

3.1. The purposes of the Medical Staff are:

3.1.1 to be the formal organizational structure through which the benefits of membership on the staff may be obtained by individual practitioners and the obligations of staff membership may be fulfilled.

3.1.2 to serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and affiliated and/or advanced practice providers, and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

3.1.3 to provide a means through which the Medical Staff may participate in the Hospital's policy making and planning process.

3.2. The responsibilities of the Medical Staff are to account for the quality and propriety of patient care rendered by all practitioners and other health professionals authorized to practice in the Hospital through the following measures:

3.2.1 a credentials program, including mechanisms for appointment and reappointment and the matching of clinical privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated competence of any applicant, for new or renewed membership and/or privileges.
3.2.2 a continuing education program, fashioned at least in part on the needs demonstrated through patient care audit and other quality improvement programs.

3.2.3 a patient care audit and monitoring function to ensure the quality, safety and efficiency of patient care within the Hospital.

3.2.4 a utilization review program to allocate medical and health services based upon patient specific determinations of individual medical needs.

3.2.5 an organizational structure that allows continuous monitoring of patient care practice to ensure the quality, safety and efficiency of patient care within the Hospital.

3.2.6 retrospective review and evaluation of the quality of patient care through a valid and reliable patient care audit procedure.

3.2.7 to recommend to the Board action with respect to appointments, reappointments, staff category, departmental assignments, clinical privileges, specified services for advanced practice providers and corrective action.

3.2.8 to account to the Board for the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of patient care audit and other quality improvement activities.

3.2.9 to initiate and pursue corrective action when warranted with respect to members and any-practitioners with clinical privileges.

3.2.10 to develop, administer and seek compliance with these Bylaws, the rules and regulations of the staff, and other patient care related Hospital policies.

3.2.11 to assist in identifying community health needs, in setting appropriate institutional goals, and in implementing programs to meet those needs and goals.

3.2.12 to participate with the administration in advising the Board about long-range planning and capital equipment acquisition related to patient care services.

3.2.13 to exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities adequately.

**ARTICLE 4 MEDICAL STAFF MEMBERSHIP**

4.1. Membership on the Medical Staff of INOVA LOUDOUN HOSPITAL is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and whose addition to the Medical Staff will be for the good of the Hospital and will not interfere with the efficient, orderly, and smooth operation of the Hospital.

4.2. **BASIC QUALIFICATIONS FOR MEMBERSHIP:**

4.2.1 Membership on the Medical Staff of Inova Loudoun Hospital is available only to practitioners who (unless categorically exempted by these bylaws):
4.2.2 Board Certification.

4.2.2.1 All Practitioners on the Medical Staff (unless categorically exempted by these bylaws) shall be either:

4.2.2.1.1 board certified by a national specialty board which is approved by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, the American Osteopathic Association or an equivalent specialty board approved by the Hospital’s Board of Trustees after considering the recommendations of the Medical Executive Committee and the Hospital CEO, or

4.2.2.1.2 for those Practitioners who have not been previously board certified in accordance with the foregoing subsection, are currently eligible to become board certified and obtain board certification within the time frame required by the applicable specialty board.
4.2.2.2 Once board certified, it shall be the obligation of any Practitioner with clinical privileges to maintain board certification in the specialty or subspecialty most closely aligned to their clinical privileges. If a Practitioner fails to maintain board certification, the Practitioner will have two years from the date the certification lapsed to have it reinstated. If the Practitioner fails to accomplish this in this time period, the provisions in Section 9.7.3.4 will apply.

4.2.2.3 Existing members of the medical staff who were not board certified as of January 1, 2004 shall be exempt from the foregoing requirement. However, this exemption shall not apply to any members of the medical staff who were not board certified as of January 1, 2004 but subsequently became board certified at any time after January 1, 2004.

4.2.2.4 In extraordinary circumstances, the Board may waive the board certification requirement or extend the time within which the Practitioner is required to become board certified, after considering the recommendations of the appropriate Section, Department, Credentials Committee and/or the Executive Committee.

4.2.3 Effect of Other Affiliations

4.2.3.1 No practitioner is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or any other state, or because he is a member of any professional organization, or because he is certified by a clinical Board, or because he had, or presently has, staff membership or privileges at another health care facility or in another practice setting.

4.2.4 Nondiscrimination

4.2.4.1 Medical staff membership or particular clinical privileges shall not be denied on the basis of sex, race, creed, color, or national origin of on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

4.2.5 Practitioners with Administrative Responsibilities

4.2.5.1 Any practitioner engaged by the Hospital with administrative as well as clinical responsibilities must be a member of the Medical Staff, achieving this status by the procedure provided in ARTICLE 7. His clinical privileges must be delineated in accordance with ARTICLE 8. The Medical Staff membership and clinical privileges of this practitioner shall not be contingent on his continued occupation of that administrative position, unless otherwise provided in his agreement with the Hospital.

4.3. BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP:

4.3.1 Each member of the Medical Staff shall:

4.3.1.1 provide his patients with care of the generally professionally recognized and accepted level of quality and efficiency, including medical assessment and treatment.

4.3.1.2 abide by the Medical Staff Bylaws and rules and regulations and by all other lawful standards, policies and rules of the Hospital.

4.3.1.3 discharge such staff, department, committee and Hospital functions for which he is responsible by appointment, election, or otherwise.
4.3.1.4 prepare and complete in a timely manner the medical and other required records for all patients he admits, or in any way provides care to, in the Hospital.

4.3.1.5 abide by the ethical principles of the medical profession

4.3.1.6 maintain current clinical proficiency and provide documentation of it, upon request.

4.3.1.7 provide emergency medical screens and emergency medical treatment to all patients without regard to age, sex, race, color, creed, handicap, national origin, or economic status.

4.3.1.8 abide by the Bylaws, Rules and Regulations, and Policies of the Medical Staff and of the Hospital, including policies regarding the privacy, confidentiality, and security of protected health information.

4.3.1.9 ensure a complete medical history and physical examination of each patient is completed by a provider credentialed to perform history and physical examinations, no more than 30 days before or 24 hours after admission or registration (but before any surgery or procedure requiring anesthesia), in accordance with the Medical Staff Rules and Regulations, Policies and Procedures, and any relevant provision of the Medical Staff Bylaws. If the history and physical examination was completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition must be completed within 24 hours after registration or admission (but before any surgery or procedure requiring anesthesia services).

4.3.1.10 report to the Administrator any physical or mental condition which could in any way impair the Practitioner’s ability to treat patients.

4.4. DURATION OF APPOINTMENT

4.4.1 Duration of Initial and Modified Appointments

4.4.1.1 All initial appointments are effective for a term extending to the last day of the practitioner’s birth month closest to two years without exceeding two years. All modifications of appointments pursuant to Section 7.6 shall be for a term extending to the next scheduled reappointment.

4.4.2 Reappointments

4.4.2.1 Reappointments to any category of the Medical Staff shall be for a period of not more than two (2) years.
4.5. PROVISIONAL STATUS

4.5.1 Initial Appointments

4.5.1.1 Except as otherwise determined by the Board, all initial appointments to any category of the staff shall be provisional. Each provisional appointee shall be assigned to a department where his performance shall be observed by the Chairperson of that department or such Chairperson's designee, and may be observed by a committee of department members appointed by the Chairperson to determine his eligibility for non provisional staff membership in the staff category to which he was provisionally appointed and for exercising the clinical privileges provisionally granted. This provisional status shall continue for no more than one year. An initial appointment and renewals thereof shall remain provisional until the appointee has furnished to the Credentials Committee and to the Chief Executive Officer or his designee:

4.5.1.1.1 a statement signed by the Chairperson of the department to which he is assigned that the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the staff category to which he was provisionally appointed; and

4.5.1.1.2 a statement signed by the Chairperson of the committee, if appointed, that the appointee has satisfactorily demonstrated his ability to exercise the clinical privileges provisionally granted to him.

4.5.2 Modification in Staff Category and Clinical Privileges

4.5.2.1 The Medical Executive Committee may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member pursuant to Section 7.6 be made provisional in accordance with procedures similar to those outlined in Section 4.5.1 for initial appointments.

4.6. LEAVE OF ABSENCE

4.6.1 Leave Status

4.6.1.1 A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and the Chief Executive Officer or his designee stating the exact period of time of the leave, which may not exceed two (2) years. During the period of leave, the staff member's privileges and prerogatives shall be relinquished. A staff member must complete all medical records prior to embarking upon his or her leave of absence.

4.6.2 Termination of Leave

4.6.2.1 At least forty five (45) days prior to the termination of the leave, or at any earlier time, the staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the Chief Executive Officer or his designee for transmittal to the Medical Executive Committee. The staff member shall submit a written summary of his relevant activities during the leave, if the Medical Executive Committee, the CEO or his designee, or the Board so requests. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of
the member’s privileges and prerogatives. Failure without good cause to request reinstatement or to provide a requested summary of activities as above provided shall result in automatic termination of staff membership, privileges, and prerogatives without right of hearing or appellate review. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

4.7. MEDICAL LEAVE

4.7.1 Any Practitioner at any time may be placed on medical leave at his or her own request. Upon the Practitioner’s request for reinstatement of membership or clinical privileges, the Practitioner shall provide any information reasonably requested to enable the Hospital to evaluate whether the condition affects the Practitioner’s ability to exercise the clinical privileges that have been granted.

4.7.2 In addition, whenever the President of the Medical Staff believes that a Practitioner could be suffering from a physical or mental condition which impairs the ability of the Practitioner to treat patients, the President of the Medical Staff, may request that the Practitioner submit to a physical or mental examination to determine whether the Practitioner is suffering from any condition that would interfere with his or her treatment of patients.

4.8. RESIGNATION

4.8.1 A resignation by a member of the medical staff shall be presented to the Credentials Committee, Medical Executive Committee and Board of Directors. The resignation is effective immediately on the date of the presentation of a letter of resignation to the Medical Staff Office and on approval by the President, provided all medical staff obligations have been met by the resigning member. Resignation shall constitute relinquishment of both Medical Staff membership and clinical privileges, but shall be considered a voluntary action by the practitioner.

4.9. TERMINATION OF MEMBERSHIP

4.9.1 Termination of membership on the medical staff may be recommended by the Medical Executive Committee but shall be determined by the Fair Hearing process as defined in ARTICLE 9 and ARTICLE 11 of these Medical Staff Bylaws.

ARTICLE 5 CATEGORIES OF THE MEDICAL STAFF

5.1. All members of the Medical Staff shall be assigned to one and only one of the following categories:

5.2. ACTIVE STAFF

5.2.1 The Active Staff shall consist of Practitioners who, in accordance with the nature of their respective practices, frequently utilize the Hospital for care of their patients or for the practice of their specialty, who satisfactorily assume all the responsibilities of Active Staff membership and who are involved in the care and treatment of at least 12 (twelve) patients per appointment period at the Hospital as measured by patient contacts, which are defined as admissions, consultations, procedures (inpatient/outpatient), and/or evaluations or services performed in the Emergency Department; provided, however, that a Department or Section
may establish reasonable alternative patient contact requirements which shall apply in lieu of the foregoing upon approval of the Executive Committee.

5.2.2 There may be established for the Active Staff specific activity requirements at the Hospital which may vary based on the characteristic practice of each specialty and the needs and operations of the Hospital. Such requirements may be established by the Executive Committee after receiving the recommendations of the appropriate Department or Section.

5.2.3 The Active Staff shall transact all business of the Medical Staff, shall be responsible for conducting and contributing to the educational programs of the Hospital and shall participate in taking call for the emergency room in their specialty as required by Hospital and/or department rules and regulations and policies.

5.2.4 Members of the Active Staff shall:
   5.2.4.1 be entitled to admit patients to the Hospital;
   5.2.4.2 have the right to vote on all matters properly coming before the Medical Staff pursuant to these Bylaws;
   5.2.4.3 be able to hold office on the Medical Staff;
   5.2.4.4 pay dues in accordance with these Bylaws;
   5.2.4.5 serve on Medical Staff committees, and perform such other assignments deemed necessary by the Executive Committee; and
   5.2.4.6 be required to attend Medical Staff meetings as provided in these Bylaws.

5.3. COURTESY STAFF

5.3.1 The Courtesy Staff shall consist of those Practitioners who are qualified for Medical Staff membership but who only occasionally admit patients to the Hospital. As members of the Courtesy Staff they shall be privileged to admit and/or attend up to twelve (12) patients per appointment period at the Hospital; provided, however, that a Department or Section may establish reasonable alternative patient contact requirements which shall apply in lieu of the foregoing upon approval of the Executive Committee.

5.3.2 Courtesy Staff members shall be required to participate in taking call for the emergency room in their specialty if requested under rules formulated by their department and approved by the Executive Committee and Board.

5.3.3 Members of the Courtesy Staff shall:
   5.3.3.1 have the right to vote on all matters properly coming before the Medical Staff pursuant to these Bylaws;
   5.3.3.2 have the right to vote on matters coming before their department when so permitted by rules formulated by their department and approved by the Executive Committee and Board;
   5.3.3.3 not be able to hold office on the Medical Staff;
   5.3.3.4 pay dues in accordance with these Bylaws;
   5.3.3.5 serve on Medical Staff committees, and perform such other assignments deemed necessary by the Executive Committee; and
   5.3.3.6 be required to attend Medical Staff meetings as provided in these Bylaws.
5.4. AFFILIATED PHYSICIAN STAFF

5.4.1 The Affiliated Physician Staff, formerly known as Community Physician Staff shall consist of those Practitioners who restrict their clinical activities to an office-based practice and desire to maintain a close connection to the Hospital and wish to remain or become a member of the Medical Staff, without clinical privileges, for educational purposes, collegiality, or to comply with a requirement for panel membership in an indemnity, PPO, or HMO insurer. The Affiliated Physician Staff shall meet the basic qualifications for Medical Staff membership set forth in these Bylaws, except that they do not have to be licensed in the Commonwealth of Virginia as long as they are duly licensed in another State.

5.4.2 Members of the Affiliated Physician Staff shall not be granted clinical privileges and shall not admit or attend to patients in the Hospital.

5.4.3 Members of the Affiliated Physician Staff shall:

5.4.3.1 have the right to vote on all matters properly coming before the Medical Staff pursuant to these Bylaws;
5.4.3.2 have the right to vote on matters coming before their department when so permitted by rules formulated by their department and approved by the Executive Committee and Board;
5.4.3.3 not be able to serve as President or Vice President of the Medical Staff;
5.4.3.4 pay dues in accordance with these Bylaws;
5.4.3.5 serve on Medical Staff committees and perform such other assignments deemed necessary by the Executive committee;
5.4.3.6 be required to attend Medical Staff meetings as provided in these Bylaws; and
5.4.3.7 have the right to hold the position of department chairperson unless that Department requires Active status under their Rules and Regulations.
5.4.3.8 be subject to the initial board certification requirement in Section 4.2.2.1 but be exempt from the recertification requirement in Section 4.2.2.2

5.5. HONORARY STAFF

5.5.1 The Honorary Staff shall consist of Practitioners the Medical Staff wishes to recognize for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing meritorious service to the Hospital. These may be Physicians, Dentists and Podiatrists retired from active practice and Hospital service, or of outstanding reputation not necessarily resident in the community.

5.5.2 The Honorary Staff shall meet the basic qualifications for Medical Staff membership, excluding the requirement to maintain professional liability insurance, board certification, DEA registration, or medical licensure.

5.5.3 Members of the Honorary Staff shall:
5.5.3.1 not have the right to vote;
5.5.3.2 not be able to hold office on the Medical Staff;
5.5.3.3 not be required to pay dues;
5.5.3.4 be permitted to serve on Medical Staff committees as non-voting members;
5.5.3.5 not be required to attend Medical Staff meetings; and
5.5.3.6 not be required to complete reappointment.
5.6. TELEMEDICINE STAFF

5.6.1 The Telemedicine Staff shall consist of Physicians who, in accordance with the nature of their respective practices, treat patients in the Hospital only via the use of telemedicine, as defined in 4.5-2.

5.6.2 Telemedicine is defined as the medical diagnosis, management, evaluation, treatment, or monitoring of injuries and diseases through the use of communication technology. The Board will determine what clinical services may be provided through telemedicine after considering the recommendations of the appropriate department chairperson, the Credentials Committee and the Executive Committee.

5.6.3 Members of the Telemedicine Staff shall:
   5.6.3.1 not have the right to vote;
   5.6.3.2 not be able to hold office on the Medical Staff;
   5.6.3.3 not be permitted to admit or attend patients;
   5.6.3.4 be required to pay dues;
   5.6.3.5 not be permitted to serve on Medical Staff Committees; and
   5.6.3.6 not be required to attend Medical Staff meetings.

5.6.4 Members of the Telemedicine Staff shall be privileged and credentialed using the same process as that for membership on the Active Staff, provided, however, if permitted by law, regulations and any applicable accreditation standards the Hospital may obtain and rely on information and documentation related to the Physician’s, Podiatrist’s, or Dentist’s qualifications and competence provided by the site or organization where the Physician, Podiatrist, or Dentist is located if that site meets all requirements of the Centers for Medicare & Medicaid Services and appropriate accreditation agencies and is accredited by The Joint Commission or another accreditation organization approved by Centers for Medicare & Medicaid Services to grant deemed status. The Hospital may verify directly through original sources such information as the Hospital deems appropriate.

5.6.5 Members of the Telemedicine Staff must be properly licensed, certified, and/or permitted to practice in the Commonwealth of Virginia.

5.7. GRADUATE MEDICAL EDUCATION (GME) PARTICIPANTS

5.7.1 Definition of Graduate Medical Education (GME) Participants: Graduate Medical Education (GME) participants (Residents and Fellows) holding temporary or permanent licenses to practice their specialty from the Commonwealth of Virginia and who meet the requirements of Virginia Code and such other qualifications as may be recommended by the Medical Executive Committee and approved by the Hospital's Board may be permitted to provide patient care services at the Hospital as part of a Graduate Medical Education Training Program as approved by the Hospital.

5.7.2 Information Required: GME participants shall complete an information form that details their background, education, training, experience, licensure and physical and mental health status prior to their appointment to Graduate Medical Education (GME) participant status.

5.7.3 Supervision of GME Participants: GME participants shall be responsible and accountable at all times to a supervising member of the medical staff with privileges appropriate to the specific residency program, who shall be approved by the Executive Committee and the Board.
supervising practitioner shall have ultimate responsibility for the care of the patient.

5.7.4 Roles, Responsibilities and Patient Care Activities of GME Participants:

5.7.4.1 The most effective learning environment for GME participants is one that allows sufficient freedom for GME participants to share responsibility for decision making in patient care and yet provides adequate faculty supervision. Adequate supervision by a supervising practitioner of the medical staff is necessary to provide feedback to GME participants about their actions, and to address the quality and safety of the care rendered to patients. GME participants will not practice independently. GME participants shall be under the direct supervision of at least one supervising practitioner. -GME participants, working under the authority and supervision of such a practitioner, may be regarded as the primary coordinators of care for their patients, and as such may be responsible for:
5.7.4.1.1 Making rounds with the supervising practitioner
5.7.4.1.2 Assisting in performing surgery and other procedures, and assisting with follow-up in those cases, when appropriate
5.7.4.1.3 Writing progress notes and maintaining medical records
5.7.4.1.4 Writing orders when in accordance with state and Federal regulations
5.7.4.1.5 Writing orders when in accordance with state and Federal regulations
5.7.4.1.6 Formulating and/or carrying out diagnostic, therapeutic and discharge plans
5.7.4.1.7 Serving as the primary coordinator of care for all patients admitted to:
   5.7.4.1.7.1 Inpatient and outpatient services
   5.7.4.1.7.2 Emergency rooms
   5.7.4.1.7.3 Clinics

5.7.4.2 Medical Record Entries: The following entries in the medical record must be co-signed by the supervising practitioner:
5.7.4.2.1 Progress notes
5.7.4.2.2 Orders

5.7.4.3 The GME participant may perform preoperative history and physical examinations on those patients classified as ASA 1 or 2 under American Society of Anesthesiology standards, provided the supervising attending has the same privilege.

5.7.5 Review of GME Participants’ Performance: Essential areas of professional competency will be evaluated regularly and in writing by the supervising practitioner and provided along with recommendations to the appropriate GME Program Director for each participant’s progressive involvement and independence in specific patient care activities:

5.7.5.1 Number and type of cases participated in
5.7.5.2 Supervising practitioner’s comments and recommendations
5.7.5.3 Medical record review deficiencies

5.7.6 Reports to the Inova Loudoun Hospital Medical Executive Committee: The Loudoun Graduate Medical Education Program Director for the Graduate Medical Education Committee (Inova GMEC) will provide quarterly reports on the following to the Inova Loudoun MEC:

5.7.6.1 Progress of participants in the program
5.7.6.2 Status of the Inova Graduate Medical Education program
5.7.6.3 The safety and quality of patient care, treatment, and services provided by the participants in professional graduate education programs, including adequacy of the performance of the supervising practitioner
5.7.6.4 The related educational and supervisory needs of the participants in professional graduate education programs

5.7.7 The GME Program Director will immediately provide to the MEC information on all program residency review committee citations including information regarding compliance.

5.7.8 Reports to the Graduate Medical Education Committee: The GME Program Director will provide, on a quarterly basis, information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.

5.7.9 The responsibility for the communication with any supervisory body outside the hospital is the responsibility of the Graduate Medical Education Committee (GMEC).

5.8. MEDICAL STUDENTS AND ADVANCED PRACTICE PROVIDER STUDENTS

5.8.1 Inova Health System shall have a written agreement with the student’s institution allowing the student to rotate through the facility and confirming the student is in good standing.

5.8.2 Students shall complete an information form that details demographic information as well as education and training. Certification re physical and mental health status will also be requested.

5.8.3 Students will be assigned duties and activities in the clinical practice of medicine as outlined in the Student Protocol, and only under the supervision, direction and control of the supervising member of the medical staff responsible for the preceptorship of the student. Specific duties will be identified in writing, specific to the specialty area of medicine.

5.8.4 Students shall comply with the Medical Staff Bylaws, Rules and Regulations, and other policies and procedures of the Hospital as may be applicable.

5.8.5 Students shall not be members of the medical staff.

5.9. OBSERVATION OF CLINICAL ACTIVITY

5.9.1 Observations at the Inova Loudoun Hospital, its affiliates, other Joint Commission accredited facilities and state certified outpatient treatment centers might be used to document clinical experience and competence when credentialing practitioners. The practitioner will provide the Inova Loudoun Hospital with an accurate and complete list of institutions where the practitioner has trained and worked. In addition, the practitioner will sign a statement allowing the Credentials Committee the right to obtain verification of activities from said institutions.

5.10. WAIVER OF QUALIFICATIONS

5.10.1 Any qualifications may be waived at the discretion of the Board upon determination that such waiver will serve the best interests of the patients and of the Hospital.
ARTICLE 6 ADVANCED PRACTICE PROVIDERS

6.1. The Board shall, after considering any recommendations by the Executive Committee, determine what types of Advanced Practice Providers should be permitted to provide health care services in the Hospital in order to meet the health care needs of the community.

6.2. Advanced Practice Providers may be accorded Clinical Privileges within the scope of their licenses or certification in accordance with Medical Staff and Hospital rules and regulations and policies and procedures. Advanced Practice Providers shall not be members of the Medical Staff and shall not be entitled to vote or hold office. The granting of Clinical Privileges to Advanced Practice Providers shall also be subject to the provisional appointment process in ARTICLE 4 of these Bylaws.

6.2.1 The Chief Nurse Executive or their designee will review and approve initial and re-credentialing applications for Advanced Practice Nurses in conjunction with approval by the Hospital’s Credentials Committee.

6.3. Advanced Practice Providers shall be required to meet all of the applicable Basic Qualifications and Responsibilities set forth in ARTICLE 4 of these Bylaws.

6.4. The Clinical Privileges of an Advanced Practice Provider shall be revoked automatically, and the Advanced Practice Provider shall not be entitled to the hearing and appeal procedures set forth in these Bylaws, upon:

6.4.1 Suspension, restriction, revocation or voluntary termination of the certification and/or license of the Advanced Practice Provider;
6.4.2 Limitation, restriction, cancellation or material modification of the Advanced Practice Provider’s professional liability insurance.

6.5. The Clinical Privileges of an Advanced Practice Provider shall be suspended automatically, and the Advanced Practice Provider shall not be entitled to the hearing and appeal procedures set forth in Article 9 of these Bylaws, upon:

6.5.1 If applicable, suspension, revocation or voluntary termination of the Medical Staff membership or clinical privileges of the Advanced Practice Provider’s supervising or collaborating Practitioner;
6.5.2 If applicable, termination of the contract between the Hospital and the Advanced Practice Provider or the Advanced Practice Provider’s employer for the provision of professional services, unless such employer continues to provide professional services to the Hospital after termination of the contract; and
6.5.3 If applicable, termination of the employment contract between the Advanced Practice Provider and the Advanced Practice Provider’s employer.

6.5.3.1 The Advanced Practice Provider shall have sixty (60) days within which to identify a successor supervising or collaborating Practitioner who is a member of the Medical Staff and to provide a copy of the written affiliation, supervision, collaboration, and/or employment agreement. If the Advanced Practice Provider does not identify a successor supervising or collaborating Practitioner and provide a copy of the written affiliation, supervision, collaboration, and/or employment agreement within that period, the clinical privileges of the Advanced Practice Provider shall be terminated automatically and the
6.6. The Clinical Privileges of an Advanced Practice Provider also may be revoked, reduced, or suspended if the performance, activities, or professional conduct of the Advanced Practice Provider is or is reasonably likely to be detrimental to patients' safety or quality patient care, unethical, below the standards of the Medical Staff or to be disruptive to the operations of the Hospital.

6.6.1 An Advanced Practice Provider who is not an employee of the Hospital whose clinical privileges are revoked, reduced, or suspended pursuant to Section 6.6 shall be entitled to a hearing pursuant to the procedures set forth in ARTICLE 11.

6.6.2 An Advanced Practice Provider who is an employee of the Hospital shall be subject to the personnel policies and procedures of the Hospital, and shall not be entitled to a hearing pursuant to the procedures set forth in these Bylaws.

6.7. Advanced Practice Providers who practice telemedicine as defined in Section 4.5-2 of the Medical Staff Bylaws shall be credentialed and privileged in the same manner as Members of the Telemedicine Staff.

ARTICLE 7 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

7.1. General Procedures:

7.1.1 The Medical Staff, through its designated departments, committees, and officers, shall investigate and consider each application for appointment to membership or reappointment to membership on the staff, and any request for modification of staff membership status and clinical privileges, and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall perform these same investigation, evaluation, and recommendation functions in connection with any advanced practice providers or other practitioner who seeks to exercise clinical privileges or provide specified services in any department or service of the Hospital, whether or not such individual is eligible for Medical Staff membership. For purposes of this Section, the term “Hospital representative” includes the Board, its directors and committees; the Chief Executive Officer, all Medical Staff members, departments and committees which have responsibility for collecting or evaluating the applicant’s credentials or acting upon his application; and any authorized representative of any of the foregoing. By applying for appointment or reappointment to the Medical Staff, the applicant:

7.1.1.1 signifies his willingness to appear for interviews in regard to his application.
7.1.1.2 authorizes Hospital representatives to consult with others who have been associated with him and/or who may have information bearing on his competence and qualifications.
7.1.1.3 consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional qualifications and ability to carry out the clinical privileges he requests as well as of his professional ethical qualifications for staff membership.
7.1.1.4 releases from any liability all Hospital representatives for their actions performed in good faith and without malice in connection with evaluating the applicant and his credentials.
7.1.1.5 releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant’s ability, professional ethics,
character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

7.1.1.6 authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters the Hospital may have concerning him, and releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

7.1.1.7 absolutely and unconditionally releases from liability the Hospital and all individuals involved in any proceedings under ARTICLE 9 or ARTICLE 11 of these Bylaws as to any statements made or actions taken by such persons in connection with such proceedings. Such practitioner also shall be deemed to have absolutely and unconditionally released from liability all other individuals and all organizations who at the Hospital’s or the Executive Committee’s request provide information relating to the matters in issue in such proceedings.

7.2. Completeness:

7.2.1 No application for appointment or reappointment shall be considered to be complete until it has been reviewed by the department chairperson, the Credentials Committee and the Executive Committee, and the Credentials Committee and Executive Committee determine that no further documentation or information is required to permit consideration of the application. Additional information may be requested by any department chairperson, or by the Credentials or Executive Committee. If the applicant fails to submit the requested information or verification within sixty (60) calendar days after being requested to do so, the application shall be deemed to be incomplete and withdrawn, and the application returned to the applicant, unless the time to obtain the information is extended by the person or committee requesting the information.

7.3. APPLICATION FOR INITIAL APPOINTMENT

7.3.1 Application Form

7.3.1.1 Each application for appointment to the staff shall be in writing, submitted on the prescribed form, and signed by the applicant.

7.3.2 A Completed Application Shall Include:

7.3.2.1 Acknowledgment and Agreement: A statement that the applicant has received and read the Bylaws, rules and regulations of the Medical Staff along with specific policies deemed appropriate to this process by the Executive Committee, and that he agrees to be bound by the terms thereof if he is granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted membership and/or clinical privileges.

7.3.2.2 Qualifications: Detailed information concerning the applicant’s qualifications, including information in satisfaction of the basic qualifications specified in Section 0 and of any additional qualifications specified in these Bylaws for the particular staff category to which the applicant requests appointment.

7.3.2.3 Requests: Specific requests stating the staff category, department, and clinical privileges for which the applicant wishes to be considered. Applicant must reveal if any privileges
being requested were previously voluntarily or involuntarily reduced, revoked, or terminated at a previous institution.

7.3.2.4 References: The names of at least three (3) persons who have worked with the applicant and observed his professional performance within the past three (3) years, and who can provide reference to the applicant's clinical ability, ethical character, and ability to work with others. References should not include a relative, practice partner, or any individual with whom the applicant has a financial relationship.

7.3.2.5 Professional Sanctions: Information as to whether the applicant’s membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or health care institution, and as to whether any of the following have occurred:

7.3.2.5.1 membership/fellowship in local, state or national professional organizations has been suspended, removed, or denied;
7.3.2.5.2 specialty Board certification has been suspended, removed, or denied;
7.3.2.5.3 license to practice any profession in any jurisdiction has been successfully challenged, is pending challenges or has been voluntarily relinquished;
7.3.2.5.4 Drug Enforcement Administration (DEA) registration has been successfully challenged, is pending challenges or has been voluntarily relinquished;
7.3.2.5.5 participation in a Medicare or Medicaid program has been limited or denied;
7.3.2.5.6 any sanction(s) or action of any type taken by a state licensing board.
7.3.2.5.7 If any such actions were ever taken, the particulars thereof shall be included. Information from local, state or federal data banks or repositories will be sought and included in information collected by Hospital representatives.

7.3.2.6 Professional Liability Insurance: Applicants for and Medical Staff members in a category not specifically exempted from this requirement are required to carry professional liability insurance. The limit of insurance per medical incident and aggregate limit must equal or exceed the amounts specified in ARTICLE 17 of these Bylaws. The aggregate limit should be three times the amount carried per medical incident amount. The applicant must submit a report of all filed claims, final judgments and settlements, on his past professional liability experience, including consent to the release of information by his present and past professional liability insurance carrier(s).

7.3.2.7 Notification of Release and Immunity Provisions: Statements that the applicant has been notified of the scope and extent of the authorization, confidentiality, immunity, and release provisions of Section 7.3 and ARTICLE 16.

7.3.2.8 Administrative Remedies: A statement whereby the practitioner agrees that, if an adverse ruling is made with respect to his staff membership, staff status, and/or clinical privileges, he will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

7.4. PROCESSING THE APPLICATION

7.4.1 Applicant's Burden: The applicant shall have the burden of producing adequate information and peer recommendations for a proper evaluation of his experience, background, training, demonstrated ability, and, upon request of the Medical Executive Committee or of the Board or of the CEO or his authorized representative, physical and mental health status, and of resolving any doubts about these or any of the other basic qualifications specified in ARTICLE 4. Failure of the applicant to produce adequate information and/or peer recommendations as aforementioned within a 3-month period from the date the application is received in the
Hospital Medical Staff Office after initial processing by the Inova Health System will constitute a voluntary withdrawal of the application.

7.4.2 **Verification of Information:** The applicant shall deliver an application containing all required information to the Chief Executive Officer, who shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Chief Executive Officer or his authorized representative shall promptly notify the applicant of any non success in such collection or verification efforts. When collection and verification is accomplished, the Chief Executive Officer or his authorized representative shall notify the Chairperson of the department in which the applicant is seeking membership, who shall present the application and all supporting materials to the Chairperson of each department in which the applicant seeks privileges.

7.4.3 **Department Action:** Upon receipt, the Chairperson of the department in which the applicant seeks membership shall review the application and supporting documents and conduct an interview with the applicant. If the applicant seeks special privileges in department(s) other than the department in which the applicant seeks membership, the Chairperson shall forward the application and supporting documentation to the Chairperson(s) of the appropriate department(s) for review and recommendation. If the applicant is seeking subspecialty privileges, the Chairperson will request that the chief of the subspecialty section or, if no section exists, an appropriately qualified member of the subspecialty, review and/or interview the applicant and return a recommendation. If the applicant is seeking privileges in a multispecialty department of the Hospital, the medical director of such department will perform such review and recommendation if so authorized by policy established by the Executive Committee. Upon completion of all review, the Chairperson of the department in which the applicant seeks membership shall forward to the Credentials Committee recommendations as to staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment.

7.4.4 **Credentials Committee Action:** The Credentials Committee, or in cases so authorized under Section 7.4.11.1.3 designated members of the Credentials Committee shall review the application, the supporting documentation, the department Chairpersons’ reports and recommendations, and such other information available to it that may be relevant to consideration of the applicant’s qualifications for the staff category, department, and clinical privileges requested. The Credentials Committee or designated members shall then transmit to the Medical Executive Committee on the prescribed form a written report and recommendations as to staff appointment and, if appointment is recommended, as to staff category and department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment or clinical privileges. The committee or its designated members may also recommend that the Medical Executive Committee defer action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which shall be transmitted with the report. Any minority views shall also be in writing, supported by reasons and references, and transmitted with the majority report.

7.4.5 **Medical Executive Committee Action:** At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall consider the report and such other relevant information available to it. Alternatively, designated members of the Committee may perform this function when authorized under Section 7.4.11.1.3. The committee or designated members shall then forward to the Board of Directors through the
President a written report and recommendation on the prescribed form as to staff appointment and, if appointment is recommended, as to staff category and department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application pursuant to Section 7.4.6.1. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which shall be transmitted with the report. Any minority views shall also be in writing, supported by reasons and references, and transmitted with the majority report.

7.4.6 Effect of Medical Executive Committee Action

7.4.6.1 Deferral: Action by the Medical Executive Committee to defer the application for further consideration must be followed up within forty five (45) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection of staff membership.

7.4.6.2 Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the President shall promptly forward this recommendation together with all supporting documentation to the Board. For the purpose of this Section "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department Chairpersons and of the Credentials Committee.

7.4.6.2.1 The Administrator shall have the authority to grant interim privileges to an applicant for Medical Staff membership or clinical privileges following the recommendation of the Executive Committee, pending final approval of privileges by the Board.

7.4.6.3 Adverse Recommendation: When the recommendation of the Medical Executive Committee is adverse to the applicant, the Chief Executive Officer shall so inform the practitioner promptly by written notice of the recommendation and the reason for denial or other adverse action, and the applicant shall be entitled to the procedural rights as provided in ARTICLE 11 and in the Fair Hearing Plan appended hereto. For the purpose of this section an adverse recommendation by the Medical Executive Committee is as defined in Section 11.1.1

7.4.7 Board Actions

7.4.7.1 On Expedited Credentialing or Temporary Privileges: The Board may establish a committee consisting of at least two (2) members of the Board, to act on its behalf either in person or electronically to approve the credentials and privileges of practitioners between regular meetings of the Board to the extent that they are seeking and qualify for either expedited credentialing or temporary privileges. Any actions taken by this committee will be reported to, and confirmed by, the Board at its next regular meeting. This sub-committee of the Board may, at its discretion, refer applications to the full Board for review and/or action.

7.4.7.2 On Favorable Medical Executive Committee Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board’s action is adverse to the applicant as defined in Section 11.1.1 the Chief Executive Officer shall promptly so inform the applicant by written notice of the recommendation and the
reason for denial or other adverse action, and he shall be entitled to the procedural rights as provided in ARTICLE 11.

7.4.7.3 Without Benefit of Medical Executive Committee Recommendation: If the Board does not receive a Medical Executive Committee recommendation within the time period specified in Section 7.4.11, it may take action on its own initiative in the manner set forth in the Hospital corporate Bylaws. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse, as defined in Section 11.1, the Chief Executive Officer or his authorized representative shall promptly so inform the applicant by written notice of the recommendation and the reason for denial or other adverse action, and the applicant shall be entitled to the procedural rights as provided in Section 11.1.2

7.4.7.4 After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Section 7.4.6.3 or an adverse Board decision pursuant to Section 7.4.7.2 or 7.4.7.3, the Board shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in ARTICLE 11. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject him for staff membership.

7.4.8 Denial for Hospital's Inability to Accommodate Applicant

7.4.8.1 A recommendation by the Medical Executive Committee or decision by the Board to deny staff membership, a department, or staff category assignment, or particular clinical privileges may be on the basis of the Hospital's present inability as supported by documented evidence to provide adequate facilities or supportive services for the applicant and his patients. If the Board's final decision pursuant to Section 7.4.7.4 remains adverse, the notice of final decision required by Section 7.4.9 shall state that upon written request by the applicant to the Chief Executive Officer, or his authorized representative.

7.4.9 Notice of Final Decision

7.4.9.1 Notice of the Board's final decision shall be given through the Chief Executive Officer, or his authorized representative, to the Chairperson of the Medical Executive Committee and the Credentials Committee, to the Chairperson of each department concerned, and to the applicant by means of written notice.

7.4.9.2 A decision and notice to appoint shall include: (1) the staff category to which the applicant is appointed; (2) the department to which he is assigned; (3) the clinical privileges he may exercise; and (4) any special conditions attached to the appointment or clinical privileges granted.
7.4.10 Reapplication

7.4.10.1 An applicant who has received a final adverse decision regarding appointment, or an applicant who has withdrawn his application prior to a final decision, shall not be eligible to reapply to the Medical Staff for a period of one (1) year from the date of adverse decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the staff or the Board may require in demonstration that the basis for any earlier adverse action no longer exists.

7.4.11 Time Periods for Initial Application Processing

7.4.11.1 Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time frames specified in this Section. The Chief Executive Officer, or his authorized representative, shall transmit an application to the Medical Staff upon completing his information collection and verification tasks.

7.4.11.1.1 Normal Processing: The department Chairperson and the Credentials Committee shall act on an application within thirty (30) calendar days after completion of the verification process by the Chief Executive Officer, or his authorized representative. The Medical Executive Committee shall review the application and the Credentials Committee report at its next scheduled meeting and make its recommendation to the Board. The Board or the appropriate committee thereof shall then take final action on the application at its next regular meeting.

7.4.11.1.2 Expedited Credentialing: Only those applications that meet identified criteria will be eligible for expedited credentialing. An expedited review and approval process may be used for initial appointment provided the application for membership/privileges does not include any areas of potential concern, including but not limited to the following:

7.4.11.1.2.1 The application is deemed incomplete;
7.4.11.1.2.2 The final recommendation of the MEC is adverse or with limitation;
7.4.11.1.2.3 The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
7.4.11.1.2.4 Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;
7.4.11.1.2.5 Applicant has had an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant;
7.4.11.1.2.6 Material discrepancy is found between information received from the applicant and references or verified information;
7.4.11.1.2.7 Applicant has an adverse NPDB report related to behavioral issues;
7.4.11.1.2.8 Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
7.4.11.1.2.9 Applicant has potentially relevant physical, mental and/or emotional health problems;
7.4.11.1.2.10 Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.
7.4.11.1.3 Applicants for expedited credentialing whose files are free from areas of potential concern may be granted medical staff membership and/or privileges after review and action by: the Department Chairperson and Section Chief, the Chairperson of the Credentials Committee, the President of the Medical Staff, and the Board credentialing sub-committee. Any actions taken by this group will be reported to, and confirmed by, the Board at its next regular meeting.

7.5. REAPPOINTMENT PROCESS

7.5.1 Information Form for Reappointment

7.5.1.1 The Chief Executive Officer shall, at least one hundred and eighty (180) days prior to expiration date of the present staff appointment of each Medical Staff member, provide such staff member with an interval information form for use in considering reappointment. The applicant for reappointment shall, at least one hundred and fifty (150) days prior to such expiration date, send this interval information form to the Chief Executive Officer, or his authorized representative. Failure, without good cause, to return the completed form shall result in automatic termination of membership at the expiration of the member’s current term of appointment.

7.5.2 Content of Interval Information Form

7.5.2.1 The interval information form shall be a prescribed form and shall contain information necessary to maintain as current the Medical Staff file on the staff member’s health care related activities other than as a member of the staff. This interval information shall include, without limitation, information about:

7.5.2.1.1 continuing training, education and experience that qualify the staff member for the privileges sought on reappointment.
7.5.2.1.2 CME credits, sufficient to comply with state licensure requirements. A portion of the CME must support the specific privileges requested.
7.5.2.1.3 upon specific request by the Medical Executive Committee or the Board, current physical and mental health status.
7.5.2.1.4 the name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding period. Applicant must reveal if any privileges currently held or being applied for have been voluntarily or involuntarily reduced, revoked, or terminated at another institution.
7.5.2.1.5 membership, awards, or other recognition conferred or granted by any professional health care societies, institutions, or organizations.
7.5.2.1.6 Professional Sanctions: Information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or health care institution, and as to whether any of the following have occurred:
7.5.2.1.6.1 membership/fellowship in local, state or national professional organizations has been suspended, removed, or denied;
7.5.2.1.6.2 specialty Board certification has been suspended, removed, or denied;
7.5.2.1.6.3 license to practice any profession in any jurisdiction has been successfully challenged, is pending challenges or has been voluntarily relinquished other than for retirement;
7.5.2.1.6.4 Drug Enforcement Administration (DEA) registration has been successfully challenged, is pending challenges or has been voluntarily relinquished other than for retirement;
7.5.2.1.6.5 any sanction(s) by Medicare or Medicaid.
7.5.2.1.6.6 any sanction(s) or action of any type by a state licensing board.
7.5.2.1.6.6.1. If any such actions were ever taken, the particulars thereof shall be included. Information from local, state or federal data banks or repositories will be sought and included in information collected by Hospital representatives.
7.5.2.1.7 details about professional liability insurance coverage, filed claims, final malpractice judgments and settlements since the last application.
7.5.2.1.8 such other specific information about the staff member's professional ethics, qualifications and ability that may bear on his ability to provide quality patient care in the Hospital.

7.5.3 Verification of Information

7.5.3.1 The Chief Executive Officer, or his authorized representative, shall in a timely fashion, seek to collect or verify the additional information made available on each interval information form and to collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in this Hospital. When collection and verification is accomplished the Chief Executive Officer or his authorized representative shall transmit the information form and supporting materials to the Chairperson of each department in which the staff member requests privileges and to the Credentials Committee.

7.5.4 Department Action

7.5.4.1 The Chairpersons of each department in which the staff member has or seeks privileges, where applicable after review by and consultation with the subspecialty section chief, shall review the information form and the staff member's file and shall transmit to the Credentials Committee on the prescribed form his report and recommendation that appointment be renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated. A Chairperson may also recommend that the Medical Executive Committee defer action. Each such report shall satisfy the requirements of Section 7.5.8.

7.5.5 Credentials Committee Action

7.5.5.1 The Credentials Committee shall review each information form and all other pertinent information available on each member being considered for reappointment, including the recommendation of each department in which the staff member has requested privileges, and shall transmit to the Medical Executive Committee on the prescribed form
its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated. The committee may also recommend that the Medical Executive Committee defer action. Each such report shall satisfy the requirement of Section 7.5.8 Any minority views shall also be written and transmitted with the majority report.

7.5.6 Medical Executive Committee Action

7.5.6.1 The Medical Executive Committee shall review such information and all other relevant information available to it and shall, on the prescribed form, forward through the President for transmittal to the Board of Directors its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation and/or clinical privileges, or terminated. The committee may also defer action. Each such report shall satisfy the requirement of Section 7.5.8. Any minority views shall also be in writing and transmitted with the majority report.

7.5.7 Final Processing and Board Action

7.5.7.1 Thereafter, the procedure provided in Section 7.4.6 through 7.4.11 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those section shall be read, respectively, as "staff member" and "reappointment."

7.5.8 Basis for Recommendations

7.5.8.1 Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon such member’s professional ability and clinical judgment in the treatment of patients, his professional ethics, his discharge of staff obligations, his compliance with the Medical Staff Bylaws, rules and regulations, his cooperation with other practitioners and with patients, peer recommendations, and other matters bearing on his ability and willingness to contribute to good patient care and practices in the Hospital.

7.5.9 Time Period for Processing

7.5.9.1 Transmittal of the interval information form to a staff member and his return of it shall be carried out in accordance with Section 7.4.1. Thereafter and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendation concerning the reappointment of a staff member shall have been transmitted to the Medical Executive Committee for its consideration and action pursuant to Section 7.4.6 and to the Board for its action pursuant to Section 7.4.7, all prior to the expiration date of the staff membership of the member being considered for reappointment.

7.6. A staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department assignment, or clinical privileges by submitting a written application to the Chief Executive Officer, or his authorized representative, on the prescribed form. Such application shall be processed in the same manner as provided in Section 7.4 for reappointment, including queries to data banks and information repositories relating to quality of care monitoring by agencies other than the Hospital.
7.7. Any misstatements or inaccuracies in, or omissions from, a preapplication form, an application for medical staff appointment and clinical privileges, a reappointment application to the medical staff, or any document submitted in conjunction therewith, or any failure to update changes in information so provided, shall constitute cause for denial of appointment or reappointment or cause for summary dismissal from the medical staff or the imposition of other peer review sanctions.

7.8. Settled malpractice claims, final judgments, and professional sanctions as listed in Section 7.3.2.5.5 and 7.3.2.6 must be reported in writing within 30 days through the Medical Staff Office to be reviewed by the department Chairperson, President, and the CEO.

ARTICLE 8 DETERMINATION OF CLINICAL PRIVILEGES

8.1. Every practitioner or other professional providing direct clinical services at this Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice and except as provided in Sections 8.4, be entitled to exercise only those clinical privileges or specified services, including admission of patients, specifically granted to him by the Board. At times of full Hospital occupancy or of shortage of hospital beds or other facilities, as determined by the Chief Executive Officer, the admitting privileges of courtesy staff members shall be subordinate to those of active and provisional staff members.

8.2. DELINEATION OF PRIVILEGES IN GENERAL

8.2.1 Requests

8.2.1.1 Each application for appointment and reappointment to the Medical Staff and/or request for privileges must contain a request for the specific clinical privileges desired by the applicant. A request by a staff member pursuant to Section 7.5 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

8.2.2 Basis for Privileges Determination:

8.2.2.1 Requests for clinical privileges shall be evaluated on the basis of the practitioner’s education, current licensure, training, experience, and demonstrated ability and judgment. The bases for privileges determinations to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the patient care audit and other quality improvement activities required by these and the Hospital corporate Bylaws to be conducted at the Hospital. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially peer recommendations, other institutions and health care settings where a practitioner exercises clinical privileges, and local, state and federal data banks or repositories relating to quality of care monitoring by agencies other than the Hospital, and all initial applications shall include a Criminal Background Check. Thereafter, at their discretion, a Criminal Background Check may be requested by the President, his designee, or the Board of Directors. This information shall be added to and maintained in the credentials file established for a staff member.

8.2.3 Procedure

8.2.3.1 All requests for clinical privileges shall be processed pursuant to the procedures outlined in ARTICLE 7.
8.2.4 Duration of Clinical Privileges

8.2.4.1 Clinical privileges shall be granted for a period of no longer than two (2) years.

8.3. SPECIAL CONDITIONS FOR MEMBERS OF THE MEDICAL STAFF

8.3.1 Dental and Oral Surgery Privileges

8.3.1.1 Dental Privileges: The scope and extent of procedures that each Dentist may perform must be specifically defined in the same manner as other surgical privileges. Procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A dentist member may act as a consultant for a patient admitted by a member of the Medical Staff privileged to perform a medical history and physical examination on the patient. That member shall be responsible for the care of any medical problem that may arise during hospitalization and shall determine the risk and effect of any proposed dental procedure on the total health status of the patient.

8.3.1.2 Oral Surgery Privileges: The scope and extent of surgical procedures that each Oral Surgeon may perform must be specifically defined in the same manner as other surgical privileges. Surgical procedures performed by Oral Surgeons shall be under the overall supervision of the Chairperson of the Department of Surgery. Oral Surgeons who are members of the Medical Staff and who have clinical privileges shall be entitled to admit patients to the Hospital, subject to any conditions or limitations in the rules and regulations of the Department of Surgery.

8.3.2 Podiatric Privileges

8.3.2.1 Request for clinical privileges from podiatrists shall be processed in the manner specified in Section 8.2. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson, Department of Orthopaedics. Podiatrists who are members of the medical staff shall be entitled to admit and do history and physicals. In instances where patients with ASA classification score of 3 or 4 require admission, an internist or family medicine physician of the medical staff shall be consulted for co-management. Podiatric care and the podiatric history and physical examination shall be the responsibility of the podiatrist. When there is a non podiatrist participating in the care of the patient, the patient may be discharged only with the concurrence of both that practitioner and the podiatrist. The podiatrist may discharge the patient in uncomplicated cases in which there is not another designated practitioner participating in the case. Each practitioner is responsible for the proper completion of his/her portion of the patient’s medical record.

8.3.3 Contracted Practitioners

8.3.3.1 In order to exercise privileges or be credentialed in any specialty or department, which is subject to an exclusive contract arrangement with Inova Loudoun Hospital, a practitioner must have both the applicable clinical privileges and the required contract right. The exercise of clinical privileges of any practitioner practicing shall be subject to these Bylaws and rules and regulations applicable to members of the medical staff. However, the granting, reduction or termination of such privileges will be superseded by any provision of the contract if there is a conflict. Whenever contract rights in a closed
service or department are denied, terminated or limited based on medical or clinical disciplinary cause or reason, the affected practitioner shall have the right to notice and a formal hearing set forth in these Bylaws. Whenever the Hospital proposes to deny, terminate or limit contract rights in a closed service or department for reasons other than medical disciplinary cause or reason, such action will be governed by the applicable contract and the Board of Directors. Any practitioner who serves under a contract with the Hospital waives all rights to the hearing process set forth in these Bylaws as to the privileges governed by the contract.

8.3.3.2 A practitioner contracted to work in the Emergency Room may only admit to the Emergency Room if credentialed to do so. Practitioners contracted to work in the Pediatric Emergency Room will also serve as pediatric hospitalists, and may admit to inpatient services, if credentialed to do so. A practitioner contracted or employed to work in Pathology may only admit to the Emergency Room or other outpatient diagnostic/treatment area and only if credentialed to do so. Anesthesiologists and Diagnostic Imagers may admit to inpatient services when credentialed to do so.

8.3.3.3 Each contracted service will be reviewed by the Medical Executive Committee at the time of contract renewal or no less frequently than every three years.

8.3.4 Privileges in the Event of an Emergency Occurrence

8.3.4.1 For the purposes of this section, an “emergency” refers to a situation in which a member of the medical staff must take immediate action to prevent serious or permanent harm to a patient and/or save the life of a patient. In the case of such an emergency, any practitioner privileged through the Medical Staff process, to the degree permitted by his or her license and regardless of service or Medical Staff status, shall be permitted to do and assisted to do everything possible to prevent such harm and/or save the life of a patient. When the emergency situation no longer exists, the practitioner may request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the active Medical Staff.

8.4. SPECIAL CONDITIONS FOR PRIVILEGES OF THE MEDICAL STAFF

8.4.1 TEMPORARY PRIVILEGES

8.4.1.1 The Administrator, upon the recommendation of the Chair of the Department or Chief of the Section concerned, shall have the authority to grant temporary Clinical Privileges to a Physician, Dentist, Podiatrist, Oral Surgeon or Advanced Practice Provider, who does not currently have Clinical Privileges at the Hospital. The Practitioner may request on the prescribed form Clinical Privileges to participate in the care of a single, currently hospitalized patient. The recommendation of the Department Chair or Section Chief must affirmatively state that he/she is satisfied as to the competence and ethical standing of the Practitioner, that the Practitioner is duly licensed in the Commonwealth of Virginia, and that the person has satisfied the requirement of Section 7.3.2.6 regarding professional liability insurance. In exercising such privileges, the Practitioner shall act under the supervision of the Chair of the department or Chief of the section to which the individual assigned. Temporary privileges may be terminated at any time by the Administrator upon recommendation of the Chair of the department or Chief of the section concerned and the person shall not be entitled to the rights accorded in Article 9.
The application for temporary privileges is $300, unless waived by the President of the Medical Staff. Temporary privileges shall be granted for a period not to exceed 30 days.

8.4.2 PRIVILEGES TO FULFILL AN IMPORTANT PATIENT CARE, TREATMENT, AND SERVICE NEED

8.4.2.1 The Administrator or designee, upon the unanimous recommendation of the President of the Medical Staff, Chief Medical Officer, Chair of the Credentials Committee, Chair of the Department and Section Chief (if applicable) concerned, shall have the authority to grant temporary Clinical Privileges to a Physician, Dentist, Podiatrist, Oral Surgeon or Advanced Practice Provider who does not currently have Clinical Privileges at the Hospital to fulfill an important patient care, treatment, and/or service need at the Hospital. The application for temporary privileges is $300, unless waived by the President of the Medical Staff.

8.4.2.2 The Practitioner shall complete an application and submit it to the Administrator in writing on prescribed forms in accordance with the application process outlined in Sections 7.1-7.3 of the Bylaws. At a minimum, the following credentialing criteria must be verified before privileges under this Section 8.4.2 can be granted: duly licensed in the Commonwealth of Virginia; professional liability insurance in accordance with Section 7.3.2.6; AMA profile or other verification of education and training; National Practitioner Data Bank report; board certification or eligibility status; three peer references; and interview with the appropriate Department Chair. The recommendation of the Department Chair must affirmatively state that he/she is satisfied as to the competence and ethical standing of the Practitioner.

8.4.2.3 In exercising privileges granted under this Section 8.4.2, the Practitioner acts under the supervision of the Chair of the Department or Chief of the Section to which the individual is assigned. Such privileges may be terminated at any time by the Administrator upon recommendation of the Chair of the Department or Chief of the Section concerned, and the person shall not be entitled to the rights accorded in Article 9.

8.4.2.4 Privileges under this Section 8.2.4 shall be granted for a period not to exceed 120 days. Further, such privileges may be granted to applicants in the appointment process and may only be granted when the Administrator and the abovementioned Medical Staff representatives have determined that the applicant will help to fulfill an important patient care, treatment and/or service need at the Hospital. If the applicant for privileges under this Section 8.2.4 is also applying for Medical Staff membership and Clinical Privileges, the application for such membership and privileges will continue to be processed under Article 7.

8.4.2.5 This process is categorically not intended to be a mechanism for accelerating the granting of privileges through the usual credentialing process in the absence of an important patient care, treatment and/or service need at the Hospital. Additionally, the granting of privileges under this Section 8.2.4 shall not obligate the Hospital to grant membership and privileges under any other section of the Bylaws.

8.4.3 LOCUM TENENS PRIVILEGES

8.4.3.1 Upon application on prescribed written form to the Administrator, a Physician, Dentist or Podiatrist serving as a locum tenens for a member of the Medical Staff may be granted Clinical Privileges to attend currently hospitalized patients of the member without
applying for membership on the Medical Staff for a period not to exceed sixty (60) days. A Physician, Dentist or Podiatrist requesting privileges to serve as a locum tenens must make full disclosure of the credentials information required. This information must be submitted at least seven (7) days prior to assuming responsibilities as a locum tenens. Providing all the credentials of the Physician, Dentist or Podiatrist are approved by the Chair of the department concerned, the Executive Committee and the Administrator, the Administrator shall notify the Practitioner, in writing, that the locum tenens is granted. The Practitioner shall sign a statement acknowledging that he/she has read and agrees to abide by the Medical Staff Bylaws, Rules and Regulations and to adhere to any reporting requirements and practice restrictions placed on the privileges. Practitioners granted locum tenens privileges shall not be permitted to participate in the Emergency Department On-Call Roster, unless approved by Medical Executive Committee. The application for locum tenens privileges is $300, unless waived by the President of the Medical Staff.

8.4.4 DISASTER PRIVILEGES IN THE EVENT OF AN EMERGENCY OCCURRENCE OR DISASTER

8.4.4.1 For the purpose of this section an "emergency occurrence or disaster" is defined as any officially declared emergency, whether local, state or national, in which the Hospital emergency management plan has been activated, and serious or permanent harm would result to patients or the lives of patients would be in immediate danger with any delay in administering treatment.

8.4.4.2 In circumstances of an emergency occurrence or disaster in which the emergency management plan has been activated, the Chief Executive Officer or Chief of the Medical Staff or their designee(s) may grant disaster privileges to a practitioner who is not a member of the medical staff. Emergency privileges are intended for the duration of the emergency only. Those with authority so designated have the right to deny emergency privileges and immediately terminate emergency privileges without notice.

8.4.4.3 Identification of volunteer health care practitioners for the granting of disaster privileges must include a valid government issued photo identification issued by a state or federal agency (for example, driver’s license or passport) AND one of the following:
   8.4.4.3.1 A current picture ID from a hospital that clearly identifies professional designation
   8.4.4.3.2 A current license to practice
   8.4.4.3.3 Primary source verification of a license to practice
   8.4.4.3.4 Identification indicating that the individual is a member of a recognized state or federal organization or group specifically organized to provide services in emergency occurrences and/or disasters
   8.4.4.3.5 Identification indicating that the individual has been granted authority to render patient care, treatment or services in emergency occurrences and/or disasters by a federal state or municipal government entity.
   8.4.4.3.6 Identification by at least one current hospital or medical staff member who possess personal knowledge regarding the individual’s ability to act as a licensed independent practitioner during a disaster

8.4.4.4 Barring severe circumstances making this action impossible, primary source verification of the documentation presented under Section 8.4.4 must be accomplished within 72 hours from the time a volunteer requests disaster privileges. Should severe circumstances from the disaster exist, such verification must still be performed as soon as possible, with documentation in the meantime of the reasons why it could not be accomplished, as well as with documentation of the demonstrated ability of the volunteer to provide adequate care, treatment and services.
8.4.4.5 The disaster–privileged practitioner will be identified with a standard hospital ID badge to be worn at all times when in the hospital.
8.4.4.6 The disaster-privileged practitioner shall be assigned to an appropriate department/section of the medical staff, and supervisory authority granted to the respective department Chairperson, section chief or other appropriate designated Medical Staff officers.
8.4.4.7 The President will determine within 72 hours of initially granting the disaster privileges to an individual whether to continue them, based on information obtained regarding the professional practice of the volunteer as well as any new background information obtained since the initial granting of disaster privileges. Once the immediate emergency or disaster situation is under control, the process of verifying the credentials of any volunteer is a high priority and is accomplished using the procedure identical to that of granting temporary privileges.

8.4.5 An adverse recommendation regarding granting of clinical privileges as specified in Section 11.1 shall entitle the applicant to procedural rights in ARTICLE 11, except as specified in ARTICLE 8.4.1 when that adverse recommendation relates to temporary privileges.

ARTICLE 9 CORRECTIVE ACTION

9.1. Recognizing that while each of the Inova Hospitals maintains an independent Medical Staff responsible through duly appointed committees for reviewing, evaluating, and making recommendations regarding the quality or adequacy of professional services rendered at each Inova Hospital, the actions of each Medical Staff are subject to the ultimate authority of the governing body of the Inova Health System Foundation. The Board, and the physicians, dentists, and podiatrists practicing at the Hospital, have determined that the interests of the patients and the interests of Practitioners in a fair, efficient resolution of professional review actions are best served by a coordinated, consistent, and streamlined process among the Inova Hospitals for addressing professional review actions as set forth in ARTICLE 9 and ARTICLE 11 of the Bylaws.

9.2. Whenever the performance, activities or professional conduct of any Medical Staff member or individual granted clinical privileges (hereinafter in ARTICLE 9 and ARTICLE 11 “practitioner”) is or is reasonably likely to be detrimental to patient safety or quality patient care, unethical, below the standards of the Medical Staff, or to be disruptive to the operations of the Hospital or the Medical Staff, or in violation of these Bylaws, the Medical Staff rules and regulations, department rules and regulations, or any policies of the Hospital, corrective action against such practitioner may be requested by any officer of the Medical Staff, by the Chairperson of any department, by the chief of any section, by the Chairperson of any standing committee of the Medical Staff, by any member of the active staff, by the Chief Executive Officer or by a designee acting in the Chief Executive Officer’s absence, or by any member of the Board. Corrective action shall include but not be limited to requiring consultation, supervision or additional training, probation, suspension or expulsion from the Medical Staff, and reduction, suspension or termination of clinical privileges. All requests for corrective action shall be in writing, shall be made to the Executive Committee, shall state the specific action requested and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.

9.2.1 Initiation of corrective action does not preclude imposition of summary suspension pursuant to ARTICLE 10 of these Bylaws, nor does it require summary suspension.
9.3. INVESTIGATION

9.3.1 Upon receipt of a request for corrective action, the Executive Committee shall forward such request for investigation to the Chairperson of the department wherein the practitioner has clinical privileges. In the event of extenuating circumstances (e.g., request for corrective action involves a department Chairperson), the request shall be forwarded to a member of the active staff selected by the Executive Committee. Investigation shall begin immediately upon receipt of the request by the department Chairperson or such active staff member. The President also may appoint, or the department Chairperson or active staff member appointed by the Executive Committee may request that the President appoint an ad hoc committee to conduct the investigation. The President shall appoint the Chairperson of the ad hoc committee. The practitioner who is the subject of the inquiry shall be notified if an ad hoc committee is appointed.

9.3.1.1 The President shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith.

9.3.2 Within thirty (30) days after receipt of the request for corrective action from the Executive Committee, the department Chairperson or selected active staff member or ad hoc committee, if appointed, shall make a written report of the investigation to the Executive Committee, and shall include a recommendation as to any corrective action to be taken. Prior to the making of such report the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the person conducting the investigation or the ad hoc committee. At such interview the practitioner shall be informed of the general nature of the matters being investigated concerning the practitioner’s conduct, and shall be invited to discuss, explain or refute the matters under investigation. The interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. The practitioner and the person conducting the investigation or the ad hoc committee may be represented by counsel, but counsel shall not be permitted to call or cross-examine witnesses. A record of such interview, if held, shall be made by the person conducting the investigation or a member of the ad hoc committee and included with his or her report to the Executive Committee.

9.4. ACTION BY EXECUTIVE COMMITTEE

9.4.1 As soon as practicable, but no more than thirty (30) days following the receipt of the report made by the department Chairperson, selected active staff member, or ad hoc committee, the Executive Committee shall take action upon the request. If the corrective action originally requested or the corrective action recommended by the person or ad hoc committee conducting the investigation involves a reduction, suspension, or revocation of clinical privileges, or a suspension or expulsion from the medical staff, the affected practitioner shall be permitted to make an appearance at a meeting of the Executive Committee prior to its taking action on such request or recommendation. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided by the Bylaws with respect to hearings shall apply thereto. The practitioner and the Executive Committee may be represented by counsel at this meeting, but counsel shall not be permitted to call and cross-examine witnesses. A record of such appearance shall be made by the Executive Committee.

9.4.2 The Executive Committee may take such action as it deems appropriate, including but not limited to: issuing a warning, a letter of admonition, or a letter of reprimand; imposing terms of probation; requiring supervision, consultation or additional training; recommending reduction, suspension or revocation of Clinical Privileges and in the case of suspension, the duration of such suspension;
recommending that an already imposed summary suspension of Clinical Privileges be terminated, modified or sustained; or recommending that Medical Staff membership be suspended or terminated.

9.4.3 Upon proper notification the Chief Executive Officer shall notify the affected practitioner, in writing, of the action of the Executive Committee. The President shall notify the Executive Committees of each Inova Hospital at which the practitioner has clinical privileges of the action of the Hospital’s Executive Committee by delivering written notice of the recommendation to the Chairpersons of such Executive Committees. Actions by, or actions resulting from policies approved by the Executive Committee, other than those specified in Section 9.4.4 shall not be subject to the provisions of ARTICLE 11. Supervision and consultation shall not be considered actions entitling the affected practitioner to the provisions of ARTICLE 11.

9.4.4 Any recommendation by the Executive Committee for reduction, suspension or termination of clinical privileges, or for suspension or termination from the medical staff shall entitle an affected practitioner to the procedural rights provided in ARTICLE 11 unless such action is specifically exempted therein.

9.5. PROCEDURE AFTER ACTION OF EXECUTIVE COMMITTEE

9.5.1 All actions by the Executive Committee, other than those specified in Section 9.4.4 as entitling an affected practitioner to the provisions of ARTICLE 11, shall be final and shall be effective at the Hospital immediately. Recommended corrective action by the Executive Committee specified in Section 9.4.4 as entitling an affected practitioner to the provisions of ARTICLE 11 shall entitle the practitioner to the procedures set forth in ARTICLE 11 of these Bylaws.

9.6. IMPOSITION OF CORRECTIVE ACTION BASED UPON ACTION INITIATED AT AN INOVA HOSPITAL

9.6.1 If an adverse recommendation regarding a practitioner’s clinical privileges or medical staff membership is made in accordance with the corrective action procedures set forth in the medical staff bylaws of any other Inova Hospital and is thereafter approved by a final decision of the Board of that Inova Hospital, then such decision shall be recognized and made effective at this Hospital.

9.7. ADMINISTRATIVE SUSPENSION, AUTOMATIC SUSPENSION AND AUTOMATIC RELINQUISHMENT

9.7.1 Administrative suspension, automatic suspension and automatic relinquishment as described in this Section 9.7 shall not be subject to the provisions set forth in ARTICLE 11.

9.7.2 Administrative Suspension

9.7.2.1 Failure to Satisfy Certain Administrative Requirements: The Hospital may adopt rules, regulations, policies, and procedures relating to certain administrative requirements, such as timely completion of medical records, immunization requirements and mandatory safety or electronic health record training. If any practitioner fails to fulfill the requirements of such administrative policies and procedures adopted by the Hospital, the Clinical Privileges of the practitioner may be administratively suspended pursuant to the policy, subject to the review and approval by the Medical Staff President or their designee. All policies and procedures subjecting practitioners to such administrative suspension shall be subject to approval by the Executive Committee. Administrative suspension will result in loss of access, including but not limited to the electronic health record, PACS and identification badge function. If practitioner
fails to fulfill the requirements of the administrative policy or procedure for which they were suspended within six (6) months, the practitioner’s Clinical Privileges may be revoked.

9.7.3 Automatic Suspension

9.7.3.1 Loss of Professional Liability Insurance: A suspension in the form of withdrawal of all clinical privileges, or permission to perform specified functions, shall be imposed automatically upon a practitioner upon cancellation, restriction or material adverse modification of the practitioner’s professional liability insurance coverage, or failure to provide satisfactory evidence of professional liability insurance, and shall remain in effect until the practitioner obtains and provides satisfactory evidence of such professional liability coverage as required by these Bylaws. If such professional liability coverage is not obtained within six (6) months from the date of suspension, the practitioner’s clinical privileges, or permission to perform specified functions, may be terminated. The Board, upon the recommendation of the Executive Committee, may grant a limited exemption from suspension to a practitioner or group of practitioners whose insurance carrier has withdrawn from the state market without adequate notice. In such circumstances, the Board should establish a time frame in which practitioners would reasonably be expected to obtain coverage. In such case, after the established deadline, suspension procedures as described above shall be imposed.

9.7.3.2 Expiration of License: A suspension in the form of withdrawal of all clinical privileges, or permission to perform specified functions, shall be imposed automatically upon a practitioner upon expiration of his/her Virginia license.

9.7.3.3 Expiration of DEA Registration: A suspension in the form of withdrawal of Clinical Privileges shall be imposed automatically upon a Practitioner upon expiration of his/her DEA registration.

9.7.3.4 Failure to Obtain or Maintain Board Certification: A suspension in the form of withdrawal of all clinical privileges, or withdrawal of permission to perform specified specialty functions, shall be imposed automatically upon a practitioner who fails to obtain or maintain board certification, when required by these Bylaws.

9.7.4 Automatic Relinquishment: After initial appointment, the following shall be considered circumstances where the practitioner has relinquished Medical Staff membership and privileges:

9.7.4.1 An action by the Virginia Board of Medicine, the Virginia Board of Dentistry, or the Virginia Board of Nursing revoking or suspending a practitioner’s license.

9.7.4.2 Expiration of a practitioner’s license to practice and failure to renew within 120 (one hundred twenty) days from the date of expiration.

9.7.4.3 Expiration of a practitioner’s DEA registration and failure to renew within 120 (one hundred and twenty) (120) days from the date of expiration.

9.7.4.4 Action by the Drug Enforcement Agency revoking a Practitioner’s license to prescribe or dispense controlled substances shall automatically terminate membership on the Medical Staff and shall automatically revoke all of the Practitioner’s Clinical Privileges.

9.7.4.5 Loss of professional liability insurance beyond the terms defined under Section 9.7.3.4 of these Bylaws.
9.7.4.6 Failure to pay medical staff dues in the amount required and by the date required by the Executive Committee as authorized by Section 17.4 of these Bylaws.

9.7.5 Automatic relinquishment shall not be subject to the provisions set forth in ARTICLE 11.

9.8. EFFECT OF RESIGNATION

9.8.1 If at any time after initiation of an action or procedure involving corrective action or summary suspension as provided in ARTICLE 9 or an action or procedure based on an adverse recommendation for reappointment or renewal of clinical privileges under ARTICLE 7, a practitioner submits a written resignation of his medical staff membership or clinical privileges, or requests that upon expiration of the practitioner’s term of appointment or clinical privileges, the practitioner not be reappointed or his clinical privileges not be renewed, such resignation or request shall be made a part of the practitioner’s file with respect to the matter involved. Such resignation or request shall not terminate any action or procedure as set forth in ARTICLE 9 or ARTICLE 11. Such resignation or request shall be reported to the Virginia State Board of Medicine, the Virginia State Board of Dentistry, or the Virginia State Board of Nursing, in accordance with statutory requirements.

ARTICLE 10 SUMMARY SUSPENSION

10.1. Imposition of Summary Suspension: The President, a department Chairperson, a section chief, the Executive Committee and the Chief Executive Officer may impose summary suspension of clinical privileges on a member of the medical staff, effective immediately, under the following circumstances:

10.1.1 Suspension for Cause: Upon a determination that action must be taken immediately to protect the life, health, or safety of any individual or to reduce the substantial likelihood of imminent injury or damage to the health or safety of any patient, prospective patient, employee or other person.

10.1.2 Suspension Pending Investigation: When from the information available there is need to investigate and determine whether or not there is a need to suspend, restrict, or revoke a practitioner’s clinical privileges. Under such circumstances suspension shall be for a period of no longer than fourteen (14) days. At the end of such a fourteen (14) day investigation period, the suspension of privileges shall be terminated, unless summary suspension for cause is imposed pursuant to Section 10.1.1. If such summary suspension is not imposed, corrective action may be initiated pursuant to Section 9.2 of these Bylaws.

10.1.3 Suspension at an Inova Hospital: If a summary suspension is imposed on a practitioner at an Inova Hospital, and such suspension is not lifted by the President or Chief of the Medical Staff of that Hospital acting under that Hospital’s Bylaws within any review time limit mandated by that Hospital’s Bylaws, and if the practitioner so suspended has clinical privileges at this Hospital, then upon consultation with the Presidents or Chiefs of Staff of the Medical Staffs of such other Inova Hospitals or their respective designees with the President of this Hospital or his designee, and upon receipt of notice of such suspension, summary suspension shall be imposed on the subject practitioner at this Hospital notwithstanding the fact that such suspension was not initiated at this Hospital. In such event, the summary suspension shall remain in effect until lifted pursuant to the Bylaws of the Inova Hospital that initiated such suspension.
10.2. Process of Summary Suspension

10.2.1 Notification: Under any of the circumstances in Section 10.1 of these Bylaws, when summary suspension is imposed, the Chief Executive Officer shall send the suspended practitioner written confirmation of the suspension, by hand delivery and certified mail, return receipt requested. This notification will include a brief statement of the specific reason for the suspension. If one or more of the reasons for the summary suspension includes issues that had been raised in a corrective action proceeding under ARTICLE 9, the notice of summary suspension will include those issues.

10.2.2 Review by the President: If summary suspension is imposed by anyone other than the President, the individual imposing the summary suspension shall immediately notify the President of the suspension. Within twenty-four (24) hours, the President shall consult with the individual who imposed the summary suspension and shall review the decision to impose summary suspension to determine that the decision to impose summary suspension was not arbitrary and capricious. The President may either ratify the decision to impose summary suspension, or with the consent of the individual who imposed the summary suspension, may lift the suspension. In the event of a disagreement between the President and the individual who imposed the summary suspension, the suspension shall remain in effect until reviewed by the Executive Committee, pursuant to Section 10.2.5 of these Bylaws. If the President and the individual who imposed the summary suspension agree to lift the suspension, the suspension shall be lifted immediately, but the matter giving rise to the suspension shall be referred to the Executive Committee for review for consideration of corrective action under Section 9.2. The President shall promptly notify the Chief Executive Officer of his decision. The Chief Executive Officer shall then send the suspended practitioner, by hand delivery and certified mail, return receipt requested, written notice of the decision of the President. Any action required of the President under this section may be taken by the vice President when the President is unavailable or, if he is unavailable or the subject of suspension, another medical staff officer designated by the President.

10.2.3 Assignment of Patients. Immediately upon the imposition of a summary suspension, the President or the responsible department Chairperson or section chief shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Hospital at the time of such suspension. The wishes of the patient, or if the patient is unable to voice an opinion, the wishes of the responsible family members shall be considered in the selection of such alternative practitioner. Such summary suspension shall be reported to the Virginia State Board of Medicine, Virginia State Board of Dentistry, or the Virginia Board of Nursing, in accordance with statutory requirements.

10.2.4 Notification of Other Hospitals: If the conditions for review of the suspension as specified in these Bylaws have been met, within twenty four (24) hours the President shall consult directly with the resident or chief of the medical staff of each Inova Hospital at which the practitioner has clinical privileges, or his/her designee, as well as furnish written notice of the summary suspension to each of the Executive Committees of the medical staffs of such Inova Hospitals.

10.2.5 Executive Committee Review: In cases where the summary suspension was not imposed directly by the Executive Committee, and if summary suspension is not lifted by the President under Section 10.2.2, the Executive Committee shall meet to review and consider the summary suspension.

10.2.5.1 The executive meeting shall be conducted within five (5) business days from the date upon which the President reviewed the suspension.
10.2.5.2 A quorum of the Executive Committee must be present for this meeting, but for the purposes of this section, a quorum may include members present by telephone or other immediate electronic communications medium that allows active vocal participation. The Executive Committee shall make its best effort to ensure that members not physically present are provided with copies of any documents or records presented at the meeting.

10.2.5.3 Upon request, the practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Executive Committee may impose. In no event, shall such meeting of the Executive Committee, with or without the practitioner, constitute a hearing within the meaning of Section 10.2.6 or ARTICLE 11, nor shall any procedural rules apply. The practitioner and the Executive Committee may be represented by counsel at this meeting, but counsel shall not be permitted to call and cross-examine witnesses.

10.2.5.4 The Executive Committee may take any of the following actions:

10.2.5.4.1 Revoke the suspension
10.2.5.4.2 Continue the suspension indefinitely
10.2.5.4.3 Continue the suspension for a specified period of time
10.2.5.4.4 Recommend termination of clinical privileges, with suspension remaining in place until the Board has approved termination.

10.2.5.5 In the event that the corrective action process in ARTICLE 9 had begun prior to the imposition of summary suspension, the actions of the Executive Committee taken under this Section shall be considered sufficient fulfillment of the requirements of Section 9.4.

10.2.5.6 Notification of Executive Committee Action:

10.2.5.6.1 The Chief Executive Officer or his/her designee shall send the suspended practitioner, by hand delivery and certified mail, return receipt requested, written notice of the decision of the Executive Committee. If the Executive Committee does not immediately terminate the suspension, such notice shall:

10.2.5.6.1.1 state the decision and the grounds upon which it is based;
10.2.5.6.1.2 advise the practitioner of his/her right to a hearing as provided by these Bylaws, including a summary of rights provided at such a hearing as set forth in these Bylaws;
10.2.5.6.1.3 specify that the practitioner shall have thirty (30) days following the receipt of the notice within which to file with the Chief Executive Officer a written request for a hearing or an appellate review;
10.2.5.6.1.4 state that failure to request a hearing or an appellate review within the said thirty (30) day period shall constitute a waiver of the practitioner’s right to same;
10.2.5.6.1.5 state that if the practitioner requests a hearing, the practitioner will be notified of the date, time and place for the hearing and the composition of the ad hoc hearing committee appointed to conduct such hearing;
10.2.5.6.1.6 state that the practitioner may request that the hearing be held within fourteen (14) days of receipt by the Chief Executive Officer of practitioner’s request for a hearing; and
10.2.5.6.1.7 advise the practitioner of applicable legal requirements for reporting suspensions of clinical privileges to the to the Virginia State Board of
10.2.6.2 The President shall immediately notify the Chief Executive Officer or administrator, as well as the Executive Committees of each of the Inova Hospitals at which the practitioner has clinical privileges of its action.

10.2.6 Hearing Procedure: If the Executive Committee does not terminate the summary suspension immediately, the practitioner shall be entitled to a hearing and appellate review pursuant to these Bylaws. The practitioner shall have thirty (30) days following the receipt of the notice within which to file with the Chief Executive Officer a written request for a hearing or an appellate review. The terms of the summary suspension, as initially recommended by the Executive Committee, shall remain in effect pending any hearing and appellate review pursuant to these Bylaws. Any corrective action proceedings that have already been initiated under the Bylaws and that have not been concluded shall be stayed during the summary suspension proceedings.

10.2.6.1 The hearing committee shall be appointed in accordance with Section 11.4 of these Bylaws.

10.2.6.2 Notification of Hearing:

10.2.6.2.1 Within three (3) business days after receipt of a request for hearing from a practitioner entitled to the same, the Executive committee shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by hand delivery and certified mail, return receipt requested.

10.2.6.2.2 The notice will identify the members of the hearing committee and a list of the witnesses, if any, expected to testify on behalf of the Hospital(s). This shall not preclude the Hospital(s) from identifying additional witnesses at the hearing, or from offering other witnesses at the hearing, providing advance notice is provided to the practitioner in accordance with provisions in ARTICLE 11 of these Bylaws.

10.2.6.2.3 The practitioner shall have the right to request that the hearing be held within fourteen (14) days of receipt of his/her request for a hearing by the Chief Executive Officer. If the practitioner does not make such request or unless otherwise agreed to by the parties, the date of the hearing shall not be less than thirty (30) days from the date of the notice of hearing.

10.2.6.3 The procedures for the hearing before the hearing committee shall be governed by Section 11.6 of these Bylaws.

10.2.6.4 Decision of the Hearing Committee: The hearing committee may modify the terms of the summary suspension, or may recommend that it be continued indefinitely or for a specified period of time, or be terminated. The hearing committee may also recommend termination of the practitioner’s clinical privileges. If a joint committee with members from other Inova Hospitals has been constituted, it may recommend termination of the practitioner’s clinical privileges at any or all Inova Hospitals at which the practitioner has clinical privileges. In the event of such recommendation for termination, the suspension shall remain in effect pending any appellate review, but the termination shall not be effective at this Hospital until and unless the Board approves the termination of the practitioner’s clinical privileges.
10.2.7 Appeal to the Board:

10.2.7.1 Request for Appeal: Within thirty (30) days after receipt of notice by a practitioner of an adverse recommendation of the Executive Committee, made after a hearing conducted by a hearing committee appointed pursuant to Section 11.4 of the Bylaws, the practitioner may, by written notice to the Board, delivered to the Chief Executive Officer, by certified mail, return receipt requested, request an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner’s written statement provided for below, or the notice also may request that oral argument be heard as part of the appellate review.

10.2.7.2 Such appellate review shall be conducted by the Board or, in the alternative, by a committee designated by the Board for this purpose.

10.2.7.3 If such appellate review is not requested within such thirty (30) day period, the practitioner shall be deemed to have waived his/her right to such appellate review and the Board shall make a final decision on the matter.

10.2.7.4 The procedures for appellate review shall be governed in accordance with Section 11.6 of these Bylaws.

10.2.7.5 Decision by the Board: If the appellate review is conducted by a designated committee, within thirty (30) days after the conclusion of the appellate review the committee shall make a report to the Board setting forth the action recommended and the grounds for the recommendation. Within thirty (30) days after receiving the report and recommendation of the designated committee, or within thirty (30) days of receipt of the recommendation of the hearing committee if the Practitioner does not request appellate review, or within thirty (30) days after the conclusion of an appellate review which is not conducted by a designated committee, the Board shall make its decision in the matter and such decision shall be made immediately effective and final and shall not be subject to further hearing or appellate review. The Board may affirm, modify, or reject the recommendation of the Executive Committee, or of the hearing committee appointed by it, or in its discretion, refer the matter back to the Executive Committee or to the said hearing committee for further review and recommendation within twenty (20) days. Such referral may include a request that the Executive Committee or the said hearing committee arrange for a further hearing to resolve specified disputed issues.
10.2.7.6 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article have been completed or waived. All action required of the Board may be taken by the Executive Committee of the Board.

10.2.7.7 The Board shall send notice thereof to the Executive Committee(s) of the Inova Hospitals at which the practitioner has clinical privileges and, through the Chief Executive Officer, to the practitioner, by certified mail, return receipt requested, which notice shall include a statement of the basis for the final decision. A final decision by the Board which adversely affects the clinical privileges of a medical staff member shall be reported to the Virginia State Board of Medicine, the Virginia State Board of Dentistry, or the Virginia Board of Nursing in accordance with statutory requirements and to the National Practitioner Data Bank if required.

ARTICLE 11 HEARING AND APPELLATE REVIEW PROCEDURE

11.1. RIGHTS TO APPEAL

11.1.1 When a practitioner is given a notice of a recommendation of the Executive Committee that, if ratified by decision of the Board, will adversely affect the practitioner’s appointment to or status as a member of the medical staff or which will result in a reduction, suspension or revocation of the practitioner’s clinical privileges, the practitioner shall be entitled to a hearing conducted by an ad hoc hearing committee. If the recommendation of the Executive Committee following such hearing is still adverse to the affected practitioner, the practitioner shall then be entitled to an appellate review as provided in this Article 9 before the Board makes a final decision on the matter. Notwithstanding the foregoing, a practitioner shall not be entitled to a hearing for, in addition to those actions previously specified, the following actions:

11.1.1.1 Change in staff category or denial of a request for change in staff category;
11.1.1.2 Denial of requested, department, section, or other clinical unit affiliation;
11.1.1.3 Minor reduction or limitation in existing clinical privileges;
11.1.1.4 The granting of substantially all, but not all, clinical privileges requested;
11.1.1.5 Denial of appointment, reappointment or clinical privileges due to failure to admit or treat a sufficient number of patients in the Hospital;
11.1.1.6 Placement on medical leave or refusal to terminate medical leave;
11.1.1.7 Letters of warning, reprimand, censure or admonition;
11.1.1.8 Imposition of monitoring, proctoring, supervision, consultation or review requirements, with no restriction on the ability to exercise privileges;
11.1.1.9 Requiring provision of information or documents, such as office records, or notice of events or actions;
11.1.1.10 Imposition of educational or training requirements;
11.1.1.11 Placement on probationary or other conditional status;
11.1.1.12 Refusal to place a practitioner on, or removal from, an on-call or interpretation roster, or requirement to serve on any such roster.
11.1.1.13 Appointment or reappointment for less than two years
11.1.1.14 Continuation of provisional status.
11.1.1.15 Failure to process a request for a privilege when the applicant/practitioner does not meet the qualifications for Medical Staff membership or clinical privileges.
11.1.1.16 Initiation of any review or investigation including any Focused Professional Practice Evaluation or external review;
11.1.1.17 Imposition of a precautionary suspension during an investigation that does not exceed 14 calendar days;
11.1.1.18 Determination that an application is incomplete
11.1.1.19 Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
11.1.1.20 Removal from or limitation of emergency department call obligations;
11.1.1.21 Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws; or
11.1.1.22 The refusal of the Board of Directors to grant a request for a waiver under Section 4.2.2.4.

11.1.2 When a practitioner is given notice of a decision by the Board that will adversely affect the member’s appointment to or status as a member of the medical staff or which will result in a reduction, suspension or revocation of the practitioner’s clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by a committee appointed by the Board, and to an appellate review before the Board makes a final decision on the matter.

11.1.3 All hearings and appellate review, except for those relating to summary suspension, shall be in accordance with the procedure set forth in ARTICLE 11. The provisions outlined herein shall apply only to those proceedings arising from circumstances delineated in Sections 11.1.1 and 11.1.2.

11.2. REQUEST FOR HEARING; EFFECT OF FAILURE TO REQUEST

11.2.1 The Chief Executive Officer or his/her designee shall direct prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested. Such notice shall:

11.2.1.1 state the adverse recommendation or decision and the grounds upon which it is based;
11.2.1.2 advise the practitioner of his/her right to a hearing or an appellate review as provided by these Bylaws, including a summary of rights provided at such a hearing as set forth in Sections 11.4, 11.5 and 11.6;
11.2.1.3 specify that the practitioner shall have thirty (30) days following the receipt of the notice within which to file with the Chief Executive Officer a written request for a hearing or an appellate review;
11.2.1.4 state that failure to request a hearing or an appellate review within the said thirty (30) day period shall constitute a waiver of the practitioner’s right to same;
11.2.1.5 state that if the practitioner requests a hearing or an appellate review, the member will be notified of the date, time and place for the hearing or appellate review.

11.2.2 The failure of a practitioner to request a hearing to which he is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of the practitioner’s right to such hearing and to any appellate review to which the practitioner might otherwise have been entitled on the matter.

11.2.3 When the hearing or appellate review waived relates to an adverse recommendation of the Executive Committee or of a hearing committee appointed by the Board, the same shall thereupon become effective and remain effective against the practitioner pending the Board’s final decision on the matter. When the hearing or appellate review waived relates to an adverse decision by the Board, the same shall thereupon become effective and remain effective against the practitioner in the same
manner as a final decision of the Board. In either of such events, the Chief Executive Officer shall promptly notify the affected practitioner of the member’s status by certified mail, return receipt requested.

11.3. NOTICE OF HEARING

11.3.1 Within thirty (30) days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. Unless agreed to by the parties, the date of the hearing shall not be less than thirty (30) days from the date of the notice of hearing.

11.3.2 The notice will identify a list of the witnesses, if any, expected to testify on behalf of the Hospital. This shall not preclude the Hospital from identifying additional witnesses at the hearing, or from offering other witnesses at the hearing, providing advance notice is provided to the practitioner consistent with Section 11.6.8.1.

11.4. COMPOSITION OF HEARING COMMITTEE AND APPOINTMENT

11.4.1 The individuals appointed to any hearing committee under this section shall not be in direct economic competition with the practitioner involved.

11.4.2 When a hearing relates to an adverse recommendation of the Executive Committee involving an application for appointment or reappointment to the Medical Staff, or when the Practitioner does not have Clinical Privileges at any other Inova Hospital, such hearing shall be conducted by an ad hoc hearing committee appointed by the Chairperson of the Executive Committee and consisting of at least three (3) members of the Active Staff. When the adverse recommendation was made pursuant to ARTICLE 9 of these Bylaws and five (5) members of the Active Staff when the adverse recommendation was made pursuant to ARTICLE 10 of these Bylaws. Alternatively, in the case of an adverse recommendation made pursuant to ARTICLE 9 or ARTICLE 10 of these Bylaws and upon written request of the Practitioner, such hearing may be conducted by an intramural ad hoc hearing committee consisting of an equal number of members of the Active Medical Staffs of each Inova Hospital, provided, however, that in no event shall the size of the hearing committee exceed twelve (12) members. The Chairperson of the Executive Committee of each Inova Hospital shall appoint members of the Active Staff of his/her hospital to serve on the intramural ad hoc hearing committee.

11.4.3 When a hearing relates to an adverse recommendation of the Executive Committee made pursuant either to Section 9.2 or ARTICLE 10 of these Bylaws and the Practitioner has Clinical Privileges at another Inova Hospital, such hearing shall be conducted by an intramural ad hoc hearing committee consisting of at least six (6) but no more than twelve (12) members of the Active Medical Staffs of the Inova Hospitals at which the Practitioner has Clinical Privileges. The Chairperson of the Executive Committee of each Inova Hospital at which the Practitioner has Clinical Privileges shall appoint up to three (3) members of the Active Staff of his/her hospital to serve on the intramural ad hoc hearing committee and each Hospital shall have equal representation on the intramural ad hoc hearing committee. The Chairperson of the Executive Committee of each Inova Hospital shall appoint members of the Active Staff of his/her hospital to serve on the intramural ad hoc hearing committee.

11.4.4 When a hearing relates to an adverse decision of the Board that is contrary to the recommendation of the Executive Committee, the Board shall appoint a hearing committee composed of not less than three (3) nor more than five (5) members of the Board to conduct such hearing.
11.5. **Hearing Officer.** The President of the Medical Staff and the Administrator shall select a hearing officer to preside at the hearing. The hearing officer shall be an attorney or other individual familiar with procedures relating to peer review hearings.

11.5.1 The hearing officer shall rule on all procedural matters at the hearing, advise the members of the hearing panel concerning legal and procedural issues, rule on any objects of testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

11.5.2 The hearing officer shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, and to limit the number of witnesses to be called by the Medical Staff or practitioner.

11.5.3 The hearing officer shall be available to the members of the hearing panel after the conclusion of the hearing to advise them on any procedural matters and to assist the panel with the preparation of their report and recommendations, but shall not vote on any recommendations.

11.5.4 The practitioner shall be notified of the name of the prospective hearing officer and if the practitioner has any objection to any hearing officer, the practitioner shall, within ten (10) calendar days after notification, state the objection in writing and the reasons for the objection. The President of the Medical Staff and the Chief Medical Officer shall, after considering such objections, decide in their sole discretion whether to replace any hearing officer objected to.

11.5.5 The hearing officer shall conduct a pre-hearing conference unless the parties all agree to waive the pre-hearing conference. At the pre-hearing conference the hearing officer may:

11.5.5.1 require that all documentary evidence and exhibits be exchanged and shall resolve any objections to proposed documentary evidence and exhibits;

11.5.5.2 ensure that the names of all proposed witnesses have been provided and that report or summaries of opinions of any experts have been provided;

11.5.5.3 establish the amount of time that shall be allotted to each side for the examination and cross-examination of witnesses, unless agreed upon by the parties; and/or

11.5.5.4 address any other issues relating to the conduct of the hearing.

11.6. **CONDUCT OF HEARINGS**

11.6.1 There shall be at least a majority of the members of the hearing committee present during the entire hearing proceedings, and only those present during the proceedings may vote.

11.6.2 An accurate record of the hearing must be kept. The means for preserving the record shall be established by the hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, and detailed transcription or by the taking of adequate minutes. Copies of the record of the hearing may be obtained by the practitioner after paying reasonable charges associated with the preparation of such documents.
11.6.3 No hearing shall be conducted without the personal presence of the affected practitioner for whom the hearing has been scheduled unless the practitioner waives such appearance or fails without good cause to appear for the hearing after appropriate notice. A practitioner who fails without good cause to appear at such hearing shall be deemed to have forfeited his/her rights in the same manner as provided in Section 11.2.2 and to have voluntarily accepted the adverse recommendation or decision involved, and the same shall thereupon become effective and remain effective as provided in Section 11.2.3.

11.6.4 Requests by the practitioner for postponement of the hearing shall be granted only for good cause shown and in the sole discretion of the Chairperson of the hearing committee.

11.6.5 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of any serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence in a court of law. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record.

11.6.6 Official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of any generally-accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of Virginia. The committee also shall be entitled to consider any pertinent material on file in the Hospital, and all other information which can be considered in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

11.6.7 The Executive Committee, when its action is the subject of the hearing, shall appoint a member of the active staff to represent it at any hearing before a hearing committee to present the facts in support of its adverse recommendation. The Board, when its action is the subject of the hearing, shall appoint one of its members to represent it at any hearing before a hearing committee to present the facts in support of its adverse decision. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by presenting appropriate evidence. The burden shall be upon the practitioner to show that the adverse recommendation is without factual basis or that it is either arbitrary, unreasonable, or capricious.

11.6.8 The practitioner shall have the following rights at the hearing: to present witnesses, to introduce written evidence, to cross-examine any witnesses on any matter relevant to the issue of the hearing, to challenge any witness, to rebut any evidence and to have representation by legal counsel or another person of the practitioner’s choice. If the practitioner does not testify in his/her own behalf, he/she may be called and questioned by the hearing committee.

11.6.8.1 At least fifteen (15) business days prior to the hearing, the practitioner involved shall be sent by certified and regular mail:

11.6.8.1.1 a statement setting forth the reasons for the proposed action;

11.6.8.1.2 identifying any witnesses expected to testify before the panel in support of the recommendation under consideration; and
11.6.8.1.3 identifying all medical records or documents expected to be submitted to the panel for consideration.

11.6.8.2 If any expert witness is to be called as a witness in support of the recommendations of the Medical Staff at the hearing, the practitioner shall be told the identity of the experts to be called, provided a copy of the expert’s curriculum vitae, provided copies of any reports from the experts, or provided a written description of the substance of the expert’s testimony if there are no written reports, and provided copies of all documents or materials provided to the expert for review. No witness may be called on behalf of the Medical Staff, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section unless the hearing officer determines that any failure to disclose was unavoidable.

11.6.9 At least seven (7) business days prior to the hearing the practitioner shall provide to the Medical Staff the following:

11.6.9.1.1 a list of any witnesses the practitioner will call to testify;

11.6.9.1.2 a summary of the subject matter of the witnesses’ testimony and a copy of all documents the practitioner intends to introduce at the hearing;

11.6.9.1.3 if the practitioner intends to call any expert witnesses at the hearing, the member shall identify the experts to be called, provide copies of any reports from the experts, provide a copy of the witnesses’ curriculum vitae, and provide in writing a description of the substance of the experts’ testimony. No witness may be called on behalf of the practitioner, nor any documents submitted for consideration by the panel, which are not disclosed in accordance with this section unless the hearing officer determines that any failure to disclose was unavoidable; and

11.6.9.1.4 a statement setting forth the reasons why the practitioner contends that the adverse recommendation is unreasonable, inappropriate or lacks any factual basis.

11.6.10 The failure of the practitioner requesting a hearing to comply with the requirements related to the disclosure or exchange of information set forth in this Fair Hearing Plan, or ordered by the hearing officer, shall be deemed to be a withdrawal of the request for a hearing, the waiver of the right to a hearing, and agreement to and acceptance of the action recommended or proposed which is the subject of the hearing.

11.6.11 The hearing committee may order that oral evidence be taken on oath or affirmation administered by a notary public.

11.6.12 The Hospital/Executive Committee and the Board shall be entitled to representation by legal counsel at any hearing under these Bylaws. The hearing committee shall also be entitled to representation by legal counsel.

11.6.13 An intramural ad hoc hearing committee appointed pursuant to Section 11.4 of these Bylaws shall consider evidence relating to and shall make a recommendation regarding the imposition of corrective action or summary suspension at both the Hospital and at any other Inova Hospital at which the practitioner has clinical privileges.
11.6.14 The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The practitioner and the Hospital/Executive Committee shall have the right to submit a written statement at the conclusion of the presentation of oral and documentary evidence. Upon receipt of such written statements, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

11.6.15 Within thirty (30) days after a final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committees of the Inova Hospitals at which the practitioner has clinical privileges or the Board, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Board. In the case of an intramural ad hoc hearing committee appointed pursuant to Section 11.4 of these Bylaws, the report may also recommend imposition of any adverse recommendation at one or more of the Inova Hospitals at which the practitioner has clinical privileges. The Hospital shall promptly provide a copy of the written recommendation of the hearing committee, including a statement of the basis for the recommendation, to the practitioner.

11.7. APPEAL TO THE BOARD

11.7.1 Within thirty (30) days after receipt of notice by a practitioner of an adverse recommendation of the Executive Committee, made after a hearing conducted by the Executive Committee or a hearing committee appointed pursuant to Section 11.4 of these Bylaws, or of an adverse recommendation of a hearing committee appointed by the Board, made after a hearing before such committee, the practitioner may, by written notice to the Board, delivered to the Chief Executive Officer, by certified mail, return receipt requested, request an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner’s written statement provided for below, or the notice also may request that oral argument be heard as part of the appellate review.

11.7.2 Such appellate review shall be conducted by the Board or, in the alternative, by a committee designated by the Board for this purpose. However, in cases where an adverse recommendation was made by an Executive Committee of an Inova Hospital with a different Board, where the recommendation was further upheld by an intramural hearing committee in which members of this Medical Staff participated under primary authority of the other Hospital’s Bylaws, any appeal by the practitioner must be directed to the Board of the other Inova Hospital, not to the Board of this Hospital.

11.7.3 If such appellate review is not requested within such thirty (30) day period, the practitioner shall be deemed to have waived his right to such appellate review and the Board shall make a final decision on the matter.

11.7.4 Within thirty (30) days after receipt of such notice of request of appellate review, the Board or designated committee shall select a date for such review, including oral argument if such has been requested, and shall, by written notice sent by certified mail, return receipt requested, through the Chief Executive Officer, notify the practitioner of the date selected or in the case of oral argument, of the time, place and date selected.

11.7.5 The appellate review shall be conducted in accordance with the following procedures:
11.7.5.1 Both the practitioner and the Hospital and/or Executive Committee are entitled to representation at the appellate review by legal counsel. The Board or designated committee may also be represented by legal counsel.

11.7.5.2 The practitioner shall have access to the hearing committee report, the hearing record (and transcription, if any), and to all other material information reviewed by the hearing committee that was considered in making the adverse recommendation or decision against him/her. The practitioner shall be required to submit a written statement setting forth those findings, conclusions, and factual and procedural matters with which the practitioner disagrees, and his/her reasons for such disagreement. The written statement shall address any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board through the Chief Executive Officer by certified mail, return receipt requested, at least ten (10) calendar days prior to the scheduled date for the appellate review. A responsive statement may be submitted by the Executive Committee within five (5) calendar days after receipt of the statement from the practitioner. The failure of the practitioner to identify any actions, findings, conclusions or factual or procedural matters with which the practitioner objects or disagrees shall be deemed to be a waiver of any such objection and consent to the actions being taken and procedures being followed. The practitioner shall not be permitted to subsequently raise any issue not identified in the statement from the practitioner.

11.7.5.3 The Board or designated committee shall act as an appellate body. It shall review the hearing committee report and the hearing record and shall consider the written statements submitted for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious, or whether there has been a substantial failure to comply with the bylaws during the course of the corrective action which has materially prejudiced the practitioner, and which the Practitioner objected to on a timely basis. If oral argument is requested as part of the review procedure, the practitioner shall be entitled to be present at such appellate review, and shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her or her by any member of the appellate review body. The Executive Committee or the hearing committee appointed by the Board shall also be represented by a member thereof who shall be permitted to speak in favor of the adverse recommendation and who shall answer questions put to him/her or her by any member of the appellate review body.

11.7.5.4 New or additional matters, facts or evidence not raised or introduced during the hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, in order to prevent injustice. The Board or designated committee shall in its sole discretion determine whether such new matters shall be accepted. The amount of time available for practitioner’s presentation may be limited by the chairperson of the Board or designated committee or made subject to such conditions as the chairperson determines to be appropriate.

11.7.5.5 If the appellate review is conducted by a designated committee, within thirty (30) days after the conclusion of the appellate review the committee shall make a report to the Board setting forth the action recommended and the grounds for the recommendation.

11.7.6 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article have been completed or waived. All action required of the Board may be taken by the Executive Committee of the Board.
11.8. FINAL DECISION BY BOARD

11.8.1 If the appellate review is conducted by a designated committee, the Board shall make its decision in the matter within thirty (30) days after receiving the report and recommendation of the committee, or within thirty (30) days of receipt of the recommendation of the hearing committee if the appellate review has been waived, or within thirty (30) days after the conclusion of an appellate review which is not conducted by a designated committee, the Board shall make its decision in the matter and such decision shall be made immediately effective and final and shall not be subject to further hearing or appellate review. When acting on a recommendation made by the Medical Executive Committee, or on a recommendation of a hearing committee appointed by the Board pursuant to section 11.1.2, the Board may affirm, modify, or reject the recommendation, or in its discretion, refer the matter back to the Executive Committee or the hearing committee for further review and recommendation. Such referral may include that the Executive Committee or the hearing committee arrange for a further hearing to resolve specified disputed issues. The Board shall send notice thereof to the Executive Committee of each Inova Hospital at which the practitioner has clinical privileges and, through the Chief Executive Officer, to the Medical Staff member, by certified mail, return receipt requested, which notice shall include a statement of the basis for the final decision. A final decision by the Board which adversely affects the clinical privileges of a Medical Staff member shall be reported to the Virginia State Board of Medicine, Virginia State Board of Dentistry, or the Virginia Board of Nursing, in accordance with statutory requirements.

11.9. LIMIT ON NUMBER OF HEARINGS AND APPEALS

11.9.1 Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee or by the Board or both.

11.10. EFFECT OF RESIGNATION

11.10.1 If at any time after initiation of an action or procedure as provided in ARTICLE 9 or ARTICLE 10, a practitioner submits a written resignation of his/her Medical Staff membership or clinical privileges or requests that upon expiration of the practitioner’s term of appointment or clinical privileges, the practitioner may not be reappointed or his/her clinical privileges not be renewed, such resignation or request shall be made a part of the practitioner’s file with respect to the matter involved. Such resignation or request shall not terminate any action or procedure as set forth in ARTICLE 9 or ARTICLE 11. Such resignation or request shall be reported to the Virginia State Board of Medicine, the Virginia State Board of Dentistry, or the Virginia State Board of Nursing.

ARTICLE 12 OFFICERS

12.1. OFFICERS OF THE STAFF

12.1.1 Identification

12.1.1.1 The officers of the staff shall be:
   12.1.1.1.1 President
   12.1.1.1.2 Vice President

12.1.1.2 These titles are renamed in these Bylaws as revised in 2011. Any mention of the Chief of Staff and Vice Chief of Staff in other Hospital documents should be understood to refer to the
President and Vice President, respectively. The new titles shall be substituted in other documents, but this may be deferred until any routine revision takes place.

12.1.2 Terms of Office

12.1.2.1 The term of office for the President and the Vice President shall be three years. Each officer shall serve a three year term, commencing on the first day of the Medical Staff year following his election. Each officer shall serve until the end of his term and until a successor is elected.

12.1.3 Term Limits

12.1.3.1 A sitting president serving a three year term shall not be eligible for another nomination or election as President, but may be nominated again after leaving office.

12.1.4 Qualifications

12.1.4.1 Officers must be members of the Active Staff at the time of nomination and election and must remain on the Active Staff during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and Vice President must be practitioners with demonstrated competence in their fields or practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and staff activities.

12.1.5 Nominations

12.1.5.1 During the year that the President’s term expires, the Executive Committee shall appoint a Nominating Committee, no later than one month before the third regular general staff meeting. This committee shall consist of:

   12.1.5.1.1 Three current department chairpersons
   12.1.5.1.2 No more than two past Presidents or Chiefs of Staff
   12.1.5.1.3 The current President, if not eligible for reelection.
   12.1.5.1.4 Additional active medical staff members, excluding the vice president, sufficient to bring the committee membership to a total of seven.

12.1.5.2 The nominating committee shall meet and, if the current President and Vice President are both completing three year terms, select the Vice President as its nominee for President and select one nominee for vice president. However, if one or both officers are not completing three year terms, the committee may also select any qualified member as its nominee for President. The Committee shall confirm with those individuals that they are in fact willing to run for the respective offices and to serve, and shall select a replacement nominee if an individual declines nomination.

12.1.5.3 At the third regular general staff meeting of the election year, the committee will announce its nominations for President and Vice President.

12.1.5.4 The Medical Staff may nominate additional candidates by petition, signed by at least eight percent (8%) of the members of the Medical Staff entitled to vote, and delivered to the President, within thirty (30) days from the announcement of the Nominating Committee’s nominees.
12.1.6 Election Process

12.1.6.1 If there is only one candidate for an office, a voice vote at the fourth regular general staff meeting is sufficient for election.

12.1.6.2 If more than one individual is nominated for President, Vice President or both, ballots, numbered for identification purposes, will be mailed to voting members of the medical staff.
   12.1.6.2.1 The Nominating Committee shall be responsible for supervising the counting of all votes for this election process. Electronic voting, if available, may be substituted for paper ballots if the process is approved by the Executive Committee.
   12.1.6.2.2 First ballots will be sent one month prior to the date of the fourth regular general staff meeting of the election year. The ballots must be returned to the medical staff office within two weeks.
   12.1.6.2.3 If no candidate for one or both offices receives a majority vote on the first ballot, a second runoff election between the candidates receiving the two highest vote totals shall be held. These ballots shall be returned by the start of the fourth regular general staff meeting.
   12.1.6.2.4 The nominating committee may confer and cast a single additional vote to resolve any tie that affects the outcome of a first or runoff ballot.

12.1.7 Removal from Office

12.1.7.1 The Medical Staff may request a vote for removal of the President or Vice President, by a petition signed by at least fifteen percent (15%) of the members of the staff entitled to vote. The Medical Staff shall then vote for or against such removal at a medical staff meeting--if no medical staff meeting is already scheduled within 45 days of receipt of such a petition, a special medical staff meeting shall be called. Removal of an Officer may not be voted on by mail or electronic ballot. A 50.1% quorum must be present for a vote to proceed at the meeting, and a 2/3 majority shall be required for removal of an officer.

12.1.8 Vacancies in Elected Office

12.1.8.1 If there is a vacancy in the office of President, the Vice President shall serve out the remaining term. A vacancy in the office of Vice President shall be filled by the Medical Executive Committee as soon after the vacancy occurs as is reasonably possible.

12.1.9 Duties of Elected Officers

12.1.9.1 President: The President shall serve as the Chief Administrative Officer and principal elected official of the medical staff. As such, he shall:
   12.1.9.1.1 aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff.
   12.1.9.1.2 be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and other quality improvement functions delegated to the staff.
12.1.9.1.3 develop and implement, in cooperation with the department Chairpersons, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice and retrospective patient care audits.

12.1.9.1.4 communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board and the Chief Executive Officer.

12.1.9.1.5 be responsible for the enforcement of Medical Staff Bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

12.1.9.1.6 call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

12.1.9.1.7 serve as Chairperson of the Medical Executive Committee, and as an ex officio member without vote of all staff committees.

12.1.9.2 Vice President: The Vice President shall:

12.1.9.2.1 be a member of the Bylaws committee and a member of the Medical Executive Committee.

12.1.9.2.2 in the temporary absence of the President, assume all the duties and have the authority of the President.

12.1.9.2.3 supervise the collection of and accounting for any funds that may be collected in the form of staff dues, assessments, or application fees.

12.1.9.2.4 perform such additional duties as may be assigned to him by the President.

12.2. OTHER OFFICIALS OF THE STAFF

12.2.1 Department Chairperson and Vice Chairperson

12.2.1.1 Qualifications

12.2.1.1.1 Each Chairperson and Vice Chairperson of each medical staff department shall be a member of the Active or Affiliated Physician staff, shall have demonstrated ability in at least one of the clinical areas covered by the department of which he is Chairperson, and shall be willing and able to discharge the functions of his office faithfully.

12.2.1.1.2 The Chairperson and Vice Chairperson of each medical staff department must be certified by an appropriate specialty board, or possesses comparable competence affirmatively established through the credentialing process.

12.2.1.2 Selection: The Chairperson shall be elected by his department from nominations submitted by the department members. Chairpersons for the Departments of Family Medicine, Orthopaedics, Pediatrics, and contract or employed Departments (Anesthesia, Diagnostic Imaging, Emergency, and Pathology) to be elected in even years; Chairpersons for the Departments of Internal Medicine, Surgery and OB/GYN to be elected in odd years. Elections shall be held by December 1, and the two-year terms shall convene on January 1 of the following year. The President shall submit the election results to the Board. Final appointment is subject to Board approval.

12.2.1.3 Term of Office: A department Chairperson will serve a two year term commencing on the first day of the medical staff year following his election. He shall serve until the end of his term and until his successor is chosen.
12.2.1.4 Removal from Office: Removal from office of a department Chairperson may be accomplished by the Board acting (i) upon its own recommendation, (ii) upon the recommendation of a majority of the Medical Executive Committee, (iii) upon the recommendation of a two thirds (2/3) majority vote of the department members present and eligible to vote at a regular or specially called meeting of the Department at which a quorum is present.

12.2.1.5 Vice Chairperson: The Department Vice Chairperson shall function on behalf of the Chairperson in his absence assuming all rights, duties and privileges of the Chairperson. Similarly, the Vice Chairperson will temporarily act as Chairperson when the Chairperson is suspended or permanently incapacitated. The Vice Chairperson shall become Department Chairperson should the Chairperson resign, be relieved of his duties, or become permanently incapacitated. If the Vice Chairperson position is vacated for any reason, the affected department will elect a new Vice Chairperson at the next regularly scheduled department meeting.

12.2.1.6 Duties: Each Chairperson shall be a member of the Executive Committee, and shall faithfully convey the decisions and opinions of the Department to that Committee. In addition, with the support and, when required by these Bylaws, the consent of the Department or of specific Department members when so required by these Bylaws, the Chairperson shall have primary responsibility for:

12.2.1.6.1 Clinically related activities of the department.
12.2.1.6.2 Administratively related activities of the department, unless otherwise provided by the hospital.
12.2.1.6.3 Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
12.2.1.6.4 Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
12.2.1.6.5 Recommending clinical privileges for each member of the department.
12.2.1.6.6 Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
12.2.1.6.7 Integration of the department or service into the primary functions of the organization.
12.2.1.6.8 Coordination and integration of interdepartmental and intradepartmental services.
12.2.1.6.9 Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
12.2.1.6.10 Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
12.2.1.6.11 Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
12.2.1.6.12 Continuous assessment and improvement of the quality of care, treatment, and services.
12.2.1.6.13 Maintenance of quality control programs, as appropriate.
12.2.1.6.14 Orientation and continuing education of all persons in the department or service.
12.2.1.6.15 Recommending space and other resources needed by the department or service.
12.2.1.6.16 Supervising the formation, organization, leadership selection and function of subspecialty sections, facilitating transmission of opinions and recommendations of
such sections to the department and the Medical Executive Committee, and
appointing such other committees as are necessary to conduct the functions of the
department specified in these Bylaws and designate a Chairperson for each.
12.2.1.6.17 Enforcing the Hospital and Medical Staff Bylaws, rules, policies and regulations
within his department, including requesting corrective action and investigation of
clinical performance and ordering required consultations.

12.2.2 Medical Directorships

12.2.2.1 The Board, after considering the advice and recommendations of the Medical Staff through
the function of the Medical Executive Committee, may appoint practitioners to medico
administrative positions within the Hospital to perform such duties as prescribed by the
Medical Executive Committee, Administration and the Board, or as defined by amendment to
these Bylaws.
12.2.2.2 To the extent that any such medical director performs any clinical function, he must become
and remain a member of the staff. In all events, he must be subject to these Bylaws and to the
other policies of the Hospital.
12.2.2.3 Appointments of medical directorships shall be for two years, with potential reappointment
based on evaluation as necessary by the medical staff through the function of the Medical
Executive Committee, and a recommendation to Administration and the Board.
12.2.2.4 Ad hoc medical directorships may be created as needed, but if effective for longer than 24
months, shall then become one of the standing medical directorships in place, to be
reevaluated every two years.
12.2.2.5 The Chairperson of each medical staff department and the medical director of each clinical
service or area must be certified by an appropriate specialty board.

12.2.3 Subspecialty Section Chiefs

12.2.3.1 Each subspecialty section must have a section chief, chosen under rules established by the
department.

ARTICLE 13 COMMITTEES AND FUNCTIONS

13.1. MEDICAL STAFF COMMITTEES

13.1.1 The committees of the Medical Staff shall consist of the standing committees set forth in Section
13.2 and special committees established by the President of the Medical Staff with the approval of
the Medical Executive Committee and the Administrator. Except as otherwise provided for in these
Bylaws, committee composition as well as frequency of meetings and reports shall be outlined in
specific policies and procedures prepared by the committee and approved by the Executive
Committee.
13.1.2 Members of each committee, except as otherwise provided for in the policies and procedures, shall
be appointed by the President of the Medical Staff at the start of his term, and approved by the
Executive Committee. Members of each committee, except Ex Officio members shall be eligible to
vote on any matter coming before such committees. The Chairperson of each committee shall
appoint administrative representatives and support staff in consultation with the Administrator.
13.1.3 The Administrator and the President of the Medical Staff shall be Ex Officio members of all Medical
Staff committees.
13.1.4 Chairperson: The Chairperson of each medical staff committee, except as otherwise provided for in
the policies and procedures, shall be appointed by the President of the Medical Staff and approved by
the Executive Committee.
13.1.5 Vacancies: Except as otherwise provided, vacancies on any medical staff committee shall be filled in the same manner in which the original appointment is made.

13.2. STANDING COMMITTEES OF THE MEDICAL STAFF

13.2.1 MEDICAL EXECUTIVE COMMITTEE.

13.2.1.1 The Executive Committee shall act for the Medical Staff as a whole except in such matters as may be precluded by these Bylaws or as otherwise directed by the Medical Staff. The Executive Committee shall perform the following functions:
13.2.1.1.1 coordinate the activities of the Medical Staff;
13.2.1.1.2 develop, adopt and recommend to the Administrator and/or Board policies of the Medical Staff; receive and act upon reports and recommendations from departments, committees and Officers of the Medical Staff; implement the policies of the Medical Staff;
13.2.1.1.3 consider and recommend action to the Administrator of a medico-administrative nature;
13.2.1.1.4 recommend to the Board all matters concerning appointments, reappointments, staff category, department and section assignments, Clinical privileges and corrective action, organized medical staff structure;
13.2.1.1.5 make recommendations on Hospital management matters to the Board through the Administrator;
13.2.1.1.6 make recommendations to the Board regarding the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities;
13.2.1.1.7 enforce the Medical Staff Bylaws and Rules and Regulations;
13.2.1.1.8 ensure professionally ethical conduct on the part of all members of the Medical Staff;
13.2.1.1.9 review, evaluate, and make recommendations to the Board regarding the quality and adequacy of professional services rendered at the Hospital;
13.2.1.1.10 initiate such disciplinary measures as are indicated;
13.2.1.1.11 review the status and coordinate, as appropriate, the maintenance of the Hospital’s accreditation programs; and
13.2.1.1.12 ensure that the Medical Staff is informed and kept current on the status of programs relating to the Hospital

13.2.1.2 Further, the Executive Committee shall have an orderly and balanced plan through which the Hospital can attempt to meet the needs of the community. It shall concern itself with the full range of diagnostic, therapeutic, preventative, educational and support programs which the Hospital might appropriately offer and recommend programs and priorities to meet health care needs.

13.2.1.3 The Medical Executive Committee shall consist of the President, Vice President, and the Chairperson of each department. Each department Chairperson shall have one vote.

13.2.1.4 The Chief Executive Officer and three hospital administrators of his choosing shall be ex officio members without vote.

13.2.1.5 When a new department is created, the Chairperson of this department shall be made a member of the Medical Executive Committee without vote until the new department has been ratified by a Board of Directors approved change in the Medical Staff Bylaws.
13.2.2 **CREDENTIALS COMMITTEE.** The Credentials Committee shall consist of members of the Medical Staff so selected as to ensure representation of the Medical Staff. Its duties shall be to review and investigate the credentials of all applicants for Medical Staff membership and/or for clinical privileges and to make recommendations thereon to the Executive Committee.

13.2.3 **BYLAWS COMMITTEE.** It shall be the functions of this committee to annually review the Bylaws and Medical Staff rules and regulations and policies to propose to the Executive Committee amendments to the Bylaws and Medical Staff rules and regulations and policies as may be deemed necessary; and to develop and propose amendments to the Bylaws and Medical Staff rules and regulations and policies as requested by the Executive Committee and/or Medical Staff.

13.3. **Special Medical Staff Committees.** Special medical staff committees may be appointed at any time by the President of the Medical Staff and confirmed by the Executive Committee to perform such duties as may be considered outside of the scope of the standing committees. Each such committee shall confine its functions to the purpose for which it is appointed, shall report to the Executive Committee, and shall be dissolved upon completion of its assignment.

13.4. **Joint Hospital-Medical Staff Committees.** There shall be established such joint Hospital-Medical Staff Committees as agreed upon by the Executive Committee and the Administrator. Such committees may be established and function jointly with other Inova hospitals.

**ARTICLE 14 STAFF DEPARTMENTS**

14.1. **ORGANIZATION OF STAFF DEPARTMENTS**

14.1.1 Each department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who is selected and has the authority, duties, and responsibilities as specified in Section 12.2.1.

14.2. **DESIGNATION**

14.2.1 **Current Departments**

14.2.1.1 The current departments are: Anesthesia, Emergency Medicine, Diagnostic Imaging, Pathology, Family Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Surgery, and Orthopaedics.

14.2.2 **Future Departments**

14.2.2.1 When deemed appropriate, the Medical Executive Committee may recommend to the Medical Staff the appropriate Bylaws changes to create a new department, eliminate, subdivide, or combine departments. With a majority vote of its members, a subspecialty section may petition the Medical Executive Committee directly to become a department.

14.2.3 **Sections of Departments**

14.2.3.1 Each department may form sections within their department to accomplish administrative needs. However, each section will be subordinate to the general department and will be required to comply with departmental rules and regulations.
14.3. ASSIGNMENT TO DEPARTMENTS

14.3.1 Each member of the staff shall be assigned membership in one department, but may be granted clinical privileges in one or more of the other departments. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of the department Chairperson. Where appropriate by training and/or experience, a member shall also be assigned to an existing subspecialty section by criteria applied consistently to all department members.

14.4. FUNCTIONS OF DEPARTMENTS

14.4.1 The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

14.4.1.1 conduct quality assurance review for the purpose of analyzing, reviewing and evaluating the quality of care within the department. The number of such reviews conducted during the year shall be as determined by the Medical Executive Committee, but shall not be less that the number required by the Joint Commission or, if higher, the number required by law. Each department shall review clinical work performed by all practitioners and advanced practice providers in its clinical area. Practitioners or advanced practice providers subject to such review may or may not be members of that department.

14.4.1.2 establish guidelines for the granting of clinical privileges within the department and submit the recommendations required under ARTICLE 7 and ARTICLE 8 regarding the specific privileges each staff member or applicant may exercise and the specified services that each advanced practice provider may provide.

14.4.1.3 conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state of the art and to findings of review and evaluation activities.

14.4.1.4 monitor, on a continuing and concurrent basis, adherence to: (1) staff and Hospital policies and procedures; (2) requirements for alternate coverage and for consultations; (3) sound principles of clinical practice; (4) regulations designed to promote patient safety.

14.4.1.5 coordinate the patient care provided by the department's members with nursing, ancillary patient care services and administrative support services.

14.4.1.6 foster an atmosphere of professional decorum within the department appropriate to the healing arts.

14.4.1.7 submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning: (1) findings of the department's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and (3) such other matters as may be requested from time to time by the Medical Executive Committee.

14.4.1.8 provide appropriate emergency medical and surgical service for the Hospital as clinical resources permit.
14.4.1.9 establish such committees, subspecialty sections, or other mechanisms as are necessary and desirable to perform properly, and, in the case of subspecialty sections, delegate specialty-specific quality assurance responsibilities and other specialty-specific elements of department function to the section.

14.4.1.10 support the department chairperson in the performance of those duties listed for the chairperson in these Bylaws.

14.5. MEETING FREQUENCY

14.5.1 Departments shall meet at least quarterly in each calendar year. Subspecialty sections shall meet at least yearly. Meetings may be convened in person and/or by electronic means.

ARTICLE 15 MEETINGS

15.1. GENERAL STAFF MEETINGS

15.1.1 Regular Meetings

15.1.1.1 Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required.

15.1.2 Order of Business and Agenda

15.1.2.1 The order of business at a regular general staff meeting shall be determined by the President. The agenda shall include at least:

15.1.2.1.1 reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
15.1.2.1.2 administrative reports from the Chief Executive Officer, the President, departments and committees.
15.1.2.1.3 the election of officers, at the last annual meeting only.
15.1.2.1.4 reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality maintenance activities of the staff and on the fulfillment of the other required staff functions.
15.1.2.1.5 recommendations for improving patient care within the Hospital.
15.1.2.1.6 voting for approval of proposed amendments to Bylaws subject to general medical staff approval as directed in ARTICLE 18.
15.1.2.1.7 voting for approval of proposed amendments to rules and regulations subject to general medical staff approval as directed in ARTICLE 17.
15.1.2.1.8 new business.

15.1.3 Attendance at Meetings of the Medical Staff

15.1.3.1 Each member of the Active, Courtesy and Affiliated Physician Staff shall be required to attend meetings of the Medical Staff. Absence from more than one-half of such meetings, when required by any department, in any Medical Staff year is just cause and shall be grounds for suspension of Medical Staff membership or Clinical privileges. Failure to meet this attendance requirement shall be reported to the Executive Committee.
15.1.3.2 Members of the Honorary Staff shall not be required to attend Medical Staff meetings, but are invited to attend and participate in these meetings.

15.1.4 Voting. Except as otherwise specifically provided, the affirmative vote of a majority of the Medical Staff Members eligible to vote at any Medical Staff meeting, at which the Quorum requirement is met, shall be the action of the group. There shall be no voting by proxy. The Executive Committee may permit the use of mail or electronic ballots for the election of officers, the amendment of the Medical Staff Bylaws, or, unless otherwise prohibited, any other action which is required to be taken by the full Medical Staff. The manner in which mail or electronic ballots are used shall be at the discretion of the Executive Committee.

15.1.5 Special Meetings

15.1.5.1 Special meetings of the general Medical Staff may be called at any time by the Board, the chief of the Medical Staff, the Medical Executive Committee or not less than twenty percent (20%) of the members of the active staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

15.2. COMMITTEE AND DEPARTMENT MEETINGS

15.2.1 Regular Meetings

15.2.1.1 Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required.

15.2.2 Special Meetings

15.2.2.1 A special meeting of any committee or department may be called by, or at the request of, the Chairperson, thereof, the Board, the President, or by twenty percent (20%) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

15.3. NOTICE OF MEETINGS

15.3.1 Written notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution shall be given to each person entitled to be present thereat not less than seven (7) days nor more than thirty (30) days before the date of such meeting. Notice of department or committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered forty-eight (48) hours after deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his address as it appears on the records of the Hospital. If sent electronically, notice of the meeting shall be deemed to have been delivered when the notice is sent to the email address on file with the Medical Staff Office. It shall be the responsibility of the Medical Staff Member to ensure a current and accurate email address is on file with the Medical Staff Office. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.
15.4. QUORUM

15.4.1 General Staff Meetings

15.4.1.1 The physical presence of thirty-three percent (33%) of the voting members of the active Medical Staff at any regular or special meeting shall constitute a quorum.

15.4.2 Department and Committee Meetings

15.4.2.1 Fifty percent (50%) of the voting members of a department or committee, but not less than two (2) members, shall constitute a quorum at any meeting of such department or committee.

15.5. VOTING

15.5.1 Except as otherwise specifically provided, the affirmative vote of a majority of the Medical Staff Members eligible to vote at any Department, section or committee meeting, at which the Quorum requirement is met, shall be the action of the group. There shall be no voting by proxy. Any Department, section or committee may choose to have any matter voted on by mail or electronic ballot. The manner in which mail or electronic ballots are used shall be at the discretion of the Department, section or committee concerned.

15.6. MINUTES

15.6.1 Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Medical Executive Committee, and made available to the staff, except where in conflict with confidentiality requirements of ARTICLE 16 and the confidentiality policy adopted by the Hospital. A permanent file of the minutes of each meeting shall be maintained.

15.7. ATTENDANCE REQUIREMENTS

15.7.1 Regular Attendance

15.7.1.1 The Medical Executive Committee will define committee meeting attendance requirements when deemed appropriate. With the approval of the Medical Executive Committee, departments may require minimum attendance at department meetings and may set attendance requirements for committees in which their members are assigned to serve.

15.7.2 Absence from meetings

15.7.2.1 Failure to meet any specified attendance requirements as described in these Bylaws may be grounds for any of the corrective actions specified in Section 9.2, including, in addition, removal from such committee.

15.7.3 Special Appearance

15.7.3.1 A practitioner or advanced practice provider whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified at least seven (7) days prior to the scheduled meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice shall include a statement of the
issue involved and that the practitioner’s or advanced practice provider’s appearance is mandatory. In this instance, if it is a special meeting, or a meeting held at some other time than the regular meeting time as established by resolution, the Chairperson of the meeting shall give the practitioner or advanced practice provider at least fourteen (14) days advance written notice of the time and place of the meeting. Failure of a practitioner or limited healthcare provider to appear at any meeting with respect to which he was given such notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, be considered grounds for summary suspension of clinical privileges in accordance with ARTICLE 10 of these Bylaws.

ARTICLE 16 CONFIDENTIALITY, IMMUNITY AND RELEASES

16.1. SPECIAL DEFINITIONS

16.1.1 For the purpose of this Article, the following definitions shall apply:

16.1.1.1 INFORMATION means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures, whether in written or oral form, relating to any of the subject matter specified in Section 16.5.2 or covered by Virginia Code Section 8.01 581 16.

16.1.1.2 MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

16.1.1.3 REPRESENTATIVE means a Board and any director or committee thereof; a Chief Executive Officer, a Medical Staff organization and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

16.1.1.4 THIRD PARTIES mean both individuals and organizations providing information to any representative.

16.2. AUTHORIZATIONS AND CONDITIONS

16.2.1 By applying for, or exercising, clinical privileges or providing specified patient care services within this Hospital, a practitioner or advanced practice provider:

16.2.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his professional ability and qualifications.

16.2.1.2 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

16.2.1.3 Acknowledges that the provisions of this Article are express conditions to his application for, or acceptance of, staff membership, or his exercise of clinical privileges or provision of specified patient services at this Hospital.

16.3. CONFIDENTIALITY OF INFORMATION

16.3.1 Information with respect to any practitioner or advanced practice provider submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor used in any way
except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general Hospital records.

16.4. IMMUNITY FROM LIABILITY

16.4.1 For Action Taken

16.4.1.1 No representative of the Hospital or Medical Staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of the provisions of state law, truth shall be an absolute defense in all circumstances.

16.4.2 For Providing Information

16.4.2.1 No representative of the Hospital or Medical Staff and no third party shall be liable in any judicial proceedings for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other hospital, organization of health professionals, or other health related organization of a practitioner or advanced practice provider who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this Hospital provided that such representative or third party acts in good faith and without malice.

16.5. ACTIVITIES AND INFORMATION COVERED

16.5.1 Activities

16.5.1.1 The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health related institution's or organization's activities concerning, but not limited to:

16.5.1.1.1 applications for appointment, clinical privileges, or specified services
16.5.1.1.2 periodic reappraisals for reappointment, clinical privileges, or specified services
16.5.1.1.3 corrective action
16.5.1.1.4 hearings and appellate reviews
16.5.1.1.5 patient care audits
16.5.1.1.6 utilization reviews
16.5.1.1.7 other Hospital, department, or committee activities related to monitoring and improving quality patient care and appropriate professional conduct
16.5.1.1.8 activities specified by Virginia Code Section 8.01 581.16

16.5.2 Information

16.5.2.1 The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's or advanced practice provider's professional qualifications, clinical ability, judgment, character, physical and mental health,
emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

16.6. RELEASES

16.6.1 Each practitioner and advanced practice provider shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

16.7. CUMULATIVE EFFECT

16.7.1 Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE 17 GENERAL PROVISIONS

17.1. STAFF RULES AND REGULATIONS AND POLICIES

17.1.1 Such rules, regulations and policies as may be necessary to implement more specifically the general principles found within these Bylaws may be adopted by the Executive Committee subject to the approval of the Administrator and/or the Board.

17.1.2 Rules, regulations and policies of the Medical Staff and of departments shall be reviewed not less than once every three (3) years.

17.1.3 Any proposed rule, regulation or policy adopted by the Medical Executive Committee shall be distributed to the members of the Medical Staff entitled to vote for review and comment in accordance with such procedures as are approved by the Medical Executive Committee before the policy is sent to the Chief Executive Officer (or designee) and/or Board of Directors for approval. Upon petition signed by at least fifteen percent (15%) of the members of the Medical Staff entitled to vote, and delivered to the President within thirty (30) days after notice of the proposed rule, regulation or policy has been sent to the Medical Staff, the proposed rule, regulation or policy shall be submitted to the Medical Staff for approval at the next general staff meeting. At that meeting, if a Quorum as defined in these Bylaws is achieved and if there is a vote for such an action by a simple majority of the Staff members who are eligible to vote, the rule, regulation or policy shall be referred back to the Medical Executive Committee for further consideration and possible revision, in which case the same process defined in this paragraph shall be followed for any revised version. If no petition seeking approval by the full Medical Staff is submitted within thirty (30) days of notification, the proposed rule, regulation or policy shall become effective upon approval by the Chief Executive Officer and/or the Board of Directors.

17.1.3.1 Departmental Prerogatives Regarding Actions of the Medical Executive Committee: As an alternative to the process detailed in 17.1.3, individual departments shall have the right to object to actions taken by the Executive Committee except for decisions regarding practitioner credentialing, granting of privileges, and corrective action decisions; objections to formal written policies shall be addressed under processes detailed above ARTICLE 17. Objection to other Medical Executive Committee action will be processed as follows:
17.3.1.1 Any Medical Executive Committee action can be raised as an agenda item at a properly called and constituted departmental meeting by any member of that department.

17.3.1.2 A simple majority vote of that properly called and constituted departmental meeting will authorize the Chairperson of the department to place the questioned action on the agenda of the next Medical Executive Committee meeting.

17.3.1.3 After reconsideration by the Medical Executive Committee, the action will be rescinded, modified or left unchanged.

17.3.1.4 If disagreement remains, a simple majority vote in any properly called and constituted departmental meeting will place the item on the agenda of the next regular Medical Staff meeting.

17.3.1.5 At the Medical Staff meeting, a simple majority vote may either rescind or leave unchanged the questioned Medical Executive Committee action.

17.4 Rules, regulations or policies may also be proposed to the Board of Directors by the Medical Staff by majority vote of the members of the Medical Staff entitled to vote. The rule, regulation or policy must be supported by a petition signed by at least fifteen percent (15%) of the members of the Active Staff. The petition shall include the precise language of the rule, regulation or policy to be considered for adoption and shall be submitted to the Medical Executive for review and comment at its next regularly scheduled meeting. The initial revisions may be amended or withdrawn with the consent of both the Executive Committee and 75% of the original petitioning members, but otherwise the original proposal shall not be altered. In either case the proposal shall be forwarded in writing to all members of the medical staff possessing voting privileges for review, along with notice of the next general staff meeting, at least ten (10) days before such a meeting. At that meeting, if a quorum as defined in these Bylaws is achieved, and if there is an affirmative vote of a simple majority of the Staff members who are eligible to vote, the revisions shall be forwarded to the Board of Directors for final approval.

17.2. DEPARTMENTAL RULES AND REGULATIONS

17.2.1 Subject to the approval of the Medical Executive Committee and the Board, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general rules and regulations of the Medical Staff, or other policies of the Hospital. Subspecialty sections shall be subject to department rules. Rules specific to subspecialty section members may be adopted by the section with approval of the department, or by initiative of the department, and shall be added to the department rules.

17.3. PROFESSIONAL LIABILITY INSURANCE

17.3.1 All practitioners (unless categorically exempted by these bylaws) with privileges granted under these Bylaws are required to carry professional liability insurance. The limit of insurance per medical incident must equal or exceed the amount of the limitation on damages on medical malpractice cases as specified by Virginia Code 8.01-581.15 and any successor amendments enacted by the Commonwealth. The aggregate limit should be three times the amount carried per medical incident amount.

17.4. STAFF DUES

17.4.1 Subject to the approval of the Board, the Medical Executive Committee shall have the power to set the amount of annual dues for each category of staff membership and the amount of the processing
fee for initial applications and to determine the manner of expenditure of funds received. The amount of annual dues may vary among the staff categories.

17.5. FORMS

17.5.1 Application forms and any other prescribed form required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be forwarded to the Board for consideration after receiving advice of the Medical Executive Committee.

17.6. CONSTRUCTION OF TERMS AND HEADINGS

17.6.1 Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

17.7. TRANSMITTAL OF REPORTS

17.7.1 Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the Chief Executive Officer.

ARTICLE 18 ADOPTION AND AMENDMENT OF BYLAWS

18.1. MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

18.1.1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Board, Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized and accepted level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

18.2. METHODOLOGY

18.2.1 Medical Staff

18.2.1.1 The usual process for revision to the medical staff Bylaws shall begin with either a request from the Medical Executive Committee to the Bylaws Committee, initiation by the Bylaws Committee, or a request from the Board of Directors. The Medical Executive Committee may accept or reject proposed changes; if accepted, all revisions, written in a format that allows comparison to the previous text, shall be referred to the individual medical staff departments for review, comment, and any proposed rewording. One or more departments may, at a time no later than their next regularly scheduled meetings, by formal vote, object to the proposed revisions or suggest rewording. In such cases, the Medical Executive Committee must reconsider the objections and/or any rewording, and either reapprove the original version or approve a reworded version. Proposed revisions, either accepted initially by all departments or, if necessary, approved by the Executive Committee on reconsideration, are then forwarded in writing to all members of the medical staff possessing voting privileges for review, along with notice of the next medical staff meeting, at least ten (10) days before such a meeting. At
that meeting, if a Quorum as defined in these Bylaws is achieved, and if there is an affirmative
vote of at least two-thirds (2/3) of the staff members who are eligible to vote and are either
present or voting by mail or electronic ballot, the revisions shall be forwarded to the Board of
Directors for final approval.

18.2.2.1 The Executive Committee shall have the authority to adopt amendments to the Bylaws
without approval of the full Medical Staff if such amendments are solely for technical
modification or clarifications, reorganization or renumbering, or to correct grammatical,
spelling, or punctuation errors; if such amendments do not change any substantive provision of
the Bylaws; and if the Executive Committee provides the full Medical Staff with information
about the change. If members of the Medical Staff are opposed to the changes, they have
fourteen (14) days after receiving the information to petition the Executive Committee, with
the signatures of at least ten (10) medical staff members, to put the amendments to a full vote
at a meeting of the Medical Staff. If no such petition is received by the Executive Committee,
such amendments shall be sent to the Board of Directors and shall be effective when approved
by the Board of Directors.

18.2.2.2 In cases when the Executive Committee determines that an urgent necessity to comply with
law or regulation exists, it may provisionally adopt an urgent amendment of a substantive
nature to these Bylaws, which shall become effective immediately when approved by the
Board. The Medical Staff shall then be immediately informed and shall have fourteen (14)
days after receiving the information to petition the Executive Committee, with the signatures of at
least twenty five (25) Medical Staff members, to put the amendments to a full vote at a
meeting of the Medical Staff.

18.2.3 The Bylaws of the Board of Directors shall prevail in the event of any conflict between the Medical
Staff Bylaws and the Bylaws of the Board of Directors.

Adopted by the Medical Staff of Inova Loudoun Hospital: November 12, 2019

Approved by the Inova Loudoun Hospital Board of Directors: December 17, 2019