

MEDICAL STAFF BYLAWS BAYHEALTH MEDICAL CENTER, INC.

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THE MEDICAL STAFF BYLAWS OF BAYHEALTH, INC.

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ARTICLE 1

DEFINITIONS

In addition to the words and terms elsewhere defined in these Bylaws, the following words and terms shall have the following meanings:

- 1.1 Active Privileges.** Credentialed to independently manage patients within the Bayhealth system.
- 1.2 Advanced Practice Nurse.** A licensed Registered Nurse who has been and continues to be certified directly or through interstate regulatory consent to practice as an independent provider with documentation of MD or DO oversight responsibility.
- 1.3 Collaborative Agreement.** An arrangement between an Allied Health Professional and a Member of the Active Medical Staff whereby the Medical Staff member agrees to supervise the Allied Health Professional to a defined degree.
- 1.4 Allied Health Professionals.** Any individual other than those specified under “Physician” who is permitted by law and by the Bayhealth, Inc. to provide certain patient care services in the system under a defined degree of Supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law, and these Bylaws and Rules and Regulations.
- 1.5 Bayhealth Inc.** The Corporation formerly known as Central Delaware Health Care Corporation, which has certain reserve powers and oversight responsibilities over Bayhealth, Inc. and its medical facilities.
- 1.6 Bayhealth Medical Center Inc.** The medical center comprised of two Hospital divisions: Kent Campus and Sussex Campus.
- 1.7 Board Admissible, Prepared or Qualified.** Eligible for Board Certification as defined by the individual specialty or subspecialty, but not yet certified.
- 1.8 Board Certified.** Initial and current certification by a board recognized by the American Board of Medical Specialists, or the relevant Osteopathic Board. Accreditation by the National Board of Physicians and Surgeons is acceptable in a lieu of recertification.
- 1.9 Board of Directors (Board).** The Board of Directors of Bayhealth, Inc.
- 1.10 Business Days.** Monday through Friday excluding Federal holidays.
- 1.11 Bylaws.** A governance framework that establishes the roles and responsibilities of the medical staff.
- 1.12 Bylaws Unification.** The date on which the Bayhealth Board of Directors approved the Conjoint Bylaws.
- 1.13 Chief Executive Officer (CEO).** The individual appointed by the Board of Directors to act on its behalf in the overall management of the System or in the absence or disability of such individual, the individual acting in his/her behalf, as more fully set forth in the System’s Bylaws.
- 1.14 Chief Medical Officer (CMO).** The senior medical officer for Bayhealth, Inc. who has oversight for all medical staff functions, policies, and standards.

1.15 Clinical Privileges. Authorization by the Board of Directors to provide specific patient care and treatment services to patients of the System given reasonable access to hospital equipment, facilities, and personnel necessary to effectively exercise such privileges.

1.16 Completed Application. An application for Medical Staff membership or Clinical Privileges in which all relevant information bearing on the applicant's qualifications has been evaluated by the Department Chair, and for which all appropriate investigations of the applicant's qualifications have been concluded.

1.17 Corporation. Bayhealth, Inc.

1.18 Dentist. An individual who has received a doctor of dental surgery degree or a doctor of dental medicine degree and who is licensed to practice Dentistry.

1.19 Department. An organized clinical component of the Bayhealth, Inc.

1.20 Division. A semi-independent organized component of a department

1.21 Ex Officio. Position by virtue of or because of an office.

1.22 Hospital Campus or Hospital. Unless otherwise specified, either Kent Campus or Sussex Campus.

1.23 Indigent Patient. A patient determined by the Chief Executive Officer to be incapable of paying for his/her medical treatment.

1.24 Kent Campus (KENT). One of the two Hospital divisions of the System.

1.25 Medical Executive Committee (MEC). The Hospital Campus executive committee of the Medical Staff.

1.26 Medical Staff. The formal organization of all licensed Physicians and Dentists who are privileged to provide patient care services in the System within the scope of their licensure and approved Clinical Privileges.

1.27 Medical Staff Year. The period from July 1 to June 30.

1.28 Member. An individual whose relationship with the organized Medical Staff entails defined responsibilities and rights associated with the category of Membership to which he/she belongs.

1.29 Sussex Campus (SUSSEX). One of two Hospital divisions of the System.

1.30 Notice. Written information delivered by certified return receipt mail, commercial overnight delivery service with a receipt or hand delivery with a receipt.

1.31 Physician. An individual who has received a doctor of medicine or a doctor of osteopathy degree and who currently is fully licensed to practice medicine. A Qualified Oral Surgeon or Podiatrist acting as an attending or consulting Physician within the scope of his/her approved delineation of privileges will be included in this definition with respect to those process related areas of these Bylaws and Rules and Regulations that apply to the practice of medicine, in general, at the Hospital Campuses.

1.32 Podiatrist. An individual who is licensed to practice podiatry.

1.33 Practitioner. An individual who has been afforded Clinical Privileges to perform patient care at a Hospital.

1.34 Qualified Oral Surgeon. An individual who has successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education. As determined by the Medical Staff pursuant to the credentialing procedures set forth in these Bylaws, the individual may be currently competent to perform a complete history and physical examination to determine the ability of each of his/her patients to undergo the oral surgical procedure the oral surgeon proposes to perform.

1.35 Qualified Physician. A doctor of medicine or osteopathy who, by virtue of Clinical Privileges granted by the Hospital, is permitted to perform a specific diagnostic or therapeutic procedure.

1.36 Quorum. Thirty-three percent of those who are eligible to vote at any regularly scheduled full staff, Department, or committee meeting; fifty percent at specially scheduled meetings. Members are considered to be present if they are in attendance at any time during the meeting, or actively participate in the pertinent discussion via two way electronic communications.

1.37 Rules & Regulations. The principles and procedures that define the management of patients as it relates to their care and treatment.

1.38 Super Medical Executive Committee (SMEC). The Conjoint Executive Committee of the Medical Staff.

1.39 Supervision. Readily accessible as outlined in the following definitions:

1.39.1 Direct Supervision: The supervising physician is physically present with the supervisee and patient.

1.39.2 Indirect Supervision with Direct Supervision Immediately Available: The supervising physician is physically within the hospital or other site of patient care and is available to provide direct supervision.

1.39.3 Indirect Supervision with Direct Supervision Available: The supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision. (When the terms “supervision”, “supervise”, or “supervising” are used in these Bylaws or the Medical Staff Rules and Regulations, they refer to this level of supervision unless specifically stated otherwise.)

1.39.4 Oversight: A physician providing oversight is available to provide review of procedures/encounters with feedback provided after care is delivered.

1.40 Suspension. A temporary withholding of privileges, in which a practitioner is not permitted to perform the privileges they were granted at the time of appointment or reappointment including, but not limited to admitting, treating, consulting, or discharging patients.

1.41 System. Bayhealth, Inc. and each of its affiliates.

ARTICLE 2

MEMBERSHIP

2.1 Contractual Obligation. These Bylaws are intended to be a contract between an individual Medical Staff Member and Bayhealth, Inc. and between the Medical Staff as an organization and the Board of Directors of Bayhealth, Inc., their successors and any successor organizations.

2.2 Hospital Campus Membership. An applicant shall designate on the application for Medical Staff Membership at which Hospital Campus(es) he/she seeks Medical Staff membership.

2.2.1 Except as otherwise provided herein, a Medical Staff Member granted Clinical Privileges at both Hospital Campuses is subject to the Department policies of both Hospital Campuses, or the combined Departments, if applicable.

2.2.2 Each Medical Staff Member shall be assigned to one Department. Some Members may be assigned to one Department at each Hospital Campus.

2.3 Basic Qualification. Membership on the Medical Staff shall be granted only to those allopathic, osteopathic, and podiatric Physicians and Dentists licensed in the State of Delaware who:

2.3.1 Document their licensure experience, background, training, professional ethics, demonstrated current competence and ability to carry out all of the Clinical Privileges requested, and, upon request of the Medical Executive Committee or of the Board of Directors, any information regarding any limitation which could preclude them from carrying out any Clinical Privilege requested, including any limitation related to physical and mental health as allowed by law, if applicable;

2.3.2 Are determined to satisfactorily meet the criteria and qualifications for the Clinical Privileges recommended by the appropriate Department chairperson, appropriate Medical Executive Committee and/or the Super Medical Executive Committee, and as adopted by the Board of Directors;

2.3.3 Are determined on the basis of satisfactorily documented references to adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Medical Staff responsibilities;

2.3.4 Are geographically located close enough to the Hospital Campus(es) in order to ensure that they can properly care for their inpatients and outpatients at the Hospital Campus(es) and meet their emergency care responsibilities. These obligations are set forth in the Rules and Regulations and in the relevant Department policies.

2.3.5 All Physicians applying for initial appointment designated for specialty or subspecialty Clinical Privileges shall be either: a) Board Certified by a Board recognized by the American Board of Medical Specialists (ABMS), the American Osteopathic Association (AOA) or the National Board of Physicians and Surgeons (NBPAS) or b) AOA/ABMS Board Admissible or Eligible in the related specialty or subspecialty. Applicants must provide supporting documentation for the category they choose. With regard to such applicants who are not Board certified, his/her credentials shall be conditioned on becoming Board Certified within seven (7) years of completion of training in an American Council for Graduate Medical Education (ACGME) accredited program. There may be exceptions causing modification of the seven (7) year time frame for circumstances such as but not limited to those of clinical practice and/or qualifying exam requirements, subspecialists, military personnel, illness or

pregnancy. Physicians may request approval of an extension to complete their Board certification. Extensions subject to approval by the certifying Board will be considered only if already approved by the certifying Board. Such a request must be well timed (greater than 6 months) and submitted with supporting documentation including proof of continued registration in the certification process. Such a request must be approved by the Credentials, Medical Executive and Hospital Board Performance Improvement committees. Members of the medical staff are not required to maintain board certification in order to be reappointed. Those not meeting the above requirements may have their privileges terminated or not renewed.

If a department wishes to add a policy that imposes more stringent obligations for certification or recertification, this policy must be approved by the Credentials Committee, Medical Executive Committee, and Performance Improvement Committee of the Board. The privileges and departmental status of every currently credentialed physician will be unaffected by the adoption of these bylaws, unless the Credentials Committee, Medical Executive Committee, and Performance Improvement Committee of the Board all choose to accept the department policy changes.

2.4 Qualification Not Automatic. No individual shall be entitled to Membership on the Medical Staff, or to exercise Clinical Privileges, merely by virtue of the fact that he/she is licensed to practice any of the healing arts, that he/she is a member of some professional organization, or that he/she has in the past, or presently has, privileges at another health care facility. Membership shall not be denied on the basis of race, creed, color, sex, national origin or on the basis of any other criterion unrelated to the quality of patient care.

2.5 Ethics and Ethical Relationships. Members of the Medical Staff shall conduct themselves in the highest ethical tradition. By accepting Membership on the Medical Staff, a medical staff member specifically agrees to abide by the Principles of Medical Ethics of his/her profession of their applicable degree. Violation of such professional ethics shall be grounds for denial to admission to Medical Staff Membership or for revocation of such Membership.

2.6 Effective Date of Appointment. Except as provided in Section 2.8.1, appointment to the Medical Staff and the granting of Clinical Privileges shall be effective upon the System's receipt of the letter of acceptance signed by an applicant who has been approved by the Board of Directors. In the event that the Board of Directors does not receive an applicant's acceptance letter within 45 (forty five) calendar days of its having been mailed to the applicant for signature, the applicant's appointment shall be considered voluntarily withdrawn.

2.7 Basic Responsibilities. Each Member of the Medical Staff shall:

2.7.1 Provide his/her patients with care of the appropriate level of quality generally applicable to the Medical Staff including but not limited to continuous care and Supervision of his/her patients and approved by the Medical Staff and the Board of Directors and to request consultation as necessary;

2.7.2 Abide by applicable laws, rules, regulations and regulatory standards, these Bylaws, the Rules and Regulations, the appropriate Department rules and policies, and all applicable Hospital Campus and System policies, procedures and other standards;

2.7.3 Satisfactorily discharge such Medical Staff, Department, committee, Hospital and System functions for which he/she is responsible by virtue of his/her Membership;

2.7.4 Notify the Chief Executive Officer as soon as the practitioner is aware of any

limitation, including physical or mental health, which could prevent the Member of the Medical Staff from exercising any Clinical Privilege(s) with care of the appropriate level of quality generally applicable to the Medical Staff.

2.7.5 Prepare and complete in a timely manner the required records for all patients he/she admits or attends in any way in the Hospital(s).

2.7.6 Abide by the ethical principles of his/her profession;

2.7.7 Safeguard the confidentiality of all information of which he becomes aware as part of any peer review process under these Bylaws;

2.7.8 Safeguard the confidentiality and privacy of all patient information in accordance with federal and state privacy laws, the policies of the Hospital, and the applicable rules or regulations of the Medical Staff, if any.

2.7.9 Maintain in force and provide satisfactory evidence of professional liability insurance in not less than the minimum amounts from time to time recommended by the Board of Directors, and within 5 (five) calendar days, notify the Medical Staff Office if there is a change in staff category or in professional liability insurance coverage, carrier, controlled substance registration (State and Federal), or licensure; and

2.7.10 Notify the Chief Executive Officer in writing within 5 (five) calendar days of receiving notice of the institution of any proceeding which, if determined adversely to the Member of the Medical Staff or Advanced Practice Clinician, would result in a revocation, suspension or limitation of his/her license to practice, his/her license to prescribe or dispense controlled substances, his/her Clinical Privileges at any other Hospital (including for repeated medical record deficiencies), or his/her Medicare or Medicaid participation status or his/her status with any managed care organization, including a settlement of any formal action of a Medicare, Medicaid or other state or federal government agency pertaining to the practice of his/her profession or payment for his/her professional services; or the imposition of sanctions of any kind imposed by any health care facility, professional review organization or licensing agency, or the Centers for Medicare and Medicaid Services.

2.7.11 Work cooperatively with Medical Staff Members, hospital staff and other Bayhealth System personnel.

2.7.12 A medical history and physical examination (H&P) must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination are completed prior to admission, an updated examination of the patient including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

2.7.12.1 In operative cases when the history and physical examination are not completed or presented to the anesthesiologist in a timely manner so as to allow for proper preoperative review, the procedure(s) shall be postponed unless the attending Physician, Podiatrist, or Qualified Oral Surgeon documents information addressing the unavailability of this material in a timely manner and states that any delay in surgery would be clearly detrimental to the patient.

2.8 Employed and Contract Physicians and Dentists

2.8.1 In Administration Capacity Only. Any Practitioner employed by the System acting in a purely administrative capacity with no Clinical Privileges shall be subject to the System's personnel policies and to the terms of his/her contract or other condition of employment. He/she shall not be required to be a member of the Medical Staff.

2.8.2 With Clinical Privileges. Any Practitioner employed by the System and under contract to act in a medico-administrative or clinical capacity with Clinical Privileges shall qualify as a Member of the Medical Staff appointed in accordance with Article 2. The Membership and Clinical Privileges of such a Practitioner shall not be contingent on his/her continued employment or contract, unless otherwise provided in his/her contract or terms of employment.

2.9 Appointment. Appointments and reappointments shall be made by the Bayhealth, Inc. Board of Directors following favorable recommendations by the Medical Executive Committee of the Medical Staff and the Performance Improvement Committee of the Board of Directors of Bayhealth, Inc. All initial appointments to the Medical Staff shall be provisional, and the terms of such appointments are limited pursuant to Section 3.1.

ARTICLE 3

CATEGORIES OF THE MEDICAL STAFF and ALLIED HEALTH

3.1 Medical Staff Appointments. Each appointee shall be appointed to a specific category of the Medical Staff which includes Active, Provisional Active, and Consulting. All initial appointments are provisional and subject to review at the conclusion of approximately one (1) year. Provisional Active limits certain rights during the provisional period. Allied Health Professionals, Honorary Staff, and Physicians-in-training are not members of the Medical Staff.

3.2 The Active Staff. The Active Staff shall consist of Practitioners who meet the basic qualifications for Membership and have advanced from Provisional Active to full Active Staff.

3.2.1 Rights. Active Staff Members at Bayhealth shall be entitled to admit patients to the Hospital(s), manage such patients' treatment, order and interpret diagnostic tests, and perform procedures as required and granted in their delineation of Clinical Privileges if credentialed to do so. Active Staff Members are entitled to vote, and are eligible to hold office.

3.2.2. Responsibilities. Active Staff Members shall pay dues, and attend a prescribed number of full Medical Staff meetings as stated in these Bylaws. Active Staff Members shall provide or arrange for coverage for their own patients. In addition, they shall cover the Hospital's emergency service and Indigent Patients or unassigned patients in the manner designated by the Department in which such Physician has Clinical Privileges. Active Staff Members shall be able to meet the criteria of response times approved by the MEC based on recommendation from the chairperson of the Department to which the Physician is assigned and be geographically located close enough to the relevant Hospital Campus(es) to assure that they can properly care for their patients. Active Staff Members shall supervise and remain accountable for any Allied Health Personnel with whom they have a collaborating or supervising relationship which includes such Allied Health Personnel rendering services in the Hospital as provided in Article 4.

3.2.3 Senior Service Exception. Members of the Active Staff who have provided ten years of service to a Bayhealth hospital and who have passed their 60th birthday may request relief of unassigned on-call duties. Such request is to be reviewed by the Department chairperson who shall weigh all data and Medical Staff implications and then present a recommendation to the Medical Executive Committee. They shall retain all other privileges of Active Staff Membership.

3.3 Associate Active Staff. The Associate Active Staff shall consist of Practitioners who have Active or Provisional Active Privileges at Bayhealth's Kent or Sussex campus, and have been granted privileges to admit and manage patients at a second Bayhealth campus.

3.3.1. Qualifications. Associate Active Staff members shall hold Active or Provisional Active Privileges at a Bayhealth campus.

3.3.2. Limited Rights. Physicians with Associate Active privileges shall hold no office or committee appointment and shall have no vote at the campus where they have Associate Active privileges. Subject to facilities and services available at the second Bayhealth campus, they may admit and manage patients in accordance with and as permitted by their Active or Provisional Active privileges.

3.3.3. Responsibilities.

a. The physicians with Associate Active privileges shall be responsible for all care

of the patients they admit, consult, operate on and/or manage at any campus. The physicians shall round on their patients on a daily basis. This can also be performed by another physician with the same privileges. Physician assistants, Nurse Practitioners, Advance practice nurses, can see the patient and function with - in their scope of practice. Their notes and orders need to be co-signed. A patient seen by PA/NP/APN does not relieve the physician from seeing the patient in person on a daily basis.

b. Physicians with Associate Active privileges may be required to take unassigned call at the second campus, as outlined in the Department Policy described in 3.3.3.1.

3.3.3.1. Scheduling. The physicians with Associate Active privileges shall be allowed to schedule patients in the procedural area used by their specialty, according to the Policy on Associate Active staff established by their Department, as approved by the MEC. The same Policy will outline what unassigned call responsibilities, if any, apply to these physicians.

3.4 The Consulting Staff. The Consulting Staff shall consist of Physicians of recognized professional ability who have signified a willingness to accept Medical Staff appointment. Members of the Medical Staff shall provide consultation without discrimination as to the patient's ability to provide reimbursement.

3.4.1. Qualifications. All Consulting Staff Members shall have Active Privileges at a facility that provides acute inpatient care and that is able to confirm their status with the following exceptions:

- a. Physicians in the Department of Psychiatry;
- b. Physicians who have attained their 60th birthday and who have had Active Medical Staff privileges at a Bayhealth facility for greater than 15 years; and
- c. Teleradiologists

3.4.2 Limited Rights. Consulting Staff Members shall hold no office or committee appointment and shall have no vote. They shall not be privileged to admit patients to the Hospital, but they may assist an Active or Provisional Staff member in patient management.

3.4.2.1 Surgeons, and obstetrician-gynecologists who are on the Consulting Staff may assist in surgery, but may not be the primary surgeon of record. Consulting Physicians may only perform elective procedures if approved by the attending Physician and the Chief of Service of the Consulting Physician.

3.4.2.2 Consulting Staff Physicians are encouraged to provide consultation when requested but are not obligated to provide consultation.

3.4.3 Responsibilities. Consulting Staff Members shall pay dues. They shall complete at least a total of five consultations and/or procedures at a Bayhealth facility in order to be considered for reappointment, unless the practice specialty or subspecialty is not otherwise represented at that Hospital Campus by any Provisional Active or Active Staff Physician.

3.5 Provisional Active Staff. Physicians who have applied for Membership and whose applications have been accepted as complete and appropriate with full credentialing and authorities granted except that they have not yet completed the mandatory one year initial evaluation shall be in Provisional Active Staff. They shall be appointed and assigned to service and Department in the same manner as the Active Staff and shall have the same rights and responsibilities, except that they may not

serve on the Medical Executive Committee, except in the instance of a Provisional Active Staff Member who has joined the medical community for the express purpose of chairing the relevant Department.

3.5.1 Evaluation of Status. The Medical Staff Office shall initiate review of the Provisional Active Staff at nine months after initial appointment. Under normal circumstances, the advancement evaluation will be completed approximately one year following the Member's initial appointment.

3.5.1.1 The evaluation of the Member for advancement to full Active Staff shall be conducted by the Department Chairperson upon the initial application for appointment. The evaluation shall take into account all information available to the Medical Staff regarding the Member's clinical performance, citizenship, and adherence to the basic qualifications of Membership.

3.5.1.2 The Department Chair shall submit his/her recommendation to the Integrated Credentials Committee which shall review and make a recommendation to the Medical Executive Committee, which shall review and make a recommendation to the Board Performance Improvement Committee.

3.5.2 Action on Status. Upon review and recommendation of the MEC, the action of the Board Performance Improvement Committee may be to (i) grant advancement to Active Staff; (ii) deny advancement to Active Staff; or (iii) extend the Provisional Active appointment for an additional specified period which will terminate no later than two years from the date of the initial appointment.

3.5.3 Termination of Provisional Active Staff. Failure to be advanced from Provisional Active Staff to Active Staff by the end of the aforementioned two year period shall result in revocation of Membership and Clinical Privileges. Denial of the application for advancement for any reason other than lack of adequate documented clinical exposure, medical record delinquency, and failure to meet response time obligations shall be considered an adverse decision and shall afford the applicant all fair hearing rights afforded by these Bylaws. In no instance may Provisional Active Staff extend more than two (2) years.

3.6 Honorary Staff. Honorary Staff are not Members of the Medical Staff, are not active clinically in the Hospital and are honored by emeritus positions. They may be Physicians who have retired from active hospital service. An invitation to become Honorary Staff may be offered following approval by MEC upon recommendation by an Active Medical Staff Member. Honorary Staff are not eligible to vote or hold office, admit, treat or discharge patients, are not assigned duties, and shall not be assessed staff dues. Honorary Staff may attend Medical Staff CME programs, Department meetings, Full Staff meetings and social events.

3.7 Dental, Oral Surgeons and Podiatric Staff. Qualified Oral Surgeons and Dentists and Podiatrists may be appointed to those categories of the Medical Staff for which they qualify in the same manner, based on the same criteria, and in accordance with the same processes that pertain to Physicians. They have the same rights and responsibilities as pertain to the staff category to which they are appointed. Members of the Dental and Podiatric Staff will be assigned to the Department of Surgery. Their Clinical Privileges are as set forth in Article 4

3.8 Allied Health Personnel

3.8.1 The categories of clinicians granted Limited Clinical Privileges is determined by the Board based upon recommendations from the Medical Executive Committee. Advanced Practice Registered Nurses [include General APNs, Clinical Nurse Specialists, Women's Health Nurse

Practitioner (WHNP), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Midwives, Neonatal Nurse Practitioners, Family Nurse Practitioners, Psychiatric Nurse Practitioners and Pediatric Nurse Practitioners], Physician Assistants, Psychologists, Licensed Professional Counselor of Mental Health, and Licensed Clinical Social Workers may only be granted Clinical Privileges when they are employed or contracted by a Medical Staff Member or Bayhealth. Allied Health Personnel are not Members of the Medical Staff.

3.8.2 Qualifications for Allied Health Professionals. Those practitioners who possess the qualifications listed below may be granted limited privileges to perform specified services under the Supervision of at least one member of the Active or Provisional Active Medical Staff who has Clinical Privileges which include those requested by the Allied Health Professional. An Allied Health Professional is not an independent Practitioner in the Bayhealth System, and may only act and perform services under the Supervision of the Physician with whom they have a Collaborative Agreement.

3.8.2.1 An Allied Health Professional shall be licensed in Delaware.

3.8.2.2 An Allied Health Professional will have delineated privileges, a job description and/or protocol(s) under which he/she performs.

3.8.2.3 After favorable completion of the Bayhealth credentialing process, each Allied Health Professional shall have a Collaborative Agreement that obligates a Member of the Medical Staff to provide medical consultation to all patients to whom the Allied Health Professional is furnishing care. At all times, the collaborative Physician or his/her Physician designee shall be Immediately Available to the Medical/Nursing Staff for urgent or emergent care and to accept referrals from the Allied Health Professional , on a twenty-four hour, seven-day a week basis.

3.8.2.4 Additional Qualifications for Allied Health Professionals:

3.8.2.4.1 The Certified Registered Nurse Anesthetist must be a graduate from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor.

3.8.2.4.2 The Certified Registered Nurse Anesthetist must be certified or eligible for certification as a Nurse Anesthetist by the Council on Certification of Nurse Anesthetists.

3.8.2.4.3 The Neonatal Nurse Practitioner must be employed or contracted by the presently contracted Neonatology Service or by Bayhealth Medical Center.

3.8.2.4.4 The Certified Nurse Midwife must hold a valid certification by the American College of Nurse Midwives, or have taken examination for same results of which are pending and have a temporary permit to practice midwifery from the State Board of Health.

3.8.2.4.5 Physician Assistants shall be licensed by the Delaware Board of Medical Licensure and Discipline and meet the basic qualifications as approved by the Board of Directors, after recommendation of the appropriate Medical Executive Committee, may be permitted to provide specified patient care services in the Hospital.

3.8.2.4.6 A Psychologist who is licensed by the Delaware Board of Examiners of Psychologists may be granted Limited Privileges to perform specified services in accordance with the provisions of this Article 4.

3.8.2.4.7 A Licensed Clinical Social Worker who has an Alliance Agreement with a Physician on the Medical Staff or who is employed by the Hospital and who is licensed by the Delaware Board of Licensed Clinical Social Work Examiners may be granted Limited Privileges to perform specified services in accordance with the provisions of this Article 4.

3.8.3 Liability Insurance Coverage for Individuals Not Members of the Medical Staff.

Individuals described in this Article 4 who are not Members of the Medical Staff shall carry professional liability insurance in amounts which have been determined by the Board of Directors of the Corporation and which are stated in resolution passed by the Board of Directors. Individuals shall be informed as to the approved insurance amounts in connection with such individual's application process.

3.8.4 Coverage and Collaboration.

Each delineation of privilege request must be reviewed and signed by the Active Medical Staff Physician(s) who are parties to the collaborative or supervising agreement in addition to the requirements of the usual and customary application process. At the time of application for initial credentials and at reappointment, Allied Health Personnel with whom the Physicians have agreements must provide acceptable documentation for urgent and emergency coverage for any Allied Health Provider when the Physician party or parties to the agreement is/are not Immediately Available to provide care to patients who require immediate evaluation at a Bayhealth hospital.

3.8.5 Grounds for Revocation.

The following shall be grounds for revocation of Clinical Privileges of Allied Health Personnel for which the CMO shall provide Notice to the individual:

- (i) Termination of employment
- (ii) Termination of all Collaborative Agreement(s) or sponsorship agreement(s) with Physician(s) who are Members of the Medical Staff, unless replaced immediately with an appropriate new Collaborative Agreement.
- (iii) Suspension or revocation of registration, certification or licensure by the Delaware State Agency authorizing the Allied Health Professional to practice.
- (iv) Termination of employment or contractual status or suspension or revocation of the professional license, Active Staff Privileges or regulatory certification of a Physician with whom an Allied Health Professional has an exclusive contract.
- (v) Failure to properly perform the duties assigned.
- (vi) Conduct which interferes with or is in any way detrimental to the provision of quality medical care.
- (vii) Suspension or revocation of the Clinical Privileges or Membership of the collaborating or sponsoring Physician.

3.8.6 Review Rights. The suspension or revocation of the Clinical Privileges of Allied Health Personnel under 3.7.5 shall not be subject to review, unless the termination is under 3.7.5(v) or 3.7.5(vi).

3.8.7 Corrective Action. A request for corrective action regarding an Allied Health Professional may be made to the CMO whenever the clinical activities and professional conduct of the Allied Health Professional are considered potentially actionable under 3.8.5(v) or 3.8.5(vi). Corrective action against such Member may be requested by any Member of the Active Staff, a Member of the Provisional/Active Staff, the Medical Executive Committee, the Super Medical Executive Committee, the Chief Executive Officer or by his/her designee, or by any Member of the Bayhealth, Inc. Board of Directors. When the CMO receives such a request, he shall inform the employing or contracting Physician and the Allied Health Professional of the general nature of the complaint and shall inform the Hospital Campus MEC, which shall discuss the matter at its next scheduled meeting to determine if further action is necessary.

3.8.7.1 If such action is necessary, the Hospital Campus MEC shall appoint a person or persons to, within 15 (fifteen) calendar days, investigate the matter and determine whether action is appropriate, and if so, what action should be taken. If no further action is to be taken, the request shall be rejected and the Hospital Campus MEC shall notify the Allied Health Professional that the matter is closed.

3.8.7.2 The CMO shall notify the Allied Health Professional and the employing or contracting Physician and shall offer them an opportunity to discuss the matter with the investigating person(s). This meeting shall not be a hearing and the rights under Article 8 shall not apply. No lawyers shall participate in this meeting.

3.8.7.3 The investigating person(s) shall complete the review and submit a written report to the MEC in sufficient time to permit consideration at the next scheduled MEC meeting, at which time the matter shall be finally considered.

3.8.7.4 Within 10 (ten) calendar days of the final consideration by the MEC, the MEC shall prepare a written report which shall be provided to the Allied Health Professional and to the Board.

ARTICLE 4

CLINICAL PRIVILEGES

4.1 Clinical Privileges Delineated. Every Practitioner practicing at a Bayhealth Hospital shall be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Board, except as provided in Sections 4.5 and 4.6 of these Bylaws. Clinical Privileges may be granted to Practitioners who are not Members of the Medical Staff. All Clinical Privileges for any Practitioner shall be specifically delineated. The scope of Clinical Privileges of any Practitioner is a clinical assessment made during the application, appointment, and reappointment processes, determined separately from assignment to the category of the Medical Staff. Based on such assessment, the Practitioner shall be assigned to one Department and shall comply with such Department's Rules and Regulations. The scope of Privileges available in the Hospitals shall be determined by the Board, taking into consideration the recommendations of the Medical Staff.

4.1.1 Determination of Qualifications for Clinical Privileges

The scope of Clinical Privileges and qualifications for them are recommended by the Department Chair to the Integrated Credentials Committee and are approved by the Medical Executive Committee for recommendation to and adoption by the Board.

4.1.2 Departmental Qualifications.

Departments may recommend and the Medical Executive Committee may approve different qualifications for Clinical Privileges to reflect the training, specialties and sub-specialties of the Practitioners assigned to the Department. To the extent there are conflicts among the qualifications recommended by different Departments for the exercise of substantially similar Clinical Privileges, the Medical Executive Committee shall have the authority to resolve such conflict after considering the positions of the relevant Departments and the responsibility of the Medical Staff to assure a single level of quality of care provided in the Hospitals.

4.2 Basis for Granting Clinical Privileges. Evaluation of all requests for Clinical Privileges shall be based upon information including but not limited to the applicant's education, training, experience, demonstrated current competence, health status, professional peer references, ability to work with others, ethics, other relevant information, and, in the case of reappointments, results of quality assessment/improvement activities, observed clinical performance and review of patient records. Applications for Clinical Privileges are processed in accordance with the procedures for appointment and reappointment in Article 5.

4.2.1 Applicant's Burden

The applicant shall have the burden of establishing his/her qualifications and competence for the Clinical Privilege(s) he/she requests. Each delineation of privilege request must be reviewed and signed by the Active Medical Staff Physician who is a party to an Allied Health Professional Collaborative Agreement in addition to the requirements of the usual and customary application procedure.

4.2.2 Prior Verification

Action on an application for Clinical Privileges is withheld until information providing the basis for granting such Clinical Privileges has been verified.

4.3 Dental, Oral Surgeon, and Podiatric Clinical Privileges. Qualified Oral Surgeons, and Podiatrists appointed to the Medical Staff shall exercise their delineated Clinical Privileges in accordance with this section.

4.3.1 Admission.

They may admit patients who have known medical problems other than that for which they are being admitted, may perform the required history and physical examination on such patients, and may assess the medical risks of the surgical procedure which they propose to perform.

4.3.2. Medical Consultation.

Consultation with an appropriate specialist is mandatory for any patient admitted by a Qualified Oral Surgeon or Podiatrist who has an active medical problem other than the dental or podiatric condition. Timeliness of this consultation is to be determined by the best judgment of the admitting Oral Surgeon or Podiatrist. Discharge of any such patient shall only take place upon documented consent by the consulting specialist or his/her designee. An elective admission of such a patient shall be accompanied by, or immediately followed by, a specialty consultation. No patient may undergo a surgical or dental procedure without a medical consultation available on the patient's chart. On-call Physicians will not be required to provide urgent or emergent consultation to a patient admitted for elective surgical procedures unless there is an acute unexpected deterioration in the patient's medical condition.

4.3.3 Discharge.

Dental and podiatric patients with presenting problems that remain confined to that issue may be discharged by the Qualified Oral Surgeon or Podiatrist. Any patient admitted under this Section 4.3 with initial or subsequent medical problems shall be discharged only with the consent of the responsible allopathic or osteopathic Physician.

4.4 Temporary Clinical Privileges. Temporary Clinical Privileges may be granted for specific reason only and for limited periods of time as set forth in this section. Temporary Clinical Privileges do not entitle any Practitioner to Membership in the Medical Staff. The termination of Temporary Clinical Privileges granted hereunder does not entitle the Practitioner to any appeal or hearing rights under Article 8.

4.4.1 Conditions for Granted Temporary Privileges

Delineated Temporary Clinical Privileges may be granted by the Chief Executive Officer upon a favorable recommendation of the appropriate Department Chairperson, the President of the Medical Staff of the Hospital Campus to which the individual seeks Temporary Clinical Privileges and the Chairperson of the Integrated Credentials Committee. Prior to the granting of such Temporary Clinical Privileges the provider shall be required to acknowledge in writing that he/she is subject to all of the requirements imposed upon a provider under these Bylaws.

4.4.2 Applicants for Medical Staff membership

An individual who has filed an application for Medical Staff Membership and/or Clinical Privileges may also file a written request for Temporary Clinical Privileges which may be granted if his/her application is complete and pending processing by the appropriate committees. The Chief Executive Officer may grant such Temporary Clinical Privileges for a period of time not to exceed 120 (one hundred and twenty) calendar days on the basis of the application information and any other available data, and favorable recommendations by the appropriate Department Chairperson, the President of the Medical Staff, and the Chairperson of the Integrated Credentials Committee of the Hospital Campus(es) at which the individual has applied for Clinical Privileges. No extensions of Privileges awarded pending approval of the application are permitted. An applicant granted Temporary Privileges may not renew such Privileges for two (2) years after they have been granted.

4.4.3 Non applicants.

An individual who is not an applicant for Medical Staff membership may be granted temporary Clinical Privileges not to exceed sixty days of service which may be continuous or interrupted, but, if interrupted, in no case should exceed more than one year of temporary staff status. Except in the case of an emergency, each such individual shall request temporary privileges in writing addressed to the Chief Executive Officer accompanied by the same information required to be included in an application for Medical Staff membership. Application processing shall be conducted as it would with any other application so as to confirm capability and suitability, but the practitioner shall not be subject to department and committee attendance requirements.

4.4.4 Physicians in Training.

4.4.4.1 Those residents or fellows participating in ongoing postgraduate education at the Bayhealth Hospital campuses shall not be responsible for any medical staff fee or committee meeting attendance requirements. Their postgraduate application and acceptance shall serve in lieu of a Medical Staff initial credentialing and privileging application and process. Furthermore, ongoing privileges in this category shall be extended as per Credential Committee review of annual documentation of the physician's competency as provided by training program personnel. It will be the responsibility of the physician in training to provide such information to the Medical Staff Office as requested by the Credentials Committee. No physician in training will be granted extended privileges if this material is not reviewed at least every 15 months following the first date of training at Bayhealth.

4.4.4.2 These physicians shall have no access to the hearing process, and shall also be unable to modify their privileges except as would any other physician who has completed or anticipates the timely completion of an appropriate postgraduate program.

4.4.3 Termination or Expiration of Temporary Privileges

Temporary Clinical Privileges are a courtesy available in the discretion of the individuals authorized to grant them. Temporary Clinical Privileges do not bestow on the applicant any rights to Membership. Temporary Clinical Privileges may be terminated in the discretion of the individuals with authority to recommend their being granted. The termination, revocation or expiration of Temporary Clinical Privileges does not entitle the applicant to any fair hearing rights under Article 8. The reason for such termination or revocation shall become part of the information to be considered in evaluating an applicant for Medical Staff Membership and/or Clinical Privileges. If that determination is adverse to the applicant, he/she shall have such rights as are available under Article 8.

4.5 Emergency Privileges. In an emergency, any Practitioner, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything he/she deems necessary and appropriate to save the life of a patient or to prevent serious harm, using every facility of the Medical Center necessary including the calling of consultations. The Practitioner shall notify the CEO or his/her designee promptly of the exercise of such Privileges.

4.5.1 Conclusion of Emergency

When the emergency no longer exists, the Emergency Privileges of the Practitioner shall automatically be extinguished.

4.5.2 Definition of Emergency

For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient and in which any delay in administering treatment would add to that harm or danger.

4.6 Disaster Privileges. During a disaster, when the organization's emergency management plan has been activated and the organization is unable to handle the immediate patient needs (defined as any officially declared emergency, whether it is local, state, or national), the President of the Medical Staff or his/her designee(s) has the option to grant Emergency Privileges. The decision to grant Privileges should be on a case-by-case basis.

4.6.1 Contingencies for Alternates Responsible for Granting Emergency Privileges.

Designee(s) for the President of the Medical Staff during a disaster include any Active Member of the Medical Executive Committee. If, and only if, a Member of the MEC is not available, the alternates follow in this order:

- Any Department Assistant Chair
- Any Active Member of the staff in good standing

4.6.2 Responsibilities of Individual Granting Disaster Emergency Privileges.

An individual granting Disaster Privileges shall consider the need for Physician Privileges on a case-by-case basis and shall ensure verification pursuant to 4.11.4.

4.6.3 Management & Identification of Practitioners Granted Emergency Privileges During a Disaster.

The Physician responsible for coordination of the command center will, to the extent possible, assign Practitioners to appropriate areas as needed in accordance with the Hospital's emergency management plan.

4.6.3.1 To the extent possible, all individuals granted Emergency Privileges will be expected to sign-in at the Command Center. A record will be made of name, specialty, and any current hospital/clinic affiliations. Practitioners granted Emergency Privileges will be issued a Disaster Identification Badge when signing into the Command Center.

4.6.3.2 A Physician shall, to the extent possible, be paired with a currently credentialed Medical Staff Member and should act only under the Supervision of a Medical Staff Member.

4.6.4 Verification Process.

Verification of the information providing the basis to grant Disaster Privileges should be done as soon as possible by the Medical Staff Services Office. A record of this information should be retained. Disaster Privileges shall be granted by the President of the Medical Staff or his/her designee(s) upon presentation of a current license to practice and a valid picture ID issued by a state, federal, or regulatory agency **and** any one of the following:

- *A current picture Hospital ID card.*
- *Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).*
- *Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.*
- *Presentation by current Hospital or Medical Staff Member(s) with personal knowledge regarding Practitioner's identity.*

4.6.5 Expiration of Disaster Privileges

Once the immediate situation creating the reason for Disaster Privileges is under control, the Disaster Privileges will expire on Notice and any further Privileges shall be requested and processed under the relevant provision of this Article pertaining to Clinical Privileges.

4.7 Allied Health Personnel Limited Privileges.

All Allied Health Personnel granted Limited Clinical Privileges hereunder shall be subject to the following conditions and limitations:

4.7.1 The specified services approved for performance by Allied Health Personnel shall not exceed the acts which their specialty is permitted to perform in accordance with their licensure, certification or other authorization to practice under Delaware State Law.

4.7.2 All acts performed by Allied Health Personnel shall be discharged under the Supervision of the collaborating supervising Physician and under the General Supervision of the Chair of the Department of which the supervising Physician is assigned.

4.7.3 Allied Health Personnel shall comply with such Bylaws and Rules and Regulations of the Medical Staff, policies and procedures as are applicable to the Medical Staff, and policies and procedures as are applicable to the Clinical Department to which they are assigned, as well as any applicable administrative policies.

4.7.4 No Admitting Privileges

No Allied Health Personnel shall have admitting privileges unless specifically granted by these Bylaws and delineated in his/her Collaborative Agreement and/or delineation of privileges, which must be signed by the Allied Health Professional, the Department Chairperson and the employer or supervising Physician unless the supervising Physician also is the Department Chairperson at the time of the initial application.

ARTICLE 5

PROCEDURE FOR APPOINTMENT AND FOR GRANTING CLINICAL PRIVILEGES

5.1 Incomplete or Inaccurate Information. Submission of false or inaccurate information or omission of pertinent information may render the application withdrawn. If the Integrated Credentials Committee deems an event significant upon discovery of such inaccurate, false or incomplete information, the application will be deemed voluntarily withdrawn and Bayhealth shall have no further obligation to review or process the application in any way. An applicant whose application is deemed withdrawn under this provision shall have no right of appeal under Article 8 and may not reapply for at least one (1) year.

5.2 Applications. All applications for appointment and reappointment to the Medical Staff and applications for Clinical Privileges shall be completed and submitted to the Medical Staff Services Office on prescribed forms.

5.2.1 Applications shall include complete and detailed statements as to the applicant's professional qualifications including;

5.2.1.1 a description of his/her past and current practice; his/her past and present hospital affiliations and privileges; his/her past and present participation as a contractor with health maintenance organizations, preferred provider organizations, or other health plans;

5.2.1.2 information as to whether his/her Medical Staff Membership and/or Clinical Privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution; whether he/she has resigned his/her Medical Staff Privileges or relinquished any Clinical Privileges at any other hospital or institution, or allowed such Membership or Privileges to expire, during the course of any peer review investigation or proceeding; whether his/her application for Membership and/or Clinical Privileges at any other hospital or institution has been denied;

5.2.1.3 whether his/her membership in local, state or national medical societies, or his/her license to practice any profession in any jurisdiction has ever been subjected to sanctions of any kind imposed by any health care facility, professional review organization, or licensing authority; or whether there has been any proceeding instituted therefore; and whether his/her registration to prescribe or dispense controlled substances has been suspended, revoked or denied, or voluntarily relinquished or not renewed.

5.2.1.4 whether his/her participation in Medicare or Medicaid or other government payment programs has ever been terminated or suspended; whether he/she has ever been a "sanctioned person" within the meaning of the Social Security Act;

5.2.1.5 a statement shall be furnished describing his/her professional liability insurance coverage, and shall provide information on his/her malpractice claims experience during the past five (5) years and any pending litigation, including a consent to the release of information by his/her present and past malpractice insurance carrier(s).

5.2.1.6 The applicant shall furnish the names and address of at least three (3) references who have had sufficient recent experience in observing and working with him/her to give a definitive opinion as to his/her professional competence, ethics, and character. References shall not include family members and no more than one of the references shall be from the current practice or

proposed practice.

5.2.1.7 The applicant shall provide such other information relevant to his/her qualifications as may be requested. All applicants shall provide details of any criminal convictions and/or pending criminal matters.

5.2.2 All application information contained within the application and/or obtained pursuant to application processing, shall be accessible to Bayhealth personnel as necessary to address Bylaws and rules and regulation related functions, but shall remain confidential and under peer review protection to the fullest extent of the law.

5.3 Application for Clinical Privileges and Reappointment at Each Hospital Campus. A Medical Staff Member in good standing at one Hospital Campus may apply for Privileges at the other Hospital Campus at any time through completion of a reappointment application or similar interval information form accompanied by a release specifically permitting access to credentialing information that may be found at the Hospital Campus of current credentialing, including material that may predate Bylaws Unification. This application will then be processed through the usual credentialing procedure at the second Hospital Campus with no fee. In the event that a Medical Staff Member is privileged at each Hospital Campus, the Medical Staff Member's application for reappointment will be reviewed concurrently at each Hospital Campus.

5.4 Designation of Hospital Campus. The applicant shall designate on his/her application the Hospital Campus(es) at which the applicant desires to obtain Clinical Privileges. All references in this Article 5 to Department Chairperson and Medical Executive Committee, unless otherwise noted, shall be to the Department Chairperson or Medical Executive Committee of the Hospital Campus(es) to which the applicant applies for Clinical Privileges for so long as two separate Departments and Medical Executive Committees exist. Requests for Clinical Privileges at both Hospitals will require processing in the prescribed credentialing procedure at each Hospital Campus.

5.5 Consent and Release by Applicant. By submitting his/her application, the applicant agrees to appear and to be examined in regard to his/her application, authorizes the System to consult with individuals who may have pertinent information regarding the applicant's qualifications, and consents to the release of his/her own medical and/or mental health records, where the Integrated Credentials Committee or the Medical Executive Committee reasonably believes that such records are necessary to the evaluation of the applicant's ability to provide patient care or to interact appropriately with the patient, the patient's family and/or other caregivers.

5.6 Agreement by Applicant. The application form shall include a statement that the applicant has read these Bylaws and the Rules and Regulations of the Medical Staff, the Medical Staff Expectations Document and that he/she agrees to be bound by the terms thereof and any amendments thereto relating to the consideration of his/her application whether or not he/she is granted membership/and or Clinical Privileges and that, if granted Clinical Privileges, he/she agrees to provide for continuous care for his/her patients in the Hospital(s) where Clinical Privileges are granted.

5.7 Initial Action Upon Receipt of Application. Upon receipt of the application, the Medical Staff Services Office shall contact the references provided by the applicant and obtain any other information pertinent to the application and the references listed thereon. The Medical Staff Services Offices shall verify from original sources the data in the application. An application is not complete until verification is complete. The Medical Staff Services Office shall transmit the Completed Application and other documents to the appropriate Department Chairperson. The applicant has the burden of producing all information necessary for the evaluation of the application. Any failure to produce information

requested shall render an application incomplete and voluntarily withdrawn with no appeal rights under Article 8. An applicant whose application has been voluntarily withdrawn hereunder may not reapply for at least one (1) year.

Throughout the application process, at each level of review from 5.8 through 5.12, if the reviewing body is in need of expert review from outside consultants with expertise in the matters under consideration, it is authorized to obtain outside consultant input to inform its decision-making.

5.8 Action by Department Chairperson. The Department Chairperson shall review the application and other documents transmitted to him/her by the Chief Executive Officer or designee and within 30 (thirty) calendar days after receipt thereof, may interview the applicant and submit to the Integrated Credentials Committee specific, written recommendations as to the applicant's qualifications and the Clinical Privileges requested. In the event that the applicant is an incoming Department Chairperson who previously has not been credentialed by the Hospital Campus, the application shall be reviewed by the President of the respective Medical Staff Hospital Campus.

5.9 Action by Integrated Credentials Committee.

5.9.1 The Integrated Credentials Committee shall examine and investigate the character, professional competence, qualifications and ethical standing of the applicant by making any further investigation as it may deem necessary, which shall be made expeditiously.

5.9.2 Within 60 (sixty) calendar days after its receipt of a Completed Application, the Integrated Credentials Committee shall review the Completed Application, including the recommendation of the Department Chairperson. The Integrated Credentials Committee may request that further investigation be completed or information obtained by the applicant or administrative representatives. Upon completion of review of all materials this committee shall forward its determinations and recommendations, together with the results of any further investigation which it has made, to the Medical Executive Committee. Such determinations and recommendations shall be in writing.

5.10 Action by the MEC.

5.10.1 At its next regular meeting after its receipt of the Completed Application and the recommendation of the Integrated Credentials Committee, but not later than 60 (sixty) calendar days after such meeting, the Medical Executive Committee shall recommend to the Board of Directors that the applicant: (i) be appointed provisionally to a specified category of the Medical Staff; or (ii) rejected for membership on the Medical Staff. If an application is only for Clinical Privileges and not Medical Staff membership the Medical Executive Committee shall recommend that the requested Clinical Privileges be: (i) granted; (ii) modified; (iii) limited; (iv) denied; or (v) that the application be deferred for not more than 60 (sixty) calendar days for further consideration. Further, any application may be returned to the Integrated Credentials Committee with direction that specified additional information be obtained and the application record, including the additional information, be returned to the Medical Executive Committee. The Medical Executive Committee shall then act at its next regular meeting after the return to it of the application file with the additional information.

5.11 Recommendation of Medical Executive Committee.

5.11.1 For applicants who have requested Privileges at one Hospital Campus, if the recommendation of the Medical Executive Committee is in favor of provisional appointment and/or in favor of granting the Clinical Privileges requested, it shall be forwarded with the complete application file

to the Board of Directors. If the Medical Executive Committee does not recommend the granting of the provisional appointment for Clinical Privileges as requested, then the recommendation shall be deemed adverse and the provisions of Article 8 shall apply.

5.11.2 For applicants who have requested Privileges at both Hospital Campuses, the recommendation of each Medical Executive Committees shall be forwarded to the Super Medical Executive Committee only if the recommendations of both Medical Executive Committees are in disagreement. The Super Medical Executive Committees then shall review the recommendations within the 30 (thirty) calendar days of receipt of the Completed Application. If the Super Medical Executive Committee does not recommend the granting of the provisional appointment for Clinical Privileges as requested, then the recommendation shall be deemed adverse and the provisions of Article 8 shall apply.

5.11.3 All recommendations of the Medical Executive Committee and the Super Medical Executive Committee must delineate specifically the Clinical Privileges recommended to be granted including any qualification for probationary or supervisory conditions relating thereto.

5.11.4 If the recommendation of the Medical Executive Committee or Super Medical Executive Committee, if applicable, is adverse to the applicant, the applicant shall be entitled to exercise the same right to a hearing provided for members of the Medical Staff in Article 8. If the applicant has requested Privileges at each Hospital Campus, the applicant is only entitled to a hearing after review and an adverse recommendation by the Super Medical Executive Committee. The adverse recommendation and the Completed Application file shall be retained by the Medical Executive Committee or Super Medical Executive Committee until after the hearing or until the applicant has waived his/her right to a hearing as provided in Article 8. Thereafter, the Completed Application file, including the original recommendation of the Medical Executive Committee or Super Medical Executive Committee, if applicable, the hearing recommendation, and the transcript or other record of the hearing shall be forwarded to the Board of Directors.

5.12 Action by Board of Directors.

5.12.1 If the recommendation of the Medical Executive Committee or Super Medical Executive Committee is favorable to the applicant, the Board of Directors shall act on the application at its next scheduled meeting which shall be at a date no later than 60 (sixty) calendar days after receiving the Completed Application.

5.12.2 If the Board of Directors does not concur with the recommendation of the Medical Executive Committee and/or Super Medical Executive Committee the matter shall be reviewed by a committee composed of six members before the Board of Directors renders its final decision. This committee shall include three individuals who shall be appointed by the Super Medical Executive Committee from the members of the Medical Staff with Clinical Privileges at the Hospital Campus(es) to which the applicant is seeking Medical Staff appointment and Clinical Privileges and three individuals who shall be appointed by the Chairperson of the Board of Directors. The Board of Directors shall consider the recommendation of this committee in making its final decision.

5.12.3 The Board of Directors may refer an application back to the Super Medical Executive Committee for reconsideration. Each such referral shall be in writing, shall state the reason for reconsideration and shall set a time limit which shall not exceed 30 (thirty) calendar days within which a reconsidered recommendation shall be made. The Board of Directors then shall act no later than its next regular meeting, which shall be scheduled for a date no later than 30 (thirty) calendar days after the Completed Application file and reconsidered recommendation are returned to it.

5.12.4 If the Board of Directors' decision on the application is adverse and contrary to the recommendation of the Medical Executive Committee or Super Medical Executive Committee, the applicant shall be entitled to the hearing and appellate procedure provided for a Member of the Medical Staff in Article 8 and the procedures and conditions of Article 8 shall apply.

5.12.5 If the recommendation of the Medical Executive Committee and/or Super Medical Executive Committee, or the action of the Board of Directors is adverse to the applicant, the Board of Directors shall take final action on the application after all of the applicant's rights under Article 8 have been exhausted or waived. The Board of Directors' decision shall be final.

5.12.6 All favorable decisions shall include a delineation of the Clinical Privileges to be granted.

5.12.7 Written Notice of the Board of Directors' final decision shall be given to the Chief Executive Officer, the Chairperson of the Medical Executive Committee, the Chairperson of the Super Medical Executive Committee, the relevant Department Chairperson, and by the Chief Executive Officer to the applicant.

5.12.8 Notice of Action. Notice of adverse actions occurring pursuant to Sections 5.11, 5.12, 5.13 or 5.14 shall be given promptly to the Chief Executive Officer who shall provide written Notice of the action taken and, with respect to an adverse recommendation, shall include a statement of the grounds thereof and of the applicant's rights to a hearing and/or appellate review as provided for Members of the Medical Staff in Article 8. In the event that the applicant concurs with the action taken, the applicant may notify the Chief Executive Office in writing. As used herein, an "adverse action" as to the applicant is one which (i) denies, limits or conditions, or recommends denial of appointment of applicant to the Medical Staff, or (ii) denies or recommends denial, limitation or conditional approval of all or any of the Clinical Privileges as requested by applicant in the Completed Application.

5.13 Reapplication after Adverse Appointment Decision. A reapplication after an adverse appointment decision shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Executive Committee or the Board of Directors may require to demonstrate that the basis for the earlier adverse action no longer exists. A rejected applicant may not reapply until at least one (1) year after the last action on his/her prior application.

5.14 Requests for Modification of Appointment.

5.14.1 A Member of the Medical Staff may, either in connection with reappointment or at any other time, request modification to his/her Medical Staff category, Department assignment, or Clinical Privileges by submitting such request in writing to the Department Chair.

5.14.2 A written request for modification shall be processed in substantially the same manner as provided in Article 5. A request for Clinical Privileges at an additional Hospital Campus shall be treated as a reappointment and shall be processed in the manner detailed in Article 6.

5.15 Exercise of Clinical Privileges. Every Medical Staff Member shall be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Board of Directors except as otherwise provided in these Bylaws.

5.16 Resignations. A Medical Staff Member may voluntarily resign from the Medical Staff by submitting written Notice at least 30 (thirty) calendar days prior to their effective resignation date to the Medical Executive Committee, with a copy to the Department Chair. The Practitioner must have completed all responsibilities as outlined in these Bylaws and Rules and Regulations, before resignation is effective.

Upon receipt of information that a Medical Staff Member has relocated from the community, he/she will be sent a letter (registered mail) indicating that he/she has 30 (thirty) calendar days to resign his/her Medical Staff privileges. If such a resignation is not received, he/she will be removed administratively from the Medical Staff.

5.17 Leaves of Absence

5.17.1 Voluntary Leaves of Absence

A staff member in good standing may request a voluntary leave of absence from the Medical Staff, not to exceed one year. The request must be submitted in writing to the Medical Executive Committee (MEC) not less than 45 days prior to commencement of the VLOA. The request must state the anticipated duration of the VLOA and the reason for it; anticipated surgical, medical or mental health interventions (including substance abuse treatment) or legal issues that in any way could impact the staff member's ability to care for patients must be disclosed. If the leave of absence is granted, it will be under the condition that all medical staff responsibilities such as chart and other documentation are completed and call coverage is resolved before beginning the VLOA, and medical staff dues must be kept current during the absence. During the period of leave, the staff member's clinical privileges, prerogatives, and responsibilities shall be suspended. At least 60 days prior to the termination of the VLOA, the practitioner must request reinstatement of Medical Staff privileges by submitting a written request for reinstatement to the MEC. Before granting the reinstatement the MEC has the right to request medical or other evaluation of the returning staff member if such is thought appropriate to guarantee safety and quality of patient care prior to granting reinstatement. Additionally, staff members requesting reinstatement must provide details regarding his/her clinical activity while on leave, if applicable. The MEC's recommendation on reinstatement will be forwarded to the CEO for final approval. If the VLOA is less than 60 days, the staff member may submit a request for reinstatement without 60 days' notice to his/her Department Chair and the Medical Staff Office; if all the above requirements are met they may grant temporary restoration of full or partial staff privileges until MEC and CEO review and decision on reinstatement can be completed. Physicians on VLOA who do not request reinstatement within one year will be automatically administratively terminated.

5.17.2 Involuntary Leave of Absence

A staff member in good standing may request an Involuntary Leave of Absence (IVLOA) not to exceed one year in the event that he or she suffers injury or illness (including mental health affliction) that might adversely impact his or her capacity or professional competence to practice or if he or she is called to Active Military Duty. The request must be submitted in writing to the Medical Executive Committee (MEC) as soon as possible after the development of the condition or call to duty prompting the IVLOA. (If the staff member is incapacitated, the department chair can initiate (submit) the request for leave of absence.) The request must state the anticipated duration of the IVLOA, the reason for it; anticipated surgical, medical or mental health interventions (including substance abuse treatment) or legal issues that in any way could impact the staff member's ability to care for patients must be disclosed. In the event of an IVLOA, the chart and other documentation completion call coverage

resolution, and payment of medical staff dues will not be required. Call coverage will be arranged by the department chair in conjunction with the Medical Staff Office. During the period of leave, the staff member's clinical privileges, prerogatives, and responsibilities shall be suspended. At least 60 days prior to the termination of the IVLOA, the practitioner must request reinstatement of medical privileges from the MEC. Before granting reinstatement, the MEC has the right to request medical or other evaluation of the returning staff member if such is thought appropriate to guarantee safety and quality of patient care prior to granting reinstatement. Additionally, staff members requesting reinstatement must provide details regarding his/her clinical activity while on leave, if applicable. The MEC's recommendation on reinstatement will be forwarded to the CEO for final approval. If the IVLOA is less than 60 days, the staff member may submit a request for reinstatement without 60 days' notice to his/her Department Chair and the Medical Staff Office; if all the above requirements are met they may grant temporary restoration of full or partial staff privileges until MEC and CEO review and decision on reinstatement can be completed. Physicians on IVLOA who do not request reinstatement within one year will be automatically administratively terminated.

5.17.3 Any recommendation by the Medical Executive Committee that limits or modifies clinical privileges is subject to the hearing and appeal process as provided in Article 8.

ARTICLE 6

PROCEDURE FOR REAPPOINTMENTS

6.1 Interval Information Form.

The Chief Executive Officer shall periodically, consistent with their initial date of appointment, provide each Medical Staff Member with an interval information form to submit to apply for reappointment.

6.1.1 Information required for reappointment shall include, without limitation, information regarding continuing training, education and experience that qualify the Medical Staff Member for the Clinical Privileges sought on reappointment and for continuing licensure in accordance with the requirements of the Board of Medical Licensure and Discipline;

6.1.1.1 the name and address of any other health care organization or practice setting where the Medical Staff Member provided clinical services during the preceding period;

6.1.1.2 membership, awards, or other recognition conferred or granted by any professional health care societies or organizations;

6.1.1.3 sanctions and/or changes of any kind, voluntary or involuntary, imposed by any other health care institution, professional review organization, or licensing authority, past, present or pending;

6.1.1.4 details of any criminal convictions and/or criminal matters pending;

6.1.1.5 details about malpractice insurance coverage, claims, suits, and settlements;

6.1.1.6 change in controlled substance registration (State and Federal) voluntary or involuntary;

6.1.1.7 information regarding any limitation which could preclude the Medical Staff Member from carrying out any Clinical Privilege requested including any limitation related to physical and mental health that impacts on the Medical Staff Member's ability to provide patient care or to interact appropriately with the patient, the patient's family, and/or other caregivers;

6.1.1.8 and such other specific information about the Medical Staff Member's professional ethics, qualifications and ability that may bear on his/her ability to provide patient care in the Hospital.

6.1.1.9 The Medical Staff Member shall designate on the form the Hospital or Hospital Campus(es) at which the Medical Staff Member desires Clinical Privileges. All references in this Article 6 to Department Chairperson and Medical Executive Committee shall be to the Department Chairperson or Medical Executive Committee respectively of the Hospital Campus(es) to which the applicant applies for Clinical Privileges for so long as separate Departments or Medical Executive Committees exist.

6.1.2 The Chief Executive Officer or his/her designee shall collect and/or verify any pertinent additional information made available and collect any other materials or information deemed material, including information regarding the Medical Staff Members professional performance and conduct inside and outside of the Hospital. When completed, the Chief Executive Officer shall transmit the completed interval information form and supporting documentation to the Medical Staff Member's Department Chairperson.

6.2 Department Review. Each Department Chairperson shall review the completed interval information form and supporting documentation and shall submit a recommendation for reappointment to the Medical Staff and for the delineation of Clinical Privileges for the ensuing two-year period. Such recommendation for each Member shall take into account the following factors: his/her professional competency and clinical judgment in the treatment of his/her patients, his/her physical and mental capability that impacts on the Medical Staff Member's ability to provide patient care or to interact appropriately with the patient, the patient's family, and/or other caregivers, his/her attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with these Bylaws, Rules and Regulations, performance relative to medical records, use of the Hospital's facilities for his/her patients, his/her ethics and conduct either inside or outside the Hospital, relations with other Medical Staff Members and providers, the maintenance of his/her continuing medical education, and his/her general attitude toward his/her medical practice, patients, the Hospital and the general public.

6.2.1 The recommendation of the Department Chairperson shall be in writing and shall be forwarded to the Integrated Credentials Committee.

6.2.2 If reappointment is not recommended, or if a change in Medical Staff category or limitation of Clinical Privileges is recommended, the reason(s) for such limitation(s) shall be stated.

6.2.3 The Medical Staff Member may be required to provide supplemental information regarding his/her clinical performance.

6.2.4 All Department primary credentialing review will be the responsibility of the Department Chair. The Assistant Chair will assume the responsibility should the Department Chair be unavailable, or be the subject of review. The Division President will assume this responsibility should both the Department Chair and the Assistant Chair be disqualified due to lack of availability.

6.3 Action by Integrated Credentials Committee. The Integrated Credentials Committee shall review the recommendation of the Department Chairperson and relevant performance data to make recommendation to the Medical Executive Committee, in writing, regarding continued Medical Staff participation, including any changes in the delineation of Clinical Privileges.

6.4 Action by Medical Executive Committee. The Medical Executive Committee shall review the recommendations of the Department Chairpersons and Integrated Credentials Committee and recommend to the Board of Directors, for each Member, his/her reappointment or non-reappointment, and any changes in staff category or specific Clinical Privileges to be granted for no more than two (2) years. In making its recommendation regarding the length of the appointment, the Medical Executive Committee may recommend a shorter period of time, taking into account such factors as whether the Member is under a corrective action, is engaged in a fair hearing or such other factors as the Medical Executive Committee shall consider appropriate. The Medical Executive Committee shall document the reason for any foreshortened recommended appointment period.

6.5 Procedure After Action by Medical Executive Committee. After action by the Medical Executive Committee, the procedure to be followed in matters of periodic reappointment and the renewal or changes in Clinical Privileges in connection therewith shall be as provided in Article 5 (5.12)

ARTICLE 7

CORRECTIVE ACTION

7.1 Request for Corrective Action. Whenever the performance, activities, physical or mental condition, or professional conduct of any Medical Staff Member are considered to be detrimental to the maintenance of the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital or the Medical Staff, or in violation of the requirements of these Bylaws, the Rules and Regulations or any policies or procedures of the Hospital, corrective action against such Member may be requested by any Member of the Active Staff, a Member of the Provisional/Active Staff, the Medical Executive Committee, the Super Medical Executive Committee, the Chief Executive Officer or by his/her designee, or by any Member of the Bayhealth, Inc. Board of Directors.

7.1.1 Any request for corrective action shall be in writing, shall be made to the Medical Executive Committee of the Hospital Campus at which the Medical Staff Member has Clinical Privileges, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. Such request should be submitted in a timely fashion, but should not exceed thirty (30) calendar days after the reporter has been made aware of the necessity to request the corrective action.

7.1.2 No request for corrective action shall proceed to MEC review under 7.2 unless there is concurrence to proceed by at least two (2) of the following individuals: the Department Chair, the Chief Medical Officer, and/or the Hospital Campus President. Any corrective action referred by the Department Chair, Chief Medical Officer or Medical Staff President must receive the concurrence of both of the other officers to proceed to the MEC.

7.1.3 Whenever a corrective action proceeds for investigation under 7.2, the President of the Medical Staff shall provide Notice to the Practitioner who is the subject of the proposed corrective action, stating the general nature of the allegations.

7.2 Investigation by Department Chairperson or Ad Hoc Committee. Within 10 (ten) calendar days of receipt of the request, the Medical Executive Committee shall determine whether the Department Chair should investigate the matter, or whether an ad hoc committee of Medical Staff Members should conduct an investigation. The Ad Hoc Committee shall consist of not less than three Members of the Active Medical Staff, none of whom shall have a direct business or personal relationship with the affected Practitioner or other interested persons, and may include Members from both Hospital Campuses. To the extent possible, no Member of the ad hoc committee shall be a direct economic competitor of the affected Practitioner or other interested persons.

7.2.1 The Member shall be informed in writing of the allegations against him/her and of the initiation of an investigation. Medical Staff member has 10 calendar days from the date of signed receipt of delivery to request in writing an interview with the ad hoc committee.

7.2.2 The Department Chair or the Ad Hoc Committee shall seek to determine the facts in the matter and shall interview relevant individuals, including the Member who is the subject of the investigation, as necessary to the investigation. To the extent there have been other issues involving the Member which relate to the circumstances giving rise to the request, these shall be considered in determining whether to proceed. If the Medical Staff Member does not request an interview or fails to attend an interview requested by the Department Chair or a committee, the Medical Staff Member will thereby be deemed to have waived his/her rights with regard to the interview. Medical Staff member has 10 calendar days from the date of signed receipt of delivery to request in writing an interview with the ad hoc committee.

7.2.3 At any interview conducted pursuant to this Paragraph 7.2, the Medical Staff Member shall be invited to discuss and respond to the allegations. This 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 Medical Staff Member may be accompanied by an attorney as an observer and advisor only. No attorney shall participate in the interview. Should any report be filed that is of a preliminary or interval nature, the final report must be submitted within an additional 30 (thirty) calendar days. No matter how many reports are filed, the total elapsed time from assignment of the investigation to receipt of final report can be no more than 60 (sixty) calendar days, unless all parties agree to an extension.

7.2.4 A written summary of any interview shall be made and included in the report to the Medical Executive Committee.

7.3 Report of the Department Chief or Ad Hoc Committee. Within 30 (thirty) calendar days after the receipt of the request for investigation, the Department Chair or the ad hoc committee shall submit a written report of its investigation to the Medical Executive Committee. This report may be a preliminary, interval, or final report and shall include suggestions regarding the type of corrective action to be taken, if any.

7.4 Recommendation of the Medical Executive Committee.

7.4.1 The Medical Executive Committee shall make a recommendation to the Performance Improvement Committee of the Board of Directors of Bayhealth, Inc., within 20 (twenty) calendar days following the receipt of the final report from a Department Chair or the Ad Hoc Committee that recommends any level of intervention. If the corrective action requested or recommended involves a reduction, limitation, or suspension of Clinical Privileges, or suspension or revocation of Medical Staff Membership, the Medical Staff Member shall be permitted to make an appearance before the Medical Executive Committee prior to its making a recommendation. The provisions at 7.2.3 shall apply to any such appearance. A record of such appearance shall be made by the Medical Executive Committee.

7.4.2 The recommendations of the Medical Executive Committee on a request for corrective action may include, but shall not be limited to, the following:

7.4.2.1 To dismiss the request for corrective action;

7.4.2.2 To modify the request for corrective action;

7.4.2.3 To issue a warning or a letter of reprimand;

7.4.2.4 To impose terms of probation or Supervision which shall require monitoring of the Member's actions with additional episodes forming the basis for corrective action necessitating further sanction or penalty;

7.4.2.5 To require that the Medical Staff Member obtain clinical consultation for patients in certain clinical situations;

7.4.2.6 To require remedial activity including additional education;

7.4.2.7 To require that the Medical Staff Member in question undergo a physical and/or behavioral evaluation as related to his/her clinical

duties;

7.4.2.8 To recommend reduction, suspension or revocation of Clinical Privileges;

7.4.2.9 To recommend that an already imposed summary suspension of Clinical Privileges be terminated, modified or sustained; or

7.4.2.10 To recommend that Medical Staff Membership be suspended or revoked.

7.4.3 The Medical Staff Office shall provide Notice of the Medical Executive Committee recommendation shall be furnished to the Medical Staff Member by Certified Mail or hand delivery. The procedural rights of a Member affected by a recommendation under 7.4.2 shall be as provided in Article 8. If the Medical Executive Committee makes a recommendation to dismiss the corrective action or a recommendation listed in Section 8.1.3, such recommendation shall be forwarded to the Performance Improvement of the Board of Directors of Bayhealth, Inc.

7.5 Precautionary Summary Suspension.

7.5.1 Upon a determination that corrective action must be taken immediately to protect the life of any patient or to reduce the substantial likelihood of immediate injury, harm or damage to the health or safety of any patient, employee or other person present in the Hospital, the summary suspension of Clinical Privileges of a Medical Staff Member may be initiated by either the Medical Executive Committee, Super Medical Executive Committee, or any two of the following authorized officers acting in concert: the Department Chairperson of the involved service at the Hospital Campus(es) where the specific behavior took place, the President(s) at the Hospital Campus(es) where the alleged occurrences took place, the President of Medical Staff (Chairman of the Super MEC), Chief Medical Officer, Chief Operating Officer, and Chief Executive Officer. Such summary suspension shall become effective immediately upon imposition.

7.5.1.1 The suspension will be automatically terminated if two additional authorized officers listed in 7.5.1 do not provide written agreement with the action within 72 hours.

7.5.2 The Chief Medical Officer, or his/her designee, shall promptly notify the Chief Executive Officer or designee, and the involved Physician. A summary suspension is precautionary in nature and will not be reported to the National Practitioner Data Bank unless it lasts longer than 30 (thirty) calendar days.

7.5.3 A summary suspension shall constitute the initiation of a corrective action. The procedures set forth at 7.2 shall apply to the investigation, except that:

7.5.3.1 The President of the Medical Staff, in consultation with the Chief Executive Officer, shall immediately appoint an ad hoc committee consisting of at least three Members of the Active Medical Staff which shall review any precautionary summary suspension as soon as practicable after imposition. To the extent possible, no Member of the ad hoc committee shall be a direct economic competitor of the affected Practitioner or other interested persons.

7.5.3.2 As soon as possible, but no later than 14 (fourteen) calendar days after appointment, the ad hoc committee shall submit to the Medical Executive Committee a written report of its review and its recommendations to modify, continue or terminate the terms of the precautionary summary suspension. Unless otherwise so indicated, this report shall not constitute the report of the ad

hoc committee on its investigation as required under Section 7.3.

7.5.3.3 The Medical Executive Committee shall act to modify, continue or terminate the precautionary summary suspension as soon as is reasonably practical but no later than 20 (twenty) calendar days from the date of imposition of the summary suspension. The action of the Medical Executive Committee shall be promptly transmitted by the Chief Medical Officer, or his/her designee, to the Chief Executive Officer and the Department Chair. Notice shall be furnished to the Member by Certified Mail or hand delivery no later than 3 (three) calendar days after the Medical Executive Committee action.

7.5.3.4 Unless the Medical Executive Committee recommendation is to terminate the suspension and/or cease all corrective action, the Member shall be entitled to the rights set forth in Article 8. The Medical Executive Committee shall notify the Chief Executive Officer of any action that it has taken and transmit all documentation to him/her. Notice shall be furnished to the Member by Certified Mail or hand delivery no later than 3 (three) calendar days after the Medical Executive Committee action.

7.5.4 In the event that the Medical Executive Committee determines that the summary suspension be revoked, the revocation will be effective immediately. The action of the MEC shall be referred to the Board of Directors.

7.5.5 The Board of Directors will review this action of the MEC and either approve or disapprove it within 30 (thirty) calendar days. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Board of Directors.

7.5.6 Immediately upon the imposition of a summary suspension, the President of the Medical Staff or the responsible Department Chairperson shall have authority to provide for alternative medical coverage for the patients of the suspended Member in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Member.

7.6 Automatic and Immediate Suspension or Revocation. Medical Staff Privileges shall immediately be suspended or revoked under the following circumstances upon which occurrence the CEO shall provide Notice to the Medical Staff Member or Allied Health Professional:

7.6.1 The occurrence of Major Deficiencies in completion of medical records as defined in section 5.5 of the Medical Staff Rules and Regulations.

7.6.2 Action by the State Board of Medical Practice or the State Board of Dental Examiners revoking or suspending a Physician's or Dentist's license shall automatically terminate the Medical Staff Membership and shall automatically revoke or suspend all of the Physician's or Dentist's Clinical Privileges.

7.6.3 Action by a State Agency revoking or suspending licensure or similar certification for any Podiatrists, other Allied Health Professional, or other limited licensed professionals shall revoke automatically all related Clinical Privileges.

7.6.4 Automatic suspensions or revocations as provided in Section 7.6 shall not be subject to the provisions of Article 8.

7.6.5 Any lapse or termination of malpractice insurance coverage will result in

temporary suspension until coverage is reinstated.

7.7 Effect of Resignation. If at any time during the pendency of an action or procedure involving corrective action as provided in Article 7, or an action or procedure based on an adverse recommendation for reappointment under Article 6, a Member of the Medical Staff submits a written resignation of his/her Medical Staff Membership at any Hospital Campus and/or Clinical Privileges at any Hospital Campus, or requests that upon expiration of his/her term of appointment, he/she not be reappointed to a Hospital Campus, such resignation shall be made a part of the Medical Staff Member's file, together with information as to the circumstances at the time of its submission. The Board of Directors may determine that the proceeding be completed despite the resignation.

ARTICLE 8

HEARING AND APPELLATE REVIEW PROCEDURE

8.1 Grounds for Hearing.

8.1.1 Purpose of Hearing. These Bylaws are for the purpose of resolving in an informal manner issues related to competence and professional conduct. The Medical Executive Committee or the Super Medical Executive Committee is responsible for making “recommendations” regarding appointment or reappointment of a Practitioner and requests for Clinical Privileges to the Board of Directors, or a Committee of the Board. The Board of Directors, or a Committee of the Board, is then responsible for making a final decision and acting on the recommendations of the MEC or SMEC. The hearing and appellate review procedures set forth in these Bylaws shall apply only to those recommendations or actions that (1) adversely affect a Practitioner's appointment to or status as a member of the Medical Staff or the exercise of Clinical Privileges; and (2) are based upon such Practitioner's competence or professional conduct.

8.1.2 Recommendations and Actions Constituting Grounds for a Hearing. Except as provided in Paragraph 8.1.3, the following recommendations and actions shall entitle a Practitioner or applicant to a hearing:

8.1.2.1 Denial of initial appointment to the Medical Staff;

8.1.2.2 Denial of reappointment to the Medical Staff;

8.1.2.3 Revocation of appointment to the Medical Staff;

8.1.2.4 Denial of requested Clinical Privileges, except where such denial relates to failure to meet an eligibility threshold criteria for granting of such privileges.

8.1.2.5 Involuntary reduction of Clinical Privileges, except where such denial relates to failure to meet an eligibility threshold criteria for granting of such privileges.

8.1.2.6

8.1.2.7 Limitation of Admitting Privileges;

8.1.2.8 Revocation of Clinical Privileges;

8.1.2.9 Mandatory concurrent consultation or monitoring requirements (*i.e.*, the consultant must approve the course of treatment in advance), but excluding monitoring incidental to Provisional Active;

8.1.2.9 Any other action or determination that will require NPDB reporting.

8.1.3 Recommendations and Actions That Do Not Constitute Grounds for a Hearing. None of the following recommendations and actions shall be considered an adverse determination; they shall not constitute grounds for a hearing or appeal, unless NPDB reportable:

- 8.1.3.1 Issuance of a letter of guidance, concern, admonition, warning, or reprimand;
- 8.1.3.2 Imposition of probation or Supervision under 7.4.2.4;
- 8.1.3.3 Imposition of conditions, monitoring or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- 8.1.3.4 Denial of Temporary Privileges or termination or revocation of Temporary Privileges;
- 8.1.3.5 Automatic relinquishment or restriction of appointment or Clinical Privileges as set forth in Paragraph 7.6.1, 7.6.2, 7.6.3, and 7.6.4 of these Bylaws;
- 8.1.3.6 Imposition of a requirement for additional training or continuing education;
- 8.1.3.7 Determination that an application will not be further processed due to an applicant's failure to complete the application;
- 8.1.3.8 Failure to meet or continue to meet requirements for eligibility for Medical Staff Membership based on Board Certification;
- 8.1.3.9 Automatic termination of Clinical Privileges and Medical Staff Membership pursuant to a hospital based employment contract;
- 8.1.3.10 Appointment or reappointment for a different period than is otherwise customary.
- 8.1.3.11 Denial of appointment or Clinical Privileges for inability of the hospital to provide the resources or facilities to exercise requested privileges;
- 8.1.3.12 Denial of appointment or privileges because the privileges are subject to an exclusive contract to which the Practitioner is not and will not be a party.

In any of the foregoing the Practitioner may submit a written explanation to be placed in his/her file.

8.2 Right to Hearing and to Appellate Review.

8.2.1 When a Practitioner is given notice of a recommendation of the Medical Executive Committee as described in Paragraph 8.1.2, for which a hearing and appellate review is available, he/she shall be entitled to request a hearing before an ad hoc hearing committee appointed by the President of the Super Medical Executive Committee. If the recommendation of the hearing committee is still adverse to the Practitioner, this Practitioner shall then be entitled to request an appellate review by the Board of Directors of Bayhealth, Inc. The decision of the Board of Directors upon appellate review shall be final.

8.2.2 When a Practitioner is given notice of a decision by the Board of Directors of an action that would constitute grounds for a hearing under Section 8.1.2, and such decision differs from the recommendation of the Medical Executive Committee, and the Practitioner did not previously request a hearing with respect to the recommendation of the Medical Executive Committee, the Practitioner shall be entitled to request a hearing before an ad hoc committee appointed by the President of the Super Medical Executive Committee. If such hearing does not result in a favorable recommendation, the Practitioner may request an appellate review by the Board of Directors. The decision of the Board of Directors upon appellate review shall be final.

8.2.3 In a proceeding under Section 8.2.1 or 8.2.2, if the recommendation of the hearing committee is favorable to the Practitioner, but the Board of Directors' action after considering the recommendation of the hearing committee is adverse to him/her, the Practitioner shall be entitled to request an appellate review by the Board of Directors. The decision of the Board of Directors upon appellate review shall be final.

8.2.4 In a proceeding under Paragraph 8.2.1 or 8.2.2, if the Practitioner is willing to accept the adverse recommendation of the hearing committee, but the Board of Directors' action after considering the recommendation of the hearing committee is considered by the Practitioner to be more adverse to him/her, the Practitioner shall be entitled to an appellate review by the Board of Directors. The decision of the Board of Directors upon appellate review shall be final.

8.2.5 Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review with respect to any recommendation or action, as described in Paragraph 8.1.2, for which a hearing and appellate review is available. This provision applies under all circumstances, including situations where an applicant has privileges at each Hospital Campus and the recommendations of each Medical Executive Committee differ in some manner.

8.3 Request for Hearing; Effect of Failure to Request.

8.3.1 The Chief Executive Officer shall direct prompt written Notice of a recommendation or decision as described in Paragraph 8.1, for which a hearing and appellate review is available, to any affected Practitioner, by hand delivery or certified mail, return receipt requested. Such notice shall include the following information: (i) the Practitioner's right to a hearing or an appellate review as provided by these Bylaws; (ii) a statement that the Practitioner shall have 30 (thirty) calendar days following receipt of such notice within which to file a written request for a hearing or an appellate review with the Chief Executive Officer; (iii) a statement that failure to make such a written request for a hearing or an appellate review within the thirty (30) day period shall constitute a waiver of the Practitioner's right to such; (iv) a statement that if the Practitioner requests a hearing or an appellate review, he/she will be notified of the date, time and place for the hearing or appellate review; and (v) a description of the grounds upon which the adverse recommendation or decision is based.

8.3.2 The failure of a Practitioner to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner provided herein shall be deemed a waiver of the Medical Staff Member's right to a hearing and to any appellate review to which he/she might otherwise have been entitled on the matter. The failure of a Practitioner to request an appellate review to which he/she is entitled by these Bylaws within the time and in the manner provided herein shall be deemed a waiver of his/her right to appellate review of the matter.

8.3.3 When the hearing or appellate review waived relates to an adverse recommendation of the Medical Executive Committee or the hearing committee appointed by the

President of the Super Medical Executive Committee, the same shall thereupon become and remain effective against the Member pending the Board of Directors' decision on the matter. When the hearing or appellate review waived relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Board of Directors. In either of such events, the Chief Executive Officer shall promptly notify the Practitioner of his/her status by hand delivery or certified mail, return receipt requested.

8.4 Notice of Hearings. Within 30 (thirty) calendar days after receiving a Practitioner's request for a hearing, the Super Medical Executive Committee shall schedule and arrange for the hearing and shall notify the Practitioner of the time, place and date so scheduled, and shall provide a list of witnesses, if any, expected to testify at the hearing on behalf of the Committee. Upon receipt of Notice, the Practitioner shall have 10 (ten) calendar days to notify the Super Medical Executive Committee of any challenge to any Committee Member as being in economic conflict. Any failure to timely make such challenge shall constitute a waiver of such challenge for all purposes. The hearing date shall be not less than 30 (thirty) calendar days from the date of the notice of hearing. A Practitioner may waive the time periods provided and may request and obtain a hearing as soon as is practical.

8.5 Composition of Hearing Committee.

8.5.1 When a hearing relates to an adverse recommendation of the Medical Executive Committee or to an adverse decision of the Board of Directors that is contrary to the recommendation of the Medical Executive Committee, such hearing shall be conducted by an ad hoc hearing committee appointed by the President of the Super Medical Executive Committee from the Membership of the Super Medical Executive Committee and Active Medical Staff; the ad hoc hearing committee shall consist of at least five (5) Members, (1) of whom shall be designated as Chairperson, none of whom have prior involvement in this investigation or who are in direct economic competition with the subject of the hearing. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

8.5.2 The use of a Hearing Officer to preside at the evidentiary hearing provided for in these Bylaws is optional and may be requested by either the President of the Super Medical Executive Committee or the Practitioner. Both the Practitioner and the President of the Super Medical Executive Committee must agree on the choice of the Hearing Officer. In no instance may the Hospital's attorney serve as the Hearing Officer. Said Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. If a Hearing Officer is appointed, he shall act as the Chairperson of the hearing. The Hearing Officer shall not have a direct business or personal relationship with, nor be a direct economic competitor of, the affected Practitioner or other interested persons. The Hearing Officer shall not act as an advocate for either Party.

8.5.3 If a Hearing Committee cannot be constituted with Members of the Active Medical Staff because of direct economic conflicts, the Super MEC may select Qualified Physicians from other categories of the Medical Staff or Physicians on staff at other hospitals.

8.6 Conduct of Hearings.

8.6.1 There shall be at least five (5) of the Members of the Hearing Committee present when a hearing takes place. Only those present may vote.

8.6.2 An accurate record of hearings must be kept. The means for preserving the record shall be established by the Hearing Committee, and may be accomplished by use of current video technology, a court reporter, or a detailed transcription.

8.6.3 No hearing shall be conducted without the personal presence of the Practitioner for whom the hearing has been scheduled unless he/she 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 waived his/her rights in the same manner as provided in Section 8.3.2 and to have accepted voluntarily the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 8.3.3.

8.6.4 A postponement of a hearing shall only be made with the approval of the Hearing Committee. A postponement shall only be granted for good cause shown and in the sole discretion of hearing committee.

8.6.5 The appointed Chairperson of the Hearing Committee or the Hearing Officer shall preside over the hearing. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and that decorum is maintained. He/she shall determine the order of procedure during the hearing.

8.6.6 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 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 who is subject of the hearing, shall be entitled to submit memoranda concerning any issue of procedure or of fact, prior to, during, or after the hearing, and such memoranda shall become a part of the hearing record. To the extent the Hearing Committee determines, in its discretion, that it needs expertise from outside consultants to evaluate the facts and circumstances at issue, it shall have the right to obtain such consultation and shall make such consultant report available to the aggrieved Practitioner if the Hearing Committee relies upon such consultant's information or opinion.

8.6.7 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 Delaware Courts. The Hearing Committee shall also be entitled to consider any pertinent material contained on file at Bayhealth Medical Center and all other information which can be considered in connection with applications for appointment to the Medical Staff and for Clinical Privileges pursuant to these Bylaws.

8.6.8 The Medical Executive Committee or Board of Directors, as the case may be, shall appoint a representative to represent it at any hearing before a Hearing Committee to present the facts in support of the recommendation or action as to which the hearing has been requested. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by presenting appropriate evidence.

8.6.9 The aggrieved Practitioner shall have the burden of proof to demonstrate that the recommendation of the body giving rise to the hearing was not based upon substantial evidence or was arbitrary and capricious.

8.6.10 The Practitioner shall have the following rights: (i) to be represented by counsel; (ii) to present witnesses; (iii) to introduce written evidence; (iv) to cross-examine any witness or any matter relevant to the issue of the hearing; (v) to challenge any witness; and (vi) to rebut any evidence. If the Practitioner does not testify on his/her own behalf, he/she may be called and questioned by the Hearing Committee.

8.6.11 Both the Representative and the Practitioner shall provide a list of witnesses, if any, expected to testify at the hearing at least 7 (seven) calendar days prior to the hearing.

8.6.12 Either the Hearing Committee, the Representative, or the Practitioner may order that oral evidence be taken on oath or affirmation administered by a Notary Public.

8.6.13 The hearings provided for in these Bylaws are intended to facilitate non-adversarial conflict resolution, though all parties shall have the right to legal representation at any hearing or as otherwise provided for in these Bylaws.

8.6.14 By action of the Hearing Committee, the hearing may, without special Notice, be recessed and reconvened for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Unless otherwise agreed to by the Representative and the Practitioner, the hearing shall be reconvened within 10 (ten) calendar days. The hearing shall be closed upon conclusion of the presentation of oral and written evidence.

8.6.15 Within 10 (ten) calendar days after 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 Super Medical Executive Committee. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or action of the Board of Directors. A copy of the report and recommendation shall also be provided to the Practitioner.

8.7 Appeal to the Board of Directors.

8.7.1 Within 30 (thirty) calendar days after receipt of a Notice by a Practitioner of an adverse recommendation of the Hearing Committee, the Practitioner may request an appellate review by sending written Notice of such request to the Chief Executive Officer by hand delivery or certified mail, return receipt requested.

8.7.2 Except as provided in Paragraph 8.2.4, if such appellate review is not requested within such thirty (30) calendar day period, the Practitioner shall be deemed to have waived his/her right to such appellate review, and to have accepted such adverse recommendation or decision, and the same shall become final immediately.

8.7.3 Within 30 (thirty) calendar days after receipt of such Notice of request of appellate review, the Board of Directors shall schedule a date for such review, including oral argument if requested. The Board of Directors shall, by written Notice, return receipt requested and through the Chief Executive Officer, notify the Practitioner of the date so scheduled, or in the case of oral argument, of the time, place and date so scheduled. The date of the appellate review shall not be less than 30 (thirty) calendar days, from the date of mailing of the Notice. Provided, however, a Member then under summary suspension may request an expedited appellate review; such review shall be scheduled as soon as arrangements for it may reasonably be made, but not more than 20 (twenty) calendar days from the date of receipt of such notice. Practitioner may waive the time periods provided and may request and obtain a hearing as soon as is practical.

8.7.4 The appellate review shall be conducted by the Board of Directors, or a committee thereof appointed for such purpose. There shall be no Member of the appellate review board in direct competition with the involved Staff Member. Relatives and business associates are also excluded. Directors who participate in the appellate review shall not have a direct business or personal relationship with the affected Practitioner or other interested persons, nor be a direct economic competitor of the

affected Practitioner or other interested persons, nor have any prior involvement in any hearing or review concerning the matter.

8.7.5 The Practitioner shall have access to the report and record (and transcription, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. The Practitioner may submit a written statement in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement shall be specified. This written statement may cover matters raised during any point of the hearing process to which the appeal is related, and legal counsel may assist in its preparation. This written statement shall be submitted to the Board of Directors through the Chief Executive Officer by hand delivery certified mail, return receipt requested, prior to the scheduled date for the appellate review. A similar statement may be submitted by the Hearing Committee.

8.7.6 The Board of Directors shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted for the purpose of determining whether the adverse recommendation or decision was supported by substantial evidence and was not arbitrary or capricious. 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. The Practitioner also shall be permitted to answer questions posed by any member of the appellate review body. The Hearing Committee 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 posed by any Member of the Board of Directors.

8.7.7 In order to prevent injustice, new or additional matters not raised during the hearing or in the hearing committee report, nor otherwise reflected in the record, shall be introduced at the appellate review only under unusual circumstances. The Board of Directors shall exercise sole discretion as to whether such new matters shall be accepted.

8.7.8 Upon the appellate review, the Board of Directors may affirm, modify, or reverse the recommendation of the Hearing Committee. The Board of Directors, in its discretion, also may refer the matter back to the Hearing Committee for further review and recommendation within 20 (twenty) calendar days. Such referral may include a request that the Hearing Committee arrange for a further hearing or resolve specified disputed issues.

8.7.9 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 8.7 have been completed or waived. All action required or permitted to be taken by the Board of Directors may be taken by the Medical Executive Committee or other designated committee of the Board of Directors.

8.7.10 Within 10 (ten) calendar days after the conclusion of the appellate review the Board of Directors shall make its final decision in the matter and shall send Notice thereof to the Medical Executive Committee and Super Medical Executive Committee and, through the Chief Executive Officer, to the Practitioner, by hand delivery or certified mail, return receipt requested. Final decisions of the Board of Directors will apply at each Hospital Campus in the event that a Practitioner has Privileges at both Hospital Campuses.

ARTICLE 9

ORGANIZATION OF THE MEDICAL STAFF

9.1 Medical Staff Year. The Medical Staff Year shall be July first through June thirtieth to coincide with Bayhealth's fiscal year.

9.2 Dues. The amount of the annual Medical Staff dues shall be established by the Super Medical Executive Committee. A Medical Staff Member with Medical Staff Membership and Clinical Privileges at each Hospital Campus shall pay annual Medical Staff dues once per year. Such dues shall be used for purposes such as medical education, medical library and acknowledgement of Medical Staff services. A portion of the medical staff dues may be utilized for charitable purposes with an arrangement through a foundation whereby designated funds will be awarded by the Medical Staff Foundation Board of Trustees to be comprised of the current president, vice president, treasurer and secretary of the Kent and Sussex medical executive committees along with three past medical staff presidents appointed by the Super MEC who will serve up to two terms lasting five years each (total of ten years.) The board of trustees will report disbursements to the medical staff at least yearly by either written or electronic means and by formal presentation at an integrated full staff meeting before the end of each fiscal year. Financial, tax and other records along with meeting minutes regarding disbursements will be made available upon request to members of the medical staff. Initial and subsequent percentage of medical staff dues allotted for charitable purposes shall be determined by a combined majority ballot of the full staff in accordance with voting procedures as stipulated in the Bayhealth Medical Staff Bylaws.

9.3 Officers of the Medical Staff. The Officers of the Medical Staff at each Hospital shall be the President, Vice President, Secretary-Treasurer and immediate Past President. Officers must be Members of the Active Staff at the time of nomination and election and must remain Members thereof during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved. Each Officer's duties shall relate to the Hospital Campus at which he/she is an Officer.

9.3.1. **The President.** The President of the Medical Staff at each Hospital Campus shall:

9.3.1.1 Act on the behalf of the Board of Directors in coordination and cooperation with the Chief Executive Officer and the Chief Operating Officer in matters of mutual concern involving the care of patients in the Hospital Campus.

9.3.1.2 To serve as the Chairperson of the Medical Staff Executive Committee and Hospital Campus Full Medical Staff, including responsibility for approving agendas and chairing said meetings.

9.3.1.3 Appoint committee chairpersons and members to all campus Medical Staff committees, except the Medical Executive Committee and integrated committees.

9.3.1.4 Serve as a nonvoting Ex Officio Member of all other Medical Staff committees.

9.3.1.5 Represent the views, policies, needs and grievances of the Medical Staff to the Super Medical Executive Committee, Board of Directors, and the Administration of the Corporation.

9.3.1.6 Serve as a voting Member of both the Super Medical Executive

Committee, and the Medical Executive Committee of the appropriate Hospital Campus.

9.3.2 The President Elect. The President Elect of the Medical Staff at each Hospital Campus shall:

9.3.2.1 Annually, appoint committee chairpersons and members to all campus Medical Staff committees, except the Medical Executive Committee and integrated committees.

9.3.3 Vice President. The Vice President of the Medical Staff at each Hospital Campus shall:

9.3.3.1 Be a voting Member of the Medical Executive Committee.

9.3.3.2 Perform such additional or special duties as shall be assigned to him/her by the President, Super Medical Executive Committee, the Medical Executive Committee or the Board of Directors.

9.3.3.3 Assume all duties of the President in his/her absence.

9.3.3.4 Serve as a voting Member of the Super Medical Executive Committee.

9.3.4 Secretary-Treasurer. The Secretary-Treasurer shall:

9.3.4.1 Be a voting Member of the Medical Executive Committee.

9.3.4.2 Maintain records of all Medical Staff and Medical Executive Committee meetings.

9.3.4.3 Serve as a voting Member of the Super Medical Executive Committee.

9.3.5 Immediate Past President. The Immediate Past President of the Medical Staff at each Hospital Campus shall:

9.3.5.1 Be a voting Member of both the Medical Executive Committee and the Super Medical Executive Committee, and shall perform such other advisory duties as are assigned by the President of the Medical Staff, Medical Executive Committee, Super Medical Executive Committee or the Board of Directors.

9.4 Election of Officers at Each Hospital Campus.

9.4.1 Officers of the Medical Staff at each Hospital Campus shall be elected at the annual meeting of the Hospital Campus' Medical Staff. The vote shall be by written ballot if requested by any Medical Staff Member. The election of each officer shall become effective on the later of the first day of the Medical Staff Year or immediately following approval by the Board of Directors. Each officer shall then serve until his/her successor has been elected and approved by the Board of Directors. The term of the President, Vice President, Secretary-Treasurer, Immediate Past President shall be one year. All Department Chairpersons shall be two years. If an officer position becomes vacant during his/her term that vacancy shall be filled in accordance with 9.6. If the Immediate Past President becomes unavailable, that position shall remain vacant.

9.4.2 In any election, if there are three or more candidates for an office and no candidate receives a majority there shall be successive balloting in which the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate. All officers may be re-elected, but the President and Vice President may not hold their respective offices for more than two consecutive terms.

9.5 Officers of the Super Medical Executive Committee.

9.5.1 The President. The President of the Super Medical Executive Committee shall:

9.5.1.1 Act on behalf of the MEC Memberships at both Hospital Campuses in coordination and cooperation with all executives of the System or the Corporation particularly in matters of credentialing disagreements or Medical Staff Membership disagreements regarding corrective actions or suspensions, and in all other matters referred to it by decision of either Medical Executive Committee, the Bayhealth, Inc. Board of Directors, the Corporation's Board of Directors, or the Chief Executive Officer.

9.5.1.2 Shall appoint committee chairpersons, members of all integrated committees, and members of the Bylaws Committee as needed throughout the year. The Bylaws members shall elect the Bylaws Committee chairperson.

9.5.1.3 Call, preside at, and be responsible for the agenda of all meetings of the Super Medical Executive Committee.

9.5.1.4 Represent the best interest of the patients, each Hospital Campus Medical Staff, and the Corporation when representing both the Medical Executive Committee and Super Medical Executive Committee at such corporate functions as Medical Executive Committee or Board of Directors meetings.

9.5.2 The President Elect. The President Elect of the Super Medical Executive Committee shall:

9.5.2.1 Annually, appoint committee chairpersons, members of all integrated committees, and members of the Bylaws Committee in the last month prior to the incoming appointment year. The Bylaws members shall elect the Bylaws Committee chairperson.

9.5.3 The Vice President. The Vice President of the Super Medical Executive Committee shall perform such additional or special duties as shall be assigned by the President of the Super Medical Executive Committee or the Board of Directors, and shall assume all duties of the President in his/her absence.

9.5.4 Super Medical Executive Committee Membership. The Membership of the Super Medical Executive Committee shall consist of the Immediate Past President of the Medical Staff of each Hospital Campus, and the President, Vice President, and Secretary- Treasurer of the Medical Staff of each Hospital Campus. Under normal circumstances this shall constitute a Membership consisting of four representatives from each Hospital Campus. However, there is no prohibition against an individual Medical Staff Member holding a Medical Executive Committee office at each Hospital Campus and, therefore, there may be less than eight Super Medical Executive Committee Members during a given Staff Year.

9.5.5 Super Medical Executive Committee Elections. The Super Medical Executive

Committee President and Vice President shall be elected on separate ballots with the President to be determined first through a majority vote by the Super Medical Executive Committee Membership. The term of office shall be one year and no officer may hold the respective office for more than two consecutive terms.

9.6 Vacancies. Vacancies in the office during the Medical Staff Year, except for the Presidency of the Medical Executive Committee and of the Super Medical Executive Committee, shall be filled by the Medical Executive Committee from Active Staff Members. If there is a vacancy in the Presidency of the Medical Executive Committee or of the Super Medical Executive Committee, the Vice President of that body shall serve the remaining term.

9.7 Removal of Officers. Any officer of either Medical Executive Committee or Super Medical Executive Committee may be removed for cause which is defined as the failure to properly discharge his/her responsibilities as determined and recommended by the Medical Executive Committee or Super Medical Executive Committee as applicable. Such action may be taken by the Board of Directors, after considering the recommendation of the appropriate Medical Executive Committee.

9.8 Meetings of the Medical Staff of Each Hospital Campus.

9.8.1 Integrated Staff. Effective January 1, 2021, the Integrated Medical Staff meetings shall be held quarterly. The last meeting of the Medical Staff year shall be denoted as the annual meeting at which time all nominations will be considered, and all elections will be completed so as to provide a slate of officers to the Board of Directors prior to commencement of the ensuing Medical Staff Year and corporate year. If the date of the scheduled meeting is a legal holiday, the quarterly meeting will be scheduled on the next business day.

9.8.2 Special meeting. Special meetings of the Medical Staff may be called at any time by the President of the Hospital Campus Medical Staff, or by a majority of the Medical Executive Committee of the Hospital Campus, and shall be called by the President of the Medical Staff upon receipt of a petition signed by not less than ten percent of the Members of the Active and Provisional Active Staffs.

9.8.3 Notice of Medical Staff Meetings. A Notice stating the place, day and time and location of the Medical Staff meetings shall be delivered to each voting Member of the Medical Staff and shall be posted in prominent positions at the Hospital Campus not less than 10 (ten) calendar days prior to such meeting.

9.8.4 Record Date. Those individuals who are Members of the Active and Provisional Staffs at noon on the date of the notification of the Medical Staff meeting shall be eligible to vote at the meeting.

9.8.5 Quorum.

9.8.5.1 Thirty-three percent of those who are eligible to vote at any regularly scheduled full staff, Department, or committee meeting; fifty percent at specially scheduled meetings. Members are considered to be present if they are in attendance at any time during the meeting, or actively participate in the pertinent discussion via two way electronic communications.

9.8.5.2 The affirmative vote of a majority of the Medical Staff Members who are eligible to vote and who are present at any meeting at which a Quorum is present is the act of the Medical Staff at the Hospital Campus.

9.8.6 Voting Methods. In the event that it is necessary for the Medical Staff to act on a question without being able to meet, the voting Medical Staff Members may be presented with the question by mail, e-mail or facsimile and their vote returned to the President of the Medical Staff of the Hospital Campus by similar methods. Such a vote shall be binding so long as the question is voted on by a majority of the Medical Staff Members eligible to vote.

9.9 Department and Committee Meetings.

9.9.1 Super Medical Executive Committee Meetings.

9.9.1.1 This committee shall meet no less than quarterly on a date to be determined by the President of the Super Medical Executive Committee.

9.9.2 Committee Meetings. Except as otherwise provided in these Bylaws, all committees shall meet at least quarterly, at a time set by the Chairperson of the committee. The agenda for the meeting and its general conduct shall be established by the Chairperson of the committee.

9.9.3 Department Meetings. Members of each Department shall meet as a Department at least quarterly at a time selected by the Chairperson of the Department to review and evaluate the clinical work of the Department and to discuss any matters concerning the Department. The agenda for the meeting and its general conduct shall be set by the Chairperson of the Department.

9.9.4 Vote Required. The vote of a majority of the Members of the Department or of the voting Members of a committee who are present during the meeting at which a Quorum is present is the act of the Department or committee.

9.9.4.1 Department and Committee Meeting Participation. Members of a Department may be present for its meeting either physically or electronically.

9.9.4.2 Department and Committee Voting Procedures. If a Department meeting has a Quorum of its members present physically or electronically, votes taken will be decided by a majority of those so present and the outcome will be the act of the Department. If a Quorum is not present, an email will be sent to the department members explaining the issue(s) requiring vote(s) and members will have 7 calendar days to cast their vote by return email. At least 1/3 of those eligible to vote must cast a yea or nay vote or express abstention for the vote to be the act of the Department.

9.9.5 Special Department and Committee Meetings.

9.9.5.1 A special meeting of any committee or Department may be called by its Chairperson or by a President of the Division Medical Staff, and shall be called by the Chairperson upon receipt of a petition signed by not less than three Members of the Department or committee. Written or oral Notice stating the place, day and hour of the special meeting shall be given to each Member of the committee or Department. If mailed, the Notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the Department or committee Member's address as it appears on the records of the Hospital Campus at a date such that there is clear expectation of receipt not less than 72 hours before the time of such meeting. Electronic or facsimile mail are permissible means of notification if the Medical Staff Member has consented to such form of notification.

9.9.5.2 In the event that it is necessary for a committee or Department to act without being able to meet, the voting Members may be presented with the matter in question in person, by mail, facsimile or telephone and their votes returned to the Chairperson of the committee or

Department. Such a vote shall be binding if the matter in question is voted on by a majority of the committee or Department eligible to vote and if no Member objects to the action being taken without a meeting.

9.9.6 Minutes. Minutes of each meeting of each committee and each Department shall be prepared and shall include a record of the attendance of Members, the recommendations made and the votes taken on each matter. The minutes shall be signed by the presiding officer and copies shall be promptly forwarded to the Medical Staff Office for distribution to the Medical Executive Committee of the Hospital Campus. Each committee and each Department shall maintain a permanent file of the minutes of each of its meetings.

9.10 Provisions Common to All Meetings.

9.10.1 Notice. As soon as possible after the beginning of the Medical Staff Year, a calendar of the regularly scheduled Medical Staff, Department, and committee meetings shall be made up for the Staff Year. This schedule shall be distributed to all Medical Staff Members.

9.10.2 Attendance Requirements. Effective January 1, 2021, each Member of the Provisional Active, or Active Medical Staff shall be required to attend at least two Integrated Medical Staff meetings per calendar year.

ARTICLE 10

ORGANIZATION OF CLINICAL DEPARTMENTS

10.1 Clinical Departments. Autonomous Clinical Departments, often of common name and including the same or similar subspecialties, exist at each Hospital Campus. Departments may integrate enterprise-wide with the vote of a majority of Department Members at each Hospital Campus. No MEC, SMEC, or Board action is necessary. Departments may be established or dissolve at either or both Hospital Campus(es) by the Board of Directors after considering recommendations from the Medical Executive Committee of the affected Hospital Campus(es).

SUSSEX	KENT
	Department of Ambulatory Medicine
Department of Anesthesia	
	Department of Cardiology
Department of Diagnostic Imaging	
Department of Emergency Medicine	
Department of Family Medicine	Department of Family Medicine
Department of Medicine	Department of Medicine
Department of OB/GYN	Department of OB/GYN
Department of Pathology	
Department of Pediatrics	Department of Pediatrics
Department of Psychiatry	
Department of Surgery	Department of Surgery
	Department of Hospitalists

10.2 Functions of Departments.

10.2.1 Each Department shall develop the delineation of Privileges for that Department. It is the responsibility of each individual Department, as communicated by the Department Chair, to advise the Integrated Credentials Committee regarding the criteria for determining Clinical Privileges for the Department. Such criteria shall be consistent with these Bylaws, the Bylaws of the Corporation, the Rules and Regulations, and the policies and procedures of the Hospital Campus, and

shall be approved by the Medical Executive Committee at the relevant Hospital Campus.

10.2.2 Each Department shall be responsible for reviewing relevant cases referred by the Performance Improvement Committee and Utilization Review Committee.

10.2.3 The Medical Executive Committee of each Hospital Campus shall work with the Super Medical Executive Committee to ensure consistency among the criteria of the Departments.

10.3 Divisions

10.3.1 A Division can be requested by a group of physicians numbering five (5) or greater who wish to form a division within a department.

10.3.2 The request to form a Division must be in writing to the Department Chairperson and be approved initially by the full Department. It then shall be forwarded to the respective MEC, Board PI, and Board of Directors for final approval.

10.3.3 The sole function of a Division is to resolve issues within the subspecialty and advise the Chairperson regarding subspecialty issues.

10.3.4 Any recommendations or policies developed by a Division must be submitted and approved by the full department. Departmentally approved policies or recommendations shall be sent to the MEC and Board PI for final approval.

10.4 Department Chairperson.

10.4.1 The Chairperson of each Department shall be a Member of the Active Staff or Provisional Active Staff of the Department and shall be certified in a specialty unless the Department Membership has affirmatively determined that the Chairperson possesses comparable competence.

10.4.2 The Chairperson and Assistant Chairperson of each Department shall be selected every two years by Members of the Department prior to the annual meeting of the Medical Staff subject to approval by the Board of Directors, except that in Departments where the Department Chairperson is under a contractual arrangement with Bayhealth, Inc., the Department Chairperson shall be appointed by the Board of Directors. In the event the Board of Directors disapproves the selection of the Department, it shall notify the Medical Executive Committee in writing explaining the reason(s) for such disapproval. If the Chairperson is unable to finish his/her term for any reason, the Assistant Chairperson shall serve as Chairperson to the end of the term. There is no limit on the number of terms that may be served by a Department Chairperson.

10.4.3 Each Department Chairperson shall:

10.4.3.1 Be accountable for all professional and administrative activities within the Department.

10.4.3.2 Assure that the quality and appropriateness of patient care within the Department are monitored and evaluated.

10.4.3.3 Maintain continuing review of the professional performance of Practitioners in the Department and report and recommend thereon to the Integrated Credentials Committee when appropriate. Such review may include requiring a Member of the Department to attend

a specified meeting for discussion of his/her clinical work.

10.4.3.4 Be responsible for enforcement within the Department of the Bylaws of the Corporation, these Bylaws, and the Rules and Regulations, including those pertaining to the establishment and fulfillment of on-call obligations.

10.4.3.5 Be responsible for departmental implementation of actions prescribed by the Medical Executive Committee, Super Medical Executive Committee or Board of Directors.

10.4.3.6 Recommend to the Integrated Credentials Committee on matters concerning the appointment, reappointment and delineation of Clinical Privileges for all Members of and applicants to the Department.

10.4.3.7 Be responsible for the establishment, implementation and effectiveness of the teaching, education and research program in the Department.

10.4.3.8 Be responsible for the general administration of the Department, reporting and recommending to Hospital management when necessary with respect to matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.

10.4.3.9 Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment and services not provided by the department or the organization.

10.4.3.10 Be responsible for integration of the department or services into the primary functions of the organization.

10.4.3.11 Be responsible for coordination and integration of interdepartmental and intradepartmental services.

10.4.3.12 Be responsible for development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

10.4.3.13 Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services.

10.4.3.14 Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

10.4.3.15 Assist the Hospital management in the preparation of annual reports and budget planning pertaining to the Department as may be required by the Chief Executive Officer of the Board of Directors.

10.4.3.16 Assign duties to an Assistant Chairperson of the Department as deemed appropriate.

10.4.3.17 In a Department where sections or divisions have been established, make recommendations as to the appointment of section or division chiefs based upon suggestions from that sub-Department.

10.4.3.18 Review the criteria for Clinical Privileges in the Department on an annual basis and recommend changes to departmental or subspecialty delineations of Clinical Privilege when necessary.

10.4.3.19 The Department Chairperson may delegate from time to time as appropriate and necessary some of these duties.

10.4.3.20 At their discretion, may allow or disallow non-members to attend department meetings.

10.4.4 A Department Chairperson may serve as both an officer of the Medical Staff and Chairperson of that Department only upon the recommendation of the Membership of that Department.

ARTICLE 11

COMMITTEES OF THE MEDICAL STAFF

11.1 Hospital Campus Autonomy. The standing committees of the Medical Staff will include the following:

Bylaws Committee
Cancer Committee
Infection Prevention Committee
Integrated Credentials Committee
Medical Executive Committee
Nominating Committee
Performance Improvement Committee
Pharmacy and Therapeutics Committee
Super Medical Executive Committee
Trauma Committee

These committees and any ad hoc committees may be integrated through the consent of the majority of the Medical Staff Membership of each committee during the same Medical Staff Year and upon consent of the Board of Directors. Members of any committee at a Hospital Campus which is not integrated, however, may attend and participate, but may not introduce motions or vote, in the meetings of the counterpart committee at the other Hospital Campus, if an Active or Provisional Active Staff Member at both hospitals.

11.1.1 Every committee of the Medical Staff shall maintain minutes and shall report to the respective Hospital Campus Medical Executive Committee. Integrated Medical Staff committees shall report to both MECs.

11.1.2 Reports. In addition to the reports required of any committee, the committee shall report to the Medical Executive Committee any instances involving questions of clinical competency, professional ethics, and infraction of these Bylaws, the Rules and Regulations, the Corporation's Bylaws, or other Hospital Campus policies or procedures.

11.1.3 Ad Hoc Committees. Ad hoc committees may be appointed at any time by the Division or SMEC President of the Medical Staff, with the approval of the Hospital Campus Medical Executive Committee and the Super Medical Executive Committee, to perform functions which are not within the purview of any standing committee. Each such committee shall confine its functions to the purposes for which it is appointed, shall report to the Hospital Campus Medical Executive Committee and be dissolved upon the completion of its assignment.

11.2 Super Medical Executive Committee.

11.2.1 Membership. The composition of this committee shall include those Medical Staff Members who serve as Medical Staff officers at each Hospital Campus and shall consist of the Presidents, Vice Presidents, Secretary/Treasurers, and Immediate Past Presidents of each Hospital Campus.

11.2.2 Duties. The duties of the Super Medical Executive Committee shall include but not be limited to addressing those issues affecting each Hospital Campus in the System such as quality assurance, risk management, and administration of the Medical Staff. Specifically, the Super

Medical Executive Committee shall:

11.2.2.1 Review and consider the information provided in actions recommended within each Medical Executive Committee set of minutes;

11.2.2.2 Intervene so as to resolve any Medical Staff credentialing, corrective action, or suspension related matter either directly referred to it or referred due to simultaneous incompatible actions at the respective Hospital Campuses;

11.2.2.3 Perform investigations or reviews as suggested by the action of a Medical Executive Committee or the Board of Directors;

11.2.2.4 Facilitate the resolution of any intercampus disagreement when requested to do so by the Board of Directors or the governing body of either Hospital's Medical Staff component;

11.2.2.5 Review the criteria of Department policies and procedures of each Hospital Campus to ensure consistency; and

11.2.2.6 Assist in standardizing departmental policies and procedures when requested by a majority of Department Members from each Hospital Campus.

11.2.2.7 The Super Medical Executive Committee shall meet at least quarterly and the Chairperson will maintain minutes of all meetings. Copies of all minutes and reports of this body shall be transmitted to the Chief Executive Officer routinely as prepared and important actions of the Super Medical Executive Committee shall be reported to the Medical Staff at each quarterly Medical Staff meeting. Recommendations of the Super Medical Executive Committee shall be transmitted to the Chief Executive Officer and through him/her to the Board of Directors or its applicable committee(s).

11.2.3 Super MEC or MEC decisions may be overridden by majority vote of the campus-specific medical staff division. If one campus votes in the majority to overturn a Super MEC decision or action, the issue will be automatically placed on the agenda of the next full staff meeting of the other campus-specific medical staff division. If both medical staffs vote in the majority against the Super MEC decision or action, it will be rescinded.

11.3 Medical Executive Committee.

11.3.1 Composition. The voting Members of the Medical Executive Committee at each Hospital Campus shall consist of the officers of the Medical Staff at each Hospital Campus, and the Chairperson of each Department at the Hospital Campus. The Hospital Campus Medical Staff Officers consist of the Immediate Past President, the President, the Vice President and the Secretary-Treasurer. Non-voting Members of the Medical Executive Committee shall consist of the Chief Executive Officer, the Chief Operating Officer, the Chief Medical Officer, the Senior Vice President for Patient Care Services, the Vice President for Quality and Medical Affairs, the Trauma Director, Integrated Credentials Committee chair, GME Committee Chair and the Medical Staff Peer Review Committee Chair.

11.3.1.1 In the absence of the Department chair, an Assistant Department Chair may represent the Department as a voting Member on a meeting-to-meeting basis. Except as specifically provided for in these Bylaws, no one may substitute for a Medical Staff Officer except to chair a meeting as set forth herein.

11.3.1.2 In the absence of a Medical Staff Officer, another officer may perform a required function on a meeting-to-meeting basis. The hierarchy for one officer to substitute for the President shall be the Immediate Past President, the Vice President, and then the Secretary-Treasurer.

11.3.2 Duties. The duties of the Medical Executive Committee shall be, with respect to each Hospital Campus:

11.3.2.1 To represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters requiring immediate attention between meetings of the Medical Staff.

11.3.2.2 To coordinate the activities and general policies of the various Departments.

11.3.2.3 To receive and act upon Medical Staff committee reports, and to make recommendations concerning such reports to the Chief Executive Officer, Chief Operating Officer and Board of Directors.

11.3.2.4 To provide liaison among the Medical Staff, its officers, and the Board of Directors.

11.3.2.5 To recommend action to the officers on matters relating to medico-administrative and Hospital Campus management.

11.3.2.6 To take all reasonable steps to ensure professionally ethical conduct and to enforce these Bylaws, the Rules and Regulations and the Corporation's Bylaws in the best interest of patient care and the Hospital Campus on the part of all Practitioners.

11.3.2.7 To review periodically all information available regarding the performance and clinical competence of Practitioners and, as a result of such review, to make recommendations for reappointments and renewal of, or changes in, Clinical Privileges.

11.3.2.8 To review the credentials of all applicants and to make recommendations for Medical Staff Membership, assignments to Departments, delineations of Clinical Privileges, and disciplinary actions.

11.3.2.9 All actions or items brought to the Medical Executive Committee for a vote MUST be placed on the Agenda BEFORE the respective MEC meeting and identified as an item or action for vote. MEC members MUST be provided with information regarding the item or action for vote at least ten (10) days in advance of the MEC meeting. Otherwise voting WILL be deferred to a subsequent meeting.

11.3.2.10 All actions or items approved by vote of the MEC which may affect privileges or result in a variance shall be placed on the agenda of the subsequent Full Staff meeting(s) as an informational item. In addition, Department Chairs must post the item or action on the agenda of their meeting subsequent to the respective MEC meeting for discussion and feedback. This Bylaw will not apply to MEC duties regarding credentialing, leave of absences, corrective actions, hearings, appeals or conflict management issues as stipulated in other areas of the Bylaws.

11.3.3 Liaison with Board of Directors. The Chairperson of the Medical Executive Committee and such Members of the committee as deemed necessary by the Chairperson shall be available to meet with the Board of Directors or its applicable committees on all recommendations that the Medical Executive Committee may make for the purpose of providing direct communication between the Board and the Medical Executive Committee on all matters in the scope of the Medical Executive Committee's duties.

11.3.4 Liaison with Super Medical Executive Committee. The Chairperson of the Medical Executive Committee and such Members of the committee as deemed necessary by the Chairperson shall be available to meet with the Super Medical Executive Committee on all recommendations that the Medical Executive Committee makes.

11.3.5 Meetings, Reports and Recommendations. The Medical Executive Committee shall meet at least once a month or more often if necessary to transact pending business. The President (or substitute presiding officer) shall have the right to call the Committee into executive session, at which session only voting Members shall be in attendance. The President (or substitute presiding officer) shall have discretion to request the presence of guests to provide information or for other legitimate reasons. The Secretary will maintain minutes of all meetings, which minutes shall include the reports for the various committees and Departments of the Medical Staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Chief Executive Officer and the Super Medical Executive Committee routinely as prepared and important actions of the Medical Executive Committee shall be reported to the Medical Staff as a part of the Medical Executive Committee's report at each quarterly Medical Staff meeting. Recommendations of the Medical Executive Committee shall be transmitted to the Chief Executive Officer and through him/her to the Board of Directors or its applicable committees.

11.4 General Organization of Committees.

11.4.1 Chairpersons. Appointment of all Committee Chairpersons, unless otherwise provided for in these Bylaws, will be made annually by the President Elect of the Medical Staff at each Hospital Campus and be subject to approval by the Board of Directors. Chairpersons of integrated committees will be appointed annually by the Super MEC President Elect and be subject to approval by the Board of Directors. The only exception is the Bylaws Chair who is elected by the Committee Membership (11.10.1). In the event the Board of Directors disapproves the selection, it shall notify the relevant Medical Executive Committee in writing the reason(s) for such disapproval. All Chairpersons shall be selected from among members of the Active or Provisional Active Staff.

11.4.2 Membership.

11.4.2.1 Members of each single Hospital Campus Committee, except as otherwise provided in these Bylaws, shall be appointed yearly by the President of the Medical Staff, with no limitation on the number of terms they may serve.

11.4.2.2 Membership of integrated committees will be appointed annually by the Super MEC President.

11.4.2.3 The Chief Executive Officer and the President of the Medical Staff or their respective designees shall be Ex Officio Members, without vote, on all committees, unless otherwise provided for in these Bylaws.

11.4.2.4 Appointed Members, except the Chairperson, may be added or removed

by the President of the Medical Staff at his/her discretion. Removal of a Chairperson and appointment of his/her successor may be effected by the President of the Medical Staff subject to approval of the Medical Executive Committee and the Board of Directors.

11.5 Integrated Credentials Committee.

11.5.1 Composition. The Integrated Credentials Committee shall consist of at least ten (10) Members of the Active Staff with equal representation from each campus, who, if practicable, shall not be serving simultaneously as a Department Chairperson, or a voting Member of the Medical Executive Committee.

11.5.2 Duties. The duties of the Integrated Credentials Committee shall be:

11.5.2.1 To review the credentials of all applicants, to ensure such investigations and interview all applicants as may be necessary, and to make recommendations for appointment and delineation of Clinical Privileges in compliance with these Bylaws.

11.5.2.2 To make a report to their respective Medical Executive Committee on each applicant for Medical Staff Membership or Clinical Privileges, including specific consideration of the recommendations from the Departments in which such applicant requests Clinical Privileges.

11.5.2.3 To review periodically on its own motion or as questions arise all information available regarding the professional and clinical competence of Medical Staff Members, their care and treatment of patients and case management, and as a result of such review to make recommendations to the respective Medical Executive Committee for the granting, reduction or withdrawal of privileges, reappointments, and changes in the assignment of Medical Staff Members to the Departments, and to various categories of the Medical Staff.

11.5.2.4 The Integrated Credentials Committee shall have the authority to obtain guidance from outside consultants, as necessary, as an approved expense of the credentialing process when it needs expertise not available within the Committee to fulfill its obligations.

11.5.3 Meetings, Reports and Recommendations. The Integrated Credentials Committee shall meet as determined by the Chairperson no less frequently than monthly and shall maintain minutes of its proceedings and actions and shall report its recommendations to the Medical Executive Committee.

11.6 Medical Staff Peer Review Committee.

11.6.1 There shall be a Medical Staff Peer Review Committee at Bayhealth. Their duties and meetings shall be as provided in the Performance Improvement Plan as adopted and amended from time to time by the Board of Directors upon recommendation of these committees.

11.6.2 The duties involve, but are not limited to, adopting specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care by establishing objective indicators that will be measured, analyzed and acted upon with findings reported to the Medical Executive Committee on a monthly basis.

11.7 Pharmacy and Therapeutics Committee.

11.7.1 Composition. The Pharmacy and Therapeutics Committees at each Hospital

Campus shall consist of at least three representatives of the Medical Staff, one representative from the nursing service, one representative from Hospital administration and a pharmacist appointed by the Director of Pharmacy.

11.7.2 Duties. The Pharmacy and Therapeutics Committee shall examine and survey all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

11.7.2.1 Serve as an advisory group to the Medical Staff and the pharmacist on matters pertaining to the choice of available drugs.

11.7.2.2 Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

11.7.2.3 Develop and review periodically a formulary or drug list for use in the Hospital.

11.7.2.4 Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

11.7.2.5 Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

11.7.2.6 Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

11.7.3 Meetings. The Pharmacy and Therapeutics Committee shall meet at least every other month, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Executive Committee and the Chief Executive Officer.

11.8 Integrated Infection Prevention Committee.

11.8.1 Composition. The Integrated Infection Prevention Committee at each Hospital Campus shall consist of at least one Physician representative from a Clinical Department other than the Department of Pathology, a Physician from the Department of Pathology, a representative from the Infection Control Department, a registered nurse otherwise clinically engaged in providing patient care services, and an administrative representative.

11.8.2 Duties. The Integrated Infection Prevention Committee, through its Chairperson or Physician Members, has the authority to institute any appropriate studies or control measures when there is reasonably considered to be a danger to any patient or personnel. Whenever possible, the Committee Chairperson will consult with the appropriate Physician or Department Chairperson prior to instituting any control measures. The Integrated Infection Prevention Committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards and the Supervision of infection control in all phases of the Hospital's activities including:

11.8.2.1 Operating rooms, delivery rooms, recovery rooms, and special care

units.

11.8.2.2 Sterilization procedures by heat, chemicals or otherwise.

11.8.2.3 Isolation procedures.

11.8.2.4 Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment.

11.8.2.5 Testing of Hospital personnel for carrier status.

11.8.2.6 Disposal of infectious material.

11.8.2.7 Required cultures of personnel or of the environment.

11.8.2.8 Antimicrobial susceptibility or resistance trend studies including recommendations to the Medical Executive Committee regarding antibiotic usage in the Hospital.

11.8.2.9 The relation of infection to length of stay.

11.8.2.10 Infections during hospitalization not reported in the final diagnosis, as referred by the Performance Improvement Committee.

11.8.2.11 Other situations as requested by the Medical Executive Committee or other Medical Staff or Corporate Committees.

11.8.3 Meetings, Reports and Recommendations. The Integrated Infection Prevention Committee shall meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report to the Medical Executive Committee, the Chief Executive Officer and the Director of Nursing Services.

11.9 Nominating Committee.

11.9.1 Composition. Each Hospital Campus Nominating Committee shall consist of the Past President, the President and the Vice President. The Chairperson of the Nominating Committee shall be the immediate Past President.

11.9.2 Duties. The Nominating Committee shall nominate candidates for the elected officers of the Medical Staff. The candidates shall be presented at the quarterly Medical Staff meeting preceding the annual meeting. At that time, nominations shall also be called for from the floor.

11.10 Bylaws Committee.

11.10.1 Composition. The Bayhealth Medical Center Bylaws Committee shall include representation from each Hospital Campus with a total of at least five Members to be appointed by the President of the Super Medical Executive Committee. The Chief Nursing Officer (CNO) shall serve as a non-voting Ex-Officio Member. The Chairperson of this Committee shall be determined annually by a vote of the Membership of the Bylaws Committee. Active and Honorary Medical Staff Members are eligible for appointment to this Committee, with Honorary Staff Members appointed as non-voting members.

11.10.2 Duties. The Bylaws Committee shall review all proposed changes to the Bylaws and Rules and Regulations recommended by any Member of the Active Medical Staff.

11.10.2.1 Bylaws Committee Membership will ensure that the entirety of the Bylaws and Rules and Regulations are reviewed at least every four years, or more often if deemed necessary.

11.10.3 Meetings. The Committee shall meet at least quarterly.

11.11 Cancer Committee. Each Hospital Campus Cancer Committee will be a standing multidisciplinary group that assures the maintenance of high standards of care for oncology patients. This Committee is responsible for planning and implementing patient care guidelines, evaluation studies, performance improvement, organization/implementation and evaluation of Tumor (Cancer) Conferences, and for acting as the governing body for the Tumor (Cancer) Registry.

11.11.1 Composition. The Cancer Committee interdisciplinary should include but is not limited to representatives from the following Departments or specialties: Medical Oncology, Pathology, Radiation Oncology, General Surgery, Diagnostic Imaging, Urology, Nursing, Performance Improvement, Tumor (Cancer) Registry, Social Services, Physical Therapy, Nutrition Services, Pharmacy, Pastoral Care, American College of Surgeons Cancer Liaison Physician, and Administration.

11.11.2 Duties. The Cancer Committee responsibilities include the following: developing and evaluating the annual goals and objectives for the clinical, educational and programmatic activities related to Cancer; promoting a coordinated, multidisciplinary approach to patient management; ensuring that educational and consultative cancer conferences cover all major sites and related issues; ensuring that an active, supportive care system is in place for patients, families and staff; monitoring quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes; promoting clinical research; supervising the Cancer Registry and ensuring accurate and timely abstracting, staging and follow-up reporting; performing quality control of registry data; encouraging data usage and regular reporting; ensuring that the content of the Annual Report meets requirements; publishing the Annual Report by November first of the following year; and upholding medical ethical standards.

11.11.3 Meetings. The Committee shall meet at least quarterly.

11.12 Trauma Committee

11.12.1 Composition. The individual Hospital Campus Trauma Committees shall be chaired by the Trauma Director and Membership on this Committee shall include representatives from all the major services that treat trauma patients including, but not limited to, the Trauma Nurse Coordinator, the Trauma Nurse Registrar, a Neurosurgeon (when applicable), an Orthopedic Surgeon, an Emergency Medicine Physician, an Anesthesiologist, and the appropriate Physician administrator. Each Member of this committee shall have one vote.

11.12.2 Duties. The responsibilities of the Trauma Committee include, but are not limited to, assistance with disaster planning, designating indicators and reviewing those cases or groups of cases that fail to meet these indicators, and critically evaluating the quality and appropriateness of care across the broad spectrum of trauma presentations.

11.13 Utilization Review Committee. There shall be an integrated Utilization Review

Committee.

11.13.1 Composition. The composition shall be made up of representatives from each campus that includes administration, physicians, the Directors of Care Management, Performance Improvement, Patient Care Services, and Payor Relations and Contracting, and Risk Management.

11.13.2 Duties. The duties shall be, but are not limited to, adopting specific programs and procedures for reviewing, evaluating over utilization, underutilization, inefficient scheduling of resources and as applicable to all patients regardless of payor, through ongoing utilization review activities and education. Objective indicators will be established that will be measured, analyzed, and acted upon with findings reported to the Medical Executive Committee on a quarterly basis.

11.14 Integrated Endoscopy Committee

11.14.1 Composition. There shall be an Integrated Endoscopy Committee at Bayhealth. It will consist of active medical staff represented by at least a gastroenterologist, a surgeon, a pulmonologist, a cardiologist and an anesthesiologist.

11.14.2 Duties. The Integrated Endoscopy Committee shall create, review from time to time, and update a uniform standard of credentialing for active medical staff who perform endoscopic procedures. It shall adopt standards to evaluate endoscopic procedure safety and appropriateness of care.

11.15 Conflict of Interest. In any instance where an officer, or Department chair or committee chair, or Member of any Medical and Dental Staff committee has a conflict of interest or is biased in any matter involving another Medical and Dental Staff appointee that comes before such individual or committee, or in any instance where any such individual or committee Member brought the complaint against that appointee, such individual or Member shall not participate in that discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee Member may be asked, and may answer, any questions, concerning the matter before leaving. As a matter of procedure, the chair of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any Member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chair by any committee Member with knowledge of the matter. The fact that the officer, or Department chair or committee chair, or Member of any Medical or Dental Staff committee practices in the same field involving another Medical and Dental Staff appointee shall not in itself be construed to constitute a conflict of interest.

A Department chair shall have a duty to delegate review of applications for appointment, reappointment or modification of Clinical Privileges, or questions that may arise to a vice chair or other Members of the Department, if the chair has a conflict of interest with the individual under review.

ARTICLE 12

CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 Definitions. For the purpose of this Article, the following definitions shall apply:

12.1.1 "INFORMATION" means records of proceedings, minutes, reports, memoranda, statements, recommendations, letters, data and other disclosures whether electronic, written or oral relating to any subject matter specified in Articles 5, 6, 7 and 8 and Sections 10.2.2, 10.2.3, or relating in any way to the qualifications or performance of a Practitioner.

12.1.2 "MALICE" means the purposeful dissemination of a known falsehood or of information with a reckless disregard for whether it is true or false.

12.1.3 "PRACTITIONER" means a Member of the Medical Staff, a holder of Clinical Privileges or an applicant for Medical Staff Membership or Clinical Privileges.

12.1.4 "REPRESENTATIVE" means a board, any Member or committee thereof; the Chief Executive Officer; the Medical Staff and any Member, officer, Department, or committee thereof; and any individual authorized (either explicitly or implicitly) by any of the foregoing or these Bylaws to perform information gathering, disseminating or communicating functions.

12.1.5 "THIRD PARTIES" means individuals and organizations providing information to any Representative.

12.2 Authorizations and Conditions. By applying or reapplying for, or requesting or exercising Medical Staff status or Clinical Privileges, a Practitioner:

12.2.1 Authorizes the Hospital and Representatives to solicit, provide, receive, review, verify and act upon Information bearing on his/her professional ability, qualifications, training, background, ethics, and any other matter relevant to his/her application, reapplication or exercise of Clinical Privileges;

12.2.2 Authorizes the Hospital and Representatives to solicit, provide, receive, review, verify and act upon Information regarding his/her physical and mental health condition which may adversely affect his/her ability to care for patients or to interact appropriately with patients, patients' families and other caregivers;

12.2.3 Agrees to be bound by the provisions of this Article and to waive forever any legal and equitable claim and/or actions (whether known or unknown to the Practitioner) against the Hospital, any Representative or Third Party who acts in accordance with the provisions of this Article; and

12.2.4 Acknowledges that the provisions of this Article are express conditions to his/her application or reapplication for, or acceptance of Medical Staff status and/or Clinical Privileges, or his/her exercise of Clinical Privileges at the Hospital.

12.3 Confidentiality of Information. Information with respect to any Practitioner submitted, collected or prepared by the Hospital or its Representative for the purpose of performing functions under these Bylaws, achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to medical research shall, to the extent permitted by federal or state law, be confidential and

shall not be disseminated to anyone other than the Hospital or its designated Representatives, except as may be otherwise required by federal or state law. This confidentiality also shall extend to Information that may be provided by third parties. This Information shall not become part of any patient files. Breach of confidentiality by response to legal process apparently valid on its face or exercise of legal rights by or on behalf of or in respect of a patient shall not nullify or void any other provisions of this Article.

12.4 Confidentiality and Liability Immunity Certification. Acceptance of Staff Membership and Allied Health appointment automatically acknowledges review of and intended conformance with the "Certification, Acknowledgement, and Agreement" document previously attested to as contained in the application and has reproduced herewith:

CERTIFICATION, ACKNOWLEDGMENT AND AGREEMENT

The undersigned Applicant, in support of his/her Application For Appointment To The Medical Staff of Bayhealth Medical Center hereby certifies, acknowledges and agrees as follows:

1. I have received and read a copy of the Bylaws, Rules & Regulations of the Medical Staff, and Medical Staff Expectations Document and agree to be bound by the terms thereof in all matters relating to consideration of this application without regard to whether I am granted appointment and/or Clinical Privileges.
2. By submission of the Application, I agree:
 - A. To provide such additional Information and to appear for interview(s) as may be reasonably required in connection with the consideration of this Application;
 - B. That any act, communication, report, recommendation or disclosure, with respect to myself, performed or made in good faith and at the request of Bayhealth or any other Hospital or health care organization, in connection with the consideration of this Application shall be privileged to the fullest extent permitted by law;
 - C. That any material misstatement in or omission from this Application shall constitute good cause for denial of appointment or for summary dismissal from the Medical Staff;
 - D. To comply with all Bayhealth and Medical Staff Bylaws, policies, procedures and directives currently in force or as subsequently amended, so long as I am a Member of the Medical Staff;
 - E. To accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff;
 - F. To provide continuous care and Supervision to all patients for whom I have a responsibility as a member of the Medical Staff; and
 - G. That any material submitted to Bayhealth may be reviewed by assigned personnel at each Bayhealth Facility, and by those outside consultants and experts whom a Bayhealth Facility may call upon to assist in fulfilling its obligations under the Medical Staff Bylaws.
3. I hereby consent to and authorize:
 - A. My present and past malpractice carrier to release professional liability insurance information to Bayhealth;
 - B. Bayhealth to consult with management and members of the Medical Staffs of other hospitals and health care organizations with which I have been associated, and with others who may have information bearing on my clinical, behavioral and ethical qualifications; and

- C. Inspection by Bayhealth of all records and documents that may be material to an evaluation of my professional qualifications or competence to hold the Clinical Privileges I request or currently possess, as well as relating to my moral and ethical qualifications or stability as they may directly or indirectly affect my competence, patient care or operations of Bayhealth or any other health care institution.
4. Release and Authorization. I hereby specifically release Bayhealth from any and all liabilities for statements made or acts performed in good faith in evaluating me for any of the purposes or reasons set forth in this Application. To the fullest extent permitted by law, I grant and extend absolute immunity to Bayhealth from any and all civil liability arising from any acts, communications, reports, recommendations or disclosures involving myself performed, made or received in good faith by Bayhealth, concerning: activities related to, but not limited to, applications for appointment or Clinical Privileges, including temporary privileges; periodic reappraisals undertaken for reappointment or for increase or decrease in Clinical Privileges; proceedings for suspension of Clinical Privileges or revocation of Staff Memberships, summary suspension, hearings and appellate reviews related thereto; medical care evaluations, utilization reviews, other hospital, departmental or service or committee activities conducted under Hospital auspices relating to the quality of patient care or my professional and ethical conduct; and, concerning matters or inquiries related to my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on my competence, on patient care, or on the orderly operation of this or any other Hospital or health care organization, including otherwise privileged or confidential information.

As used in this Certification, "Bayhealth" means Bayhealth, Inc., its parent Corporation, subsidiaries and affiliated entities, the members of their Boards of Directors and their appointed Representatives, the Chief Executive Officer and his/her subordinates or designees, Bayhealth's attorneys, and their assistants or designees, all Members of the Medical Staff who have any direct or indirect responsibility for obtaining or evaluating this Application, my credentials and/or acting upon my Application or conduct at Bayhealth. The term "Third Parties" means all individuals, agencies (including government agencies, organizations, associations, partnerships, Corporations or entities whether health care organizations or not, from whom information has been requested by Bayhealth or who have requested such Information from Bayhealth.

12.5 Releases. Each Practitioner shall, at any time and from time to time upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to the requirements and conditions of this Article and shall sign written authorizations to other hospitals, state licensing boards, or other health related organizations which have Information described in Sections 12.2.1 or 12.2.2 to release such Information to the Hospital.

12.6 Cumulative Effect. 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 federal or state law and not in limitation thereof.

ARTICLE 13

ADOPTION OF RULES AND REGULATIONS

13.1 Medical Staff Rules and Regulations. The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles set forth in these Bylaws. Such Rules and Regulations shall have the effect of these Bylaws.

13.2 Department Rules and Regulations. Each Department established through these Bylaws at each Hospital Campus may formulate and implement Department policies and procedures which will become effective upon approval by the Hospital Campus Medical Executive Committee(s) and the Board of Directors. The Super Medical Executive Committee shall review such Rules and Regulations and/or policies and procedures to ensure consistency between and among the Departments at each Hospital Campus and shall report any inconsistencies to the Medical Executive Committees. Department policies and procedures shall be consistent with these Bylaws, the Rules and Regulations of the Medical Staff, and policies established by the System, the Corporation or the Hospital Campus.

ARTICLE 14

AMENDMENTS

14.1 Proposed Amendments. Any proposed amendments to the Bylaws and Rules and Regulations will be reviewed by the Bylaws Committee at a regularly scheduled meeting. They must be distributed to the Full Medical Staff Members at least 20 (twenty) calendar days prior to the meeting of the Medical Staff at which they are to be considered.

14.1.1 For such amendments to be accepted by each division Medical Staff, they must be accepted by a majority vote of the Members of the Active and Provisional Active Medical Staff who are present at the Full Medical Staff Meeting at which a Quorum is attained. Physicians with Active or Provisional Active Privileges at each Hospital Campus may vote at each Hospital Campus.

14.1.2 Proposed amendments being considered at the Full Medical Staff Meetings may be approved or disapproved in the form that was posted prior to the meeting, or tabled for referral with recommendations to the Bylaws Committee.

Such amendments that are accepted by the Medical Staff at both campuses will be forwarded for consideration to the Performance Improvement Committee of the Board.

14.2 Approved Amendments. If an amendment is rejected at either campus, it is considered to have failed.

ARTICLE 15

CONFLICT MANAGEMENT

15.1 Conflict Management Initiation. The following conflict management process shall be followed in the event of conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted medical staff bylaw, medical staff rule and regulation, or associated medical staff policy, or other significant matter. A written petition to trigger the conflict management process signed by at least 50 members of the Medical Staff shall be submitted to the President of the Medical Staff. The petition shall include

15.1.1 A clear statement of the reason for the conflict and the terms of any alternative bylaw, rule and regulation or associated policy, and

15.1.2 The designation of 3 active members of the Medical Staff as selected by the petitioners to serve as the petitioners' representatives.

15.2 Conflict Management Process. The President of the Medical Staff shall convene a meeting between the petitioners' representatives and 3 active members of the Medical Executive Committee as selected by the Chairman of the Medical Executive Committee.

15.2.1 The representatives of the Medical Executive Committee and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee and the safety and quality of patient care at the Hospital. Resolution of the matter shall require a majority vote of the representatives of the Medical Executive Committee and a majority of the petitioners' representatives. If such a resolution proposes a new or amended medical staff bylaw, medical staff rule and regulation, or associated medical staff policy, such resolution shall be forwarded to the Board of Trustees for final action.

15.2.2 If the parties' representatives are unable to reach a resolution, they may, by mutual agreement, utilize other persons skilled in conflict management to assist in resolving their conflict. Differences that remain unresolved shall be submitted to the Board of Directors for its consideration in making a final decision with respect to the proposed medical staff bylaw, medical staff rule and regulation, or associated medical staff policy, or other matter. The Board of Directors shall determine the method by which unresolved conflicts are submitted to it.

15.2.3 In matters involving Bylaws, it must go back for a vote by the Full Medical Staff.

15.3.3 At all times the participants in the conflict management process shall observe the following principles:

15.3.3.1 Resolution of all conflicts shall be undertaken in a manner that promotes productive, collaborative, and effective teamwork, and in an atmosphere of mutual respect and understanding.

15.3.3.2 Resolution of the conflict shall be consistent with the organization's mission, values, strategic objectives, policies and organizational ethics; shall protect patient safety and quality of care; and shall best serve the interests of the patient.

15.3.3.3 All discussions regarding the issues that are the subject of the conflict shall be confined to internal communications, and the highest level of confidentiality shall be maintained with respect to such discussions and issues. Communication to the public with respect to the issues is not appropriate.

ARTICLE 16

GENERAL PROVISIONS

16.1 Construction of Terms and Headings. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

16.2 Transmittal of Reports. Unless otherwise specified, all reports and other information which these Bylaws require the Medical Staff to transmit to the Board of Directors shall be deemed transmitted when delivered to the Chief Executive Officer.

16.3 Action by Board of Directors. Whenever these Bylaws require or authorize action by the Board of Directors, such action may be taken by a committee of the Board of Directors to which the Board has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

ARTICLE 17

RESERVED AUTHORITY OF THE BOARD OF DIRECTORS

17.1 Reserved Authority. No provision contained in these Bylaws or the Rules and Regulations, nor any amendments thereto, shall in any way be construed to alter the authority or powers of the Board of Directors as prescribed under Delaware law and as stated in the governing documents of the System and the Corporation.

ARTICLE 18

INDEMNIFICATION

18.1 Indemnification. The Medical Staff Bylaws Indemnification policy shall be identical to that of the current Bayhealth Inc. and Bayhealth Medical Center Indemnification policies and shall remain so as long as full indemnification is afforded to Medical Staff Leadership; most specifically the Medical Staff Executive Committee Membership and the Chairpersons of those Committees mandated by the Medical Staff Bylaws.