

ANGEL MEDICAL CENTER

MEDICAL STAFF BYLAWS

2010

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ARTICLE I - DEFINITIONS

- 1.1** “Hospital” means Angel Medical Center, Inc., of Franklin, North Carolina, and includes facilities established therein.
- 1.2** “Board” or “Board of Trustees” means the governing body having the overall responsibility for the conduct of the Hospital.
- 1.3** “Chief Executive Officer” or “CEO” means the individual appointed by the Board of Trustees to act on its behalf in the overall administrative management of the Hospital.
- 1.4** “Medical Staff” means physicians and oral surgeons who have been granted membership in such organization and who are privileged to treat in the Hospital.
- 1.5** “Physicians” includes both Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.).
- 1.6** “Oral Surgeon” means a licensed dentist who has successfully completed a post-graduate program in Oral Surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.
- 1.7** “Ex Officio” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
- 1.8** “Medical Staff Membership Categories” describes the responsibilities and prerogatives as a member of the Medical Staff.
- 1.9** “Clinical Privileges” are those procedures or acts practitioners are approved to perform in the hospital.

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

ARTICLE II - MEDICAL STAFF CATEGORIES

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff. All appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other areas as applied for and recommended pursuant to Article XII, Credentialing Process, and approved by the Board.

2.1 ACTIVE STAFF

2.1.1 Qualifications:

The Active Staff shall consist of those physicians and oral surgeons who:

- A. meet the basic qualifications for staff appointment as outlined in Article XII, Section 12.1
- B. regularly admit, consult, or perform procedures.

2.1.2 Responsibilities:

- A. assume all the functions and responsibilities of appointment to the Medical Staff including, where appropriate, care for unassigned patients and emergency service care;
- B. attend medical staff and departmental meetings;
- C. serve on medical staff and hospital committees;
- D. faithfully perform the duties of any office or position to which elected or appointed;
- E. actively participate in performance improvement and utilization review activities;
- F. and other Staff functions as may be required.

2.1.3 Prerogatives:

- A. be entitled to treat patients within the limits of their assigned clinical privileges;
- B. be entitled to vote; and
- C. be entitled to hold office.

2.2 COURTESY STAFF

Courtesy Staff members do not regularly admit or perform procedures.

2.2.1 Qualifications:

- A. meet the basic qualifications for staff appointment as outlined in Article XII;
- B. is a member in good standing on the Active Staff of another JOINT COMMISSION accredited hospital where he actively participates in quality assurance monitoring.

2.2.2 Responsibilities:

- A. shall participate in performance improvement and utilization review activities; and
- B. shall retain responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services.

2.2.3 Prerogatives:

- A. shall be entitled to treat patients within the limits of their assigned clinical privileges;
- B. are not required to assume care for unassigned patients and emergency service care;
- C. may attend medical staff and departmental meetings;
- D. shall not be eligible to vote; and
- E. shall not be eligible to hold office.

2.3 CONSULTING STAFF

2.3.1 Qualifications:

- A. meet the basic qualifications for staff appointment as outlined in Article XII;
- B. are a member in good standing on the Active Staff of another Joint Commission accredited hospital where he actively participates in quality assurance monitoring.

2.3.2 Responsibilities:

- A. consult on patients at the request of a Medical Staff member, and render a timely medical opinion, documenting it in the medical record for each consultation.

2.3.3 Prerogatives:

- A. is not required to assume care for unassigned patients and emergency service care;
- B. may order diagnostic studies;
- C. may not perform invasive procedures;
- D. may attend medical staff and departmental meetings;
- E. shall not be eligible to vote; and
- F. shall not be eligible to hold office.

2.4 HONORARY STAFF

2.4.1 Qualifications:

- A. have retired from Active Medical Staff; and
- B. are deemed deserving of Honorary Staff membership by virtue of their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous longstanding service to the Hospital.

2.4.2 Prerogatives:

- A. may attend Medical Staff meetings;
- B. may participate in Medical Staff educational activities;
- C. are not eligible to admit, attend to, or care for patients in the Hospital;
- D. are not entitled to vote;
- E. are not eligible to hold staff office;
- F. are not required to meet the CME, licensure, or insurance requirements; and
- G. are appointed for life once placed in this category.

2.5 COMMUNITY AFFILIATE STAFF

2.5.1 Qualifications:

- A. meet the basic qualifications for staff appointment in Article XII; and
- B. desire to be associated with but do not intend to practice in the hospital. The primary purposes of the Community Affiliate Staff are to enhance continuity of patient care, to promote professional and educational opportunities including continuing medical education, and to permit these individuals access to hospital services for their patients by referral to members of the medical staff for admission and care.
- C. Individuals requesting appointment or reappointment to the Community Affiliate Staff must submit an application as prescribed in Article XII, Section 12.3.

2.5.2 Prerogatives:

- A. may attend meetings of the Medical Staff without vote;
- B. have no committee responsibilities but may agree to serve on committees if requested with vote;

- C. may attend educational programs for the Medical Staff and the Hospital;
- D. may refer patients to members of the Medical Staff for admission or care but are expected to coordinate the transfer of patients to a member of the medical staff in such a way as to facilitate continuity of care;
- E. may visit their patients when hospitalized and review their medical records but may not write orders or actively participate in the provision or management of care to patients;
- F. are permitted to use the Hospital's diagnostic facilities; may order outpatient medication administration.
- G. may not admit or treat inpatients at the Hospital;
- H. may access their patients' clinical information electronically as per established Hospital policy.

2.6 REQUEST FOR CHANGE OF CATEGORY

- 2.6.1 A member of the Medical staff may request a change in membership category by submitting a written request accompanied by the reason(s) to the Medical Executive Committee for consideration. If the physician meets the qualifications for the requested category, the Medical Executive Committee shall make a recommendation to the Board of Trustees.

2.7 PHYSICIANS UNDER CONTRACT OR HOLDING ADMINISTRATIVE POSITIONS

- 2.7.1 Physicians holding appointments to the Medical Staff who have contractual or employment relationships with the Hospital shall be governed by the provisions of their contracts or the terms, conditions and provisions of employment which provisions may be more restrictive, but not less restrictive, than the Bylaws and the Rules and Regulations of the Medical Staff. The contract shall not amend or supercede the Medical Staff Bylaws or Rules and Regulations.
- 2.7.2 Individuals in administrative positions who desire membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges unless specifically addressed and approved by the Active Medical Staff.

ARTICLE III - ORGANIZATION OF THE MEDICAL STAFF

3.1 GENERAL

- 3.1.2 Medical Staff Year:

- A. For the purpose of these Bylaws, the Medical Staff year commences on the first day of October and ends on the 30th day of September.

3.1.3 Qualifications of Medical Staff Officers and other Members Performing Administrative Duties

- A. Only Active Staff members in good standing shall be eligible to serve as officers of the Medical Staff. If at any time during their term of office the individual fails to remain in good standing as an Active Staff member, such failure shall immediately result in his termination as an officer creating a vacancy in the office involved.

3.1.4 Conflict of Interest

- A. In any instance where a Medical Staff Officer (or any physician member acting on behalf of the hospital in an administrative position, i.e. committee chairperson) could be perceived as having a conflict of interest or a bias in any matter involving another Medical Staff appointee that comes before the individual or committee, or in any instance where the individual brought a complaint against that appointee, such individual may participate in the discussion but not vote on the matter, and shall be excused from the meeting during the vote. However, prior to being excused from the meeting, the individual may be asked, and may answer, any question concerning the matter.
- B. Prior to any discussion of the matter in question, the Chairperson of the committee in charge of the review shall inquire whether any member has a conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of the committee member may be called to the attention of the Chairperson by any committee member with knowledge of such.
- C. The Department Chairperson shall have a duty to delegate review of applications for appointment, reappointment, clinical privileges, and/or questions that may arise to another member of the Department if the Department Chairperson has a conflict of interest with the individual under review or could be reasonably perceived to be biased in his or her review of the matter.

3.2 MEDICAL STAFF OFFICERS

- 3.2.1 The officers of the Medical Staff shall consist of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, Chairman of Surgery and Chairman of Medicine.

3.3 DUTIES OF THE OFFICERS

- 3.3.1 The Chief of Staff shall:

- A. account to the Board for the quality, efficiency, and performance of patient care services within the Hospital, and for the effectiveness of quality assessment functions delegated to the Medical Staff;
- B. aid and coordinate Medical Staff activities with the activities and concerns of the Board, CEO, nursing and other patient care services;
- C. communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, CEO, and other Medical Staff leaders;
- D. assume responsibility for enforcing the Medical Staff Bylaws, Rules and Regulations, and policies, and recommend sanctions when necessary;
- E. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- F. serve as Chairperson of the Medical Executive Committee and may attend as an ex officio member without vote on all other Medical Staff committees; and
- G. serve as a voting member of the Board of Trustees.

3.1.3 The Vice Chief of Staff shall:

- A. assume all duties and have the authority of the Chief of Staff in the event of the Chief's temporary inability to perform due to illness, absence from the community, or unavailability for any other reason;
- B. serve on the Medical Executive Committee;
- C. automatically succeed the Chief of Staff should the office become vacated for any reason;
- D. serve as an ex officio member of the Board, and in the absence of the Chief of Staff, may vote; and
- E. perform such duties as are assigned by the Chief of Staff.

3.3.3. The Immediate Past Chief of Staff shall:

- A. serve on the Medical Executive Committee;
- B. act as advisor to the Chief of Staff; and
- C. perform such duties as are assigned by the Chief of Staff.

3.3.4 Department Chairpersons shall:

- A. serve on the Medical Executive Committee;
- B. fulfill duties of the department chairperson as outlined in Article IV.5; and
- C. perform such duties as are assigned by the Chief of Staff.

3.3.5 Other Officials of the Staff shall include Medical Directors/Advisors, Director of the Medical Education, and Treasurer. Duties are prescribed by the Medical Executive Committee and the Board of Trustees and shall be followed in a manner consistent with these Bylaws, Rules and Regulations and policies.

3.4 NOMINATION AND ELECTION PROCESS

3.4.1 Nomination and Election of Officers

- A. Candidates for office shall be nominated pursuant to any of the following methods:
 - (1) The Medical Executive Committee shall act as the Nominating Committee. The Committee shall convene at its scheduled meeting at least two months prior to the Annual Meeting and shall submit to the Vice Chief of Staff one (1) or more qualified nominees for each office. The Vice Chief of Staff shall contact the nominees to verify their willingness to serve. The names of such nominees shall be presented to the Medical Staff at least 15 days prior to the Annual Meeting. Nominees shall be presented to the Board at their Annual Meeting for approval. In the event any of the individuals nominated shall, prior to the election, refuse, be disqualified from, or otherwise be unable to accept such nomination, the MEC may submit one or more substitute nominees at the Annual Meeting.
 - (2) Nominations may also be accepted from the floor during the Annual Meeting.
- B. Officers shall be voted on at the Annual Meeting by members of the Active Staff. Voting may be by secret written ballot or acclamation. The candidates receiving the majority of the votes shall be elected.

3.4.2 Exceptions

- A. The Vice Chief of Staff shall, upon completion of his term of office in that position, immediately succeed to the office of Chief of Staff.
- B. The Chief of Staff shall, upon the completion of his term of office in that position, immediately succeed to the office of Immediate Past Chief of Staff.

3.4.3 Term

- A. The Chief of Staff shall serve a term of two (2) years, commencing on the first day of the month following the annual meeting, unless the officer resigns or is removed from office.
- B. The Vice Chief of Staff shall serve a term of two (2) years, commencing on the first day of the month following the Annual Meeting, unless the officer resigns or is removed from office.
- C. The Immediate Past Chief of Staff shall serve a term of two (2) years, commencing on the first day of the month following the Annual Meeting, unless the officer resigns or is removed from office.
- D. Department Chairpersons shall serve a term of at least one (1) year, commencing on the first day of the month following the Annual Meeting, unless the officer resigns or is removed from office.

3.4.4 Removal

- A. An officer may be removed from office by majority vote of the Medical Executive Committee or by the affirmative vote of at least two-thirds (2/3) of the voting members of the Medical Staff. Removal shall be based upon:
 - (1) failure to perform the duties of the office;
 - (2) conduct detrimental to the interests of the Hospital; or
 - (3) physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office.
- B. Prior to the initiation of any removal action, the individual in question must be provided with notice of the date at which such action shall be undertaken. The notice must be in writing and must be given at least ten (10) days prior to the date of the meeting. The Officer shall be afforded an opportunity to speak prior to a vote on such removal being taken.

ARTICLE IV - MEDICAL STAFF DEPARTMENTS

4.1 ORGANIZATION OF DEPARTMENTS

Departments shall be organized by category to promote the effective delivery of patient care services. Accordingly, each department shall be organized as a separate administrative unit of the Medical Staff and shall have a chairman who is elected pursuant to Article III, Section 4; and who has the authority, duties and responsibilities as specified in this Article IV. Each department chairman shall be directly responsible for overseeing the quality of care rendered by all practitioners within his department.

4.2 DEPARTMENT/SERVICES ASSIGNMENT

4.2.1 Departments of the Medical Staff shall be designated as follows:

- A. Department of Surgery
 - (1) Anesthesia Services
 - (2) General Surgery Services
 - (3) Obstetric/Gynecology Services
 - (4) Ophthalmology Services
 - (5) Orthopedic Services
 - (6) Otolaryngology Services
 - (7) Pain Management
 - (8) Pathology Services
 - (9) Radiology Services
 - (10) Radiation Oncology Services
 - (11) Urology Services

- B. Department of Medicine
 - (1) Ambulatory/Urgent Care Services
 - (2) Cardiology Services
 - (3) Dermatology Services
 - (4) Emergency Medicine Services
 - (4) Family Practice Services
 - (5) Gastroenterology Services
 - (6) Hospice & Palliative Care Services
 - (7) Internal Medicine Services
 - (8) Neurology Services
 - (9) Oncology Services
 - (10) Pediatric Services
 - (11) Physical Rehabilitation Services
 - (12) Pulmonary Medicine Services

4.3 FUNCTIONS OF DEPARTMENTS

- A. Conduct departmental meetings to evaluate patient care review findings and findings of the department's other review activities.

- B. Address other departmental concerns that arise from time to time.

4.4 DEPARTMENT CHAIRPERSON

4.4.1 Qualifications

- A. Each Department Chairperson shall be a member of the Active Staff and shall be certified by an appropriate specialty board or affirmatively establishes

comparable competency through the credentialing process and shall be willing and able to discharge the functions of the office.

4.4.2 Selection; Term of Office

- A. Each Department Chairperson shall be elected pursuant to Article VI 6.1.2.A. for a one (1) year term to commence on the first day of the month following the Annual Meeting. A Department Chairperson may serve consecutive offices.

4.4.3 Removal

- A. Removal of a Chairperson during term of office may be accomplished by the majority vote of 2/3 of the members of the Department.

4.5 DUTIES

Each Department Chairperson shall perform the following duties:

- (1) all clinically related activities of the department;
- (2) all administratively related activities of the department unless otherwise provided for by the Hospital;
- (3) integrate department or service into the primary functions of the organization;
- (4) coordinate and integrate interdepartmental and intra departmental services;
- (5) develop and implement policies and procedures that guide and support the provision of patient care, treatment, and services;
- (6) make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (7) continuous surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;
- (8) recommend to the medical staff criteria for clinical privileges that are relevant to the care provided in the department;
- (9) recommend clinical privileges for each member of the department;
- (10) determine the qualifications and competence of the department / service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (11) continuous assessment and improvement of the quality of care, treatment, and services provided;
- (12) 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;
- (13) maintain quality control programs, as appropriate;
- (14) ensure orientation and continuing education of all persons in the department or service;
- (15) recommend space and other resources needed by the department or service; and

ARTICLE V - MEDICAL STAFF COMMITTEES

5.1 GENERAL

There shall be a Medical Executive Committee (MEC) and such other standing and special committees of the Medical Staff as may from time to time be necessary or appropriate to perform the duties and responsibilities of the Medical Staff set forth in these Bylaws. The MEC may itself establish such committees to perform such duties and responsibilities. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by Staff representation on such Hospital management committees as are established to perform such duties.

5.2 MEDICAL EXECUTIVE COMMITTEE

5.2.1 Composition

A. All members of the Active Medical Staff, regardless of their specialty or discipline are eligible for membership. The MEC shall consist of at least five members. The Chief of Staff shall be its Chairperson and shall preside at meetings. The other members of the MEC shall be the Vice Chief of Staff, the Immediate Past Chief of Staff, Chairperson for the Department of Surgery and Chairperson for the Department of Medicine to be elected annually by the Medical Staff. The CEO, COO, CNO, Director of Quality Resources, Physician Services Executive and the Medical Staff Coordinator shall serve as ex-officio member without vote.

5.2.2 Duties

A. The following are the duties of the MEC:

- (1) Act on behalf of the Medical Staff during periods between meetings.
- (2) Coordinate the activities of and policies adopted by the Staff, departments and committee functions;
- (3) Make recommendations to the Board concerning Staff appointments and reappointment, Staff category assignments, delineation of clinical privileges, specified services and corrective action,
- (4) Report to the Board and to the Staff concerning the overall quality and efficiency of patient care,
- (5) Initiate and implement Medical Staff policies,
- (6) Assume responsibility for Staff compliance with accreditation standards, and
- (7) Represent the Medical Staff in matters before the Board.
- (8) Review and act on reports of medical staff committees, departments and other assigned activity groups;

- (9) Review all credentials of applicants for medical staff membership and delineated clinical privileges;
- (10) Make recommendations regarding the mechanism designed to review credentials and delineate individual clinical privileges;
- (11) Develop the mechanism by which medical staff membership may be terminated.
- (12) Create the mechanism designed for use in fair hearing procedures.
- (13) Review the Medical Staff Bylaws, Rules and Regulations at least annually, including submitting recommendations to the Medical Staff and then to the Trustees for changes in the documents;
- (14) Assure effective processes for monitoring the quality of care provided by the medical staff including peer review.

5.2.3 Meetings

- A. The MEC shall meet at least 10 times per year and maintain a permanent record of its proceedings and actions. The MEC shall also present pertinent information, if any, at each general Medical Staff meeting.

5.3 JOINT CONFERENCE COMMITTEE

5.3.1 Composition

- A. The Joint Conference Committee shall be composed of the six (6) members of the Board Executive Committee, the five (5) members of the Medical Executive Committee, and the CEO.

5.3.2 Duties

- A. The Joint Conference Committee shall provide a forum for the discussion of matters of Hospital and Medical Staff policy, practice and planning and for interaction among the Medical Staff, the Board and the Hospital.
- B. The Joint Conference shall meet as needed (PRN) and maintain a permanent record of its proceedings and actions.

5.4 MATERNAL/FETAL COMMITTEE

5.4.1 General Purpose

The general purpose of the Maternal/Fetal Committee is to monitor and evaluate clinical aspects in Women's and Children's Services.

5.4.2 Composition

The Maternal/Fetal Committee shall consist of an Obstetrician/Gynecologist to serve as chairperson. If there is no OB/GYN, the Committee will elect a chairman. In addition, membership shall consist of a pediatrician, a family practice physician with OB privileges, a physician member at large, the director of Women's & Children's Unit. The Hospital Risk Manager and the Chief Nursing Officer shall serve as ex officio members.

5.4.3 Specific Duties

A. The functions of the Maternal/Fetal Committee are:

1. to meet at least quarterly and present a written report to the MEC and make recommendations as necessary;
2. review cases on the following:
 - All 5 minute Apgar Scores less than 7
 - All Maternal Blood Transfusions
 - All Cesarean Hysterectomies
 - All Neonatal Transfers
 - All Maternal and/or neonatal deaths
 - Other cases which the medical staff or nursing staff feel needs to be addressed.
3. invite a physician to a meeting or respond to a question with written correspondence if necessary.

5.5 CREATION OF STANDING COMMITTEES

A. The Medical Executive Committee may, with amendment to these bylaws as necessary and approval of the Board, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties or compensation as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

5.6 OTHER COMMITTEES

A. Other Ad Hoc Committees or "teams" may be formed as appropriate. Reports of the activities shall be made to the MEC.

ARTICLE VI - MEETINGS OF THE MEDICAL STAFF

6.1 MEDICAL STAFF MEETING

6.1.1 Regular Meetings of Medical Staff

- A. There shall be regular meetings of the Medical Staff in March, June, and December. The Chief of Staff shall determine the order of business at the regular meetings. The agenda shall include at least the following:
- (1) Acceptance of the minutes of the last meeting and of all special meetings held since the last regular meeting;
 - (2) Reports from the CEO, the Chief of Staff, Department Chairmen and appropriate committee chairpersons, including, but not limited to the overall results of patient care valuation and quality maintenance activities of the Staff and fulfillment of other required Staff functions.
 - (3) Other old and new business as appropriate.

6.1.2 Annual Meeting of the Medical Staff

- A. There shall be an annual meeting of the Medical Staff in September. The Chief of Staff shall determine the order of business at the annual meeting. The agenda shall include at least the following:
- (1) Annual report from the Treasurer;
 - (2) The election of officers and other officials of the Staff;
 - (3) Announcement of committee assignments and Medical Directors.
 - (4) Other business as outlined in 6.1.1.A.

6.2 SPECIAL MEETINGS

- A. Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC or shall be called upon the written request of no less than twenty percent (20%) of members of the Active Staff. The person or persons calling or requesting the special meeting shall state the purpose of such meeting in writing. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by mail and their votes returned to the Chief of Staff by mail. Such a vote shall be binding so long as the questions are voted on by a majority of the Staff eligible to vote. No business shall be transacted at any special meeting except that stated in the meeting notice.

ARTICLE VII - PROVISIONS COMMON TO ALL MEETINGS

7.1 QUORUM

- A. The presence of any Active Medical Staff member at any regular or special meetings shall constitute a quorum for the purposes of amendment to these Bylaws. All actions taken after a quorum is established shall be binding even though less than a quorum may be present at a later time in the meeting.

- B. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall constitute action of that group. Action may be taken without a meeting if a unanimous consent in writing setting forth the action so taken is signed by each appointee entitled to vote thereat.

7.2 MINUTES

Except as otherwise provided in these Bylaws, minutes of all meetings shall be prepared and retained. They shall include, at a minimum, a record of attendance of members and any conclusion, recommendation or action. A copy of the minutes shall be forwarded to members and made available to the Staff.

7.3 ATTENDANCE

- A. There are no meeting attendance requirements.
- B. Absence, excused or unexcused, shall not be differentiated for any meeting.

7.4 MEETING PROCEDURES

The order of business at all Staff or committee meetings shall be determined by the Chief of Staff or Committee Chairman.

7.5 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any Medical Staff meeting, any special meeting, or of any committee meeting not held pursuant to resolution, shall be delivered either personally or by mail to each person entitled to be present to attend such meeting not less than fourteen (14) nor more than thirty (30) days before the day of such meeting.

7.6 SPECIAL APPEARANCE

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a committee meeting shall be so notified. The chairperson of the committee shall give the practitioner at least fourteen (14) days advance written notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, "special notice" shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he was given such "special notice" shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or a portion of the practitioner's clinical privileges. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Trustees.

ARTICLE VIII - ROLE IN ORGANIZATIONAL PERFORMANCE IMPROVEMENT

8.1 PERFORMANCE IMPROVEMENT

A. The Medical staff has a leadership role in organization performance-improvement activities designed to ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership for the process measurement, assessment, and improvement. These processes include, though are not limited to those within the:

- (1) Medical assessment and treatment of patients.
- (2) Use of medications.
- (3) Use of blood and blood components
- (4) Operative and other operative procedure(s).
- (5) Appropriateness of clinical practice patterns.
- (6) Significant departures from established patterns of clinical practice.
- (7) The use of developed criteria for autopsies.

B. The medical staff has a leadership role in organization performance-improvement activities designed to ensure that the medical staff participates in the measurement, assessment, and improvement of other patient care processes. These processes include, though are not limited to, those related to:

- (1) Education of patients and families.
- (2) Coordination of care with other practitioners and hospital personnel, as relevant to the care, treatment and services of an individual patient.
- (3) Accurate, timely, and legible completion of patients' medical records.
- (4) Findings of the assessment process relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.
- (5) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

8.2 FOCUSED PROFESSIONAL PRACTICE EVALUATION AND ONGOING PROFESSIONAL PRACTICE EVALUATION

A. Focused Professional Practice Evaluation (FPPE): Evaluation of performance to determine privilege-specific competence of a practitioner who does not have documented evidence of proficiency in performing the requested privilege at the organization; to evaluate and determine professional performance; or when a question arises about a currently privileged practitioner's ability to provide safe, high quality patient care - i.e. information from ongoing evaluation.

- B. Ongoing Professional Practice Evaluation (OPPE): Routine monitoring of current competency for current medical staff members through systematic data and evaluation. If unacceptable results are reported, this will be reviewed with the physician before further action is taken.

ARTICLE IX - GENERAL PROVISIONS

9.1 BOARD APPROVAL AND INDEMNIFICATION

- A. All Medical Staff Officers, Committee Chairpersons, Committee Members, and individual staff appointees who act for and on behalf of the Hospital in discharging their hospital responsibilities and professional review activities pursuant to these Bylaws and Rules and Regulations shall be indemnified, to the fullest extent permitted by law, upon approval of the appointment and/or election of the individual by the Board.

9.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges or approved to render specified services in the Hospital shall continuously maintain in force professional liability insurance in not less than the minimum amounts as determined by the Board. The minimum amount of such insurance shall be a minimum of \$1,000,000 per occurrence, per named insured. Policy coverage shall be applicable to the entire tenure of appointment. Each practitioner shall continuously provide satisfactory evidence of such coverage to the Executive Committee and shall immediately notify the Chief of Staff or the Medical Staff Office of any change in such coverage.

9.3 MEDICAL STAFF DUES

The Medical Staff will establish the amount of the annual Staff dues. Dues shall be payable to the Treasurer at the beginning of each new Medical Staff year.

9.4 CONFIDENTIALITY

- A. Members of the Staff shall respect and preserve the confidentiality of all communications and information relating to Credentialing, peer review and quality assurance activities. Any breach of this provision, except as required by law, shall subject the Staff member to corrective action.
- B. HIPAA PRIVACY RULE: OHCA (Organized Health Care Arrangement)
Members of the medical staff will follow the Joint Notice of Privacy Practices and facility policies and procedures.

9.5 MEDICAL STAFF CRISIS

A crisis of the Medical Staff shall be defined as the loss or imminent loss of a physician specialty/service as determined by the Medical Executive Committee or the Chief of Staff. If the Chief of Staff declares a medical staff crisis, the Medical Executive Committee will concur with or reverse the Chief of Staff's declaration. If the Medical Executive Committee concurs, it will recommend a response to the Board of Trustees, which may adopt, modify, or reject the Medical Executive Committee's recommendation.

ARTICLE X - RULES AND REGULATIONS OF THE MEDICAL STAFF

10.1 PURPOSE

Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with these Bylaws. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital and shall act as an aid to evaluating performance under, and in compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

ARTICLE XI - ADOPTION AND AMENDMENT OF BYLAWS/RULES AND REGULATIONS

11.1 ADOPTION

- A. The medical staff develops and adopts bylaws and rules and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body.
- B. The medical staff bylaws / rules and regulations are adopted by the medical staff and approved by the governing body before becoming effective. Neither body may unilaterally amend the medical staff bylaws or rules and regulations.
- C. The medical staff bylaws / rules and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.

11.2 AMENDMENTS

Proposed amendments to the medical staff bylaws/ rules and regulations shall be presented to the Medical Executive Committee for consideration. Upon approval by the Medical Executive Committee, the proposed amendment shall be mailed in ballot form to active members of the medical staff. The medical staff shall be given 30 days to review and vote on the amendment. If the proposed amendment passes, it shall be presented to the Board of Trustees for approval.

11.3 TECHNICAL MODIFICATIONS

The Medical Executive Committee shall have the power to adopt such changes to these Bylaws / Rules and Regulations as are, in its judgment, technical modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately.

11.4 CONSTRUCTION OF TERMS AND HEADINGS

Except as otherwise stated herein, words used in these Bylaws / Rules and Regulations shall be read as the masculine or feminine gender and as singular or plural, as the context requires. The captions and headings in these Bylaws / Rules and Regulations are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws / Rules and Regulations.

11.5 PRIOR BYLAWS

These Bylaws / Rules and Regulations shall be adopted and made effective upon their approval by the Board and shall supersede and replace any and all previous Medical Staff Bylaws / Rules and Regulations.

ARTICLE XII - APPOINTMENT TO THE MEDICAL STAFF

12.1 QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

12.1.1 General:

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent physicians who continuously meet the qualifications, standards, and requirements set forth in Article XII and in policies as are adopted by the Board. All physicians practicing medicine in this Hospital must be appointed to the Medical Staff.

12.1.2 Specific Qualifications

- A. Only physicians and oral surgeons who satisfy the following conditions shall be qualified for appointment to the Medical Staff:
- B. Holds a current unrestricted license to practice in this state.
The individual possess the requisite professional education and training, including completion of an approved residency program, experience and demonstrated ability to provide optimal patient care.
- C. Community Affiliate Staff are strongly encouraged to become board certified, but are not required to do so. New applicants for Active, Courtesy and

Consulting Staff shall be board certified or eligible to take the certification exam by a board recognized by The American Board of Medical Specialties, the American Osteopathic Association (AOA), or the American Board of Physician Specialties. Physicians working at the Urgent Care shall be board certified/eligible in Family Practice, Emergency Medicine or Med-Peds. If a physician, other than a Community Affiliate Staff member, is not certified but eligible to take the certification exam, the physician must become certified within six years. The MEC can offer up to a two year extension for obtaining board certification upon the acceptance of a specific plan for obtaining certification within that timeframe. Otherwise, the physician will not be eligible for reappointment to the medical staff. Once certified, physicians are strongly encouraged to maintain their certification.

- D. Possess current, valid professional liability insurance coverage in the amount of at least one (1) million dollars per claim and one (1) million dollars in the aggregate, with a company licensed or approved by the state of North Carolina. (New applicants must furnish certification of compliance at the time application is being made; appointees must submit a current certificate of insurance that verifies compliance with this requirement).
- E. Initial applicants shall present a minimum of 60 hours Category I CME or 40 hours of category I and 20 hours Category II. The American Medical Association (AMA) Physicians Recognition Award certificate will serve as documentation of this requirement.
- F. Physician and oral surgeon applicants can document their:
 - (1) background, experience, training, and demonstrated competence;
 - (2) adherence to the ethics of their profession;
 - (3) good reputation and character, including the ability to safely and competently perform the clinical privileges as requested;
 - (4) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them at the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner; and
 - (5) can attest to the fact that they have never been convicted of a felony or any crime related to fraud.

12.1.3 No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual:

- A. is licensed to practice a profession in this or any other state;
- B. is a member of any particular professional organization;
- C. has had in the past, or currently has, Medical Staff appointment or privileges at any other hospital; or

- D. resides in the geographic service area of the Hospital.

12.1.4 Non-Discrimination

No individual shall be discriminated against on the basis of age, disability, sex, race, religion, color, or national origin or any other criteria unrelated to the delivery of quality patient care in the Hospital.

12.2 BASIC RESPONSIBILITIES FOR APPLICANTS AND APPOINTEES

12.2.1 Each applicant or appointee shall:

- A. provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;
- B. work cooperatively with Medical Staff appointees, Allied Health Professionals, nurses and other Hospital personnel as outlined in the Code of Conduct Policy;
- C. conduct themselves consistent with the Hospital Mission;
- D. accept committee assignments and such other reasonable duties and responsibilities, including professional review activities, quality assessment activities, service call, and patient care rotations as assigned;
- E. participate in the monitoring and evaluation activities of clinical departments;
- F. seek consultation whenever necessary;
- G. complete in a timely manner the medical other required records for all patients, as required by the Bylaws and the Medical Staff Rules and Regulations;
- H. participate in continuing education programs;
- I. abide by generally recognized ethical principles applicable to the applicant's profession;
- J. abide by all Bylaws, Policies, and Rules and Regulations of the Medical Staff and Hospital;
- K. accurately represent himself to patient, family members and staff by wearing the Hospital's ID badge;
- L. refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
- M. refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- N. promptly notify the CEO of any change in eligibility for payments by third-party payers or for participation in Medicare on a reimbursable basis, including any notification of sanction(s) imposed or recommended by the federal Department of Health and Human Services or any state program, or of any change in membership status or privileges at any other hospital or healthcare facility;
- O. appear, if requested, for personal interviews in regard to the application;
- P. provide to the Medical Staff Office, with or without request, new or updated information, as it occurs, that is pertinent to any question on the application form;

- Q. agree that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment has been granted prior to discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute voluntary relinquishment of clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in Article XXI the Fair Hearing Plan;
- R. authorize the release of all information necessary for an evaluation of the individual's qualifications for initial and continued appointment, reappointment, and/or clinical privileges;
- S. agree that the hearing and appeal procedures set for in Article XXI shall be the sole and exclusive remedy with respect to any professional review action taken at the Hospital; and
- T. extend immunity to the fullest extent permitted by law, to the Hospital, the Medical Staff, and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to appointment, reappointment, and clinical privileges or the individual's qualifications for the same.
- U. Acknowledge the legal requirements placed upon the Hospital and members of the Medical Staff by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), The Health Insurance Portability and Accountability Act ("HIPAA"), and the requirements promulgated by the Centers for Medicare and Medicaid Services ("CMS"), and agree to comply with such laws and regulations.

12.2.2 The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

12.2.3 The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

12.3 PROCEDURE FOR APPOINTMENT

12.3.1 Submission of Application

- A. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:
 - (1) the names and complete addresses of at least three (3) physicians, dentists, or other practitioners, as appropriate, who are currently practicing in the same hospital community with the applicant or who have extensive experience in observing and working with the applicant, and can provide adequate information pertaining to the applicant's present professional competence and character. (These references may

not be from individuals associated or about to be associated with the applicant or anyone with whom the applicant has a financial relationship. At least one reference shall be from the same specialty area as the applicant);

- (2) the names and complete addresses of the Department Chairpersons of any and all hospitals or other institutions at which the applicant has worked or trained including subspecialty chiefs and training program directors;
- (3) a complete chronological listing of the applicant's professional and educational appointments, employment or positions;
- (4) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary conditions, reduced or not renewed at any other hospital or health care facility;
- (5) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, or clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing Board;
- (6) information as to whether the applicant's membership in any local, state or national professional society, is or has ever been suspended, modified, or terminated, restricted, or is currently being challenged;
- (7) information as to whether the applicant's licensure to practice any profession in any state, or Drug Enforcement Administration registration is or has ever been suspended, modified, terminated, restricted, is currently being challenged, or has been voluntarily relinquished. The submitted application shall include a list or copy of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration certificate, medical or dental school diploma, and certificates from all post graduate training programs completed;
- (8) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, the amount and classification of such coverage, and whether the insurance covers the clinical privileges the applicant seeks to exercise at the Hospital;
- (9) information concerning the applicant's professional liability litigation experience, including information concerning any final judgments or

settlements, which shall include the substance of the allegations; [b] the findings; [c] the ultimate disposition'; and [d] any additional information concerning such proceedings or actions as the Medical Executive Committee may deem appropriate;

- (10) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, which may be closed or still pending;
- (11) information concerning Medicare Sanctions, re: the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program, and for information as to whether the applicant is currently under investigation;
- (12) a consent and release form from all parties involved with regard to the appointment and reappointment process, including a second consent and release to perform a background check at initial appointment;
- (13) verification that the practitioner is the same practitioner identified in the credentialing documents by viewing any of the following: (a) a current picture hospital ID card; or (b) a valid picture ID issued by a state or federal agency (e.g., drivers license or passport);
- (14) information on the applicant's ability to safely and competently perform the privileges requested;
- (15) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;
- (16) documentation of 60 hours of continuing medical education, a portion of which must support the privileges requested. Applicants applying directly from a ACGME accredited residency or fellowship are considered to have met this requirement. The American Medical Association Physicians Recognition Award certificate will serve as documentation of this requirement. Physicians submitting a listing of continuing medical education will be required to have a minimum of 40 hours of Category I credit, and the remaining 20 may be either Category I or II hours, as defined by the Medical Administrative Committee/System Planning Team.
- (17) information on the citizenship and/or visa status of the applicant;
- (18) the applicant's signature; and

- (19) such other information as the Medical Executive Committee or the Board may require.
- B. The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be part of criteria used for evaluation at appointment, reappointment, and the granting of particular clinical privileges. The mere presence of verdict(s), settlement(s), or claim(s) will not, in and of itself, be sufficient to deny appointment or particular clinical privileges. What will be evaluated is the extent to which verdict(s), settlement(s), or claim(s) evidence a pattern of care that raises questions of clinical competence. In addition, a particularly serious, single incident that gives rise to a claim or settlement verdict must be examined: (i) to ascertain whether an evaluation of all the similar precedents or incidents is required; or (ii) whether, in and of itself, it represents such a deviation from good practice as to raise overall questions of clinical competence, skill in the particular clinical privilege, or general behavior in giving care.
- C. The application for appointment shall be submitted by the applicant to the Medical Staff Office. Upon receipt of the completed and signed application, the Medical Staff Office shall notify the applicant if any remaining documentation is needed. It is the burden of the applicant to assure adequate information is produced for a proper evaluation.

Failure by the applicant to respond to the request for such documentation within thirty 30 days of such request shall result in the termination of the processing of the application. Upon receipt of all documentation, the Medical Staff Office shall verify from primary source, when possible, all information on the application, including, but not limited to the following:

- (1) Medical Education
- (2) Internships/Residencies/Fellowships
- (3) Physician References
- (4) Previous Hospital Affiliations (if requested)
- (5) Professional Liability Insurance Coverage and Claims History
- (6) Licensures
- (7) DEA
- (8) Board Certification

In addition, the following entities shall be queried:

- (9) National Practitioner Data Bank (NPDB)
- (10) American Medical Association
- (11) Office of the Inspector General (OIG) Medicare Exclusions
- (12) Criminal Background Check

- D. Completed applications for privileges shall be acted on within 90 days or shall be deemed automatically withdrawn.
- E. The application shall be deemed complete when verification of all information necessary to properly evaluate an applicant's qualifications has been received and is consistent with the information provided in the application. If additional information is requested of the applicant and the information is not submitted within thirty (30) days, the application shall be deemed to be withdrawn.

12.3.2 Review of the Application

- A. The applicant's file shall then be presented to the Department Chairperson for review. The decision to recommend approval of privileges is an objective, evidence based process. The Department Chairperson shall present a written evaluation to the Medical Executive Committee as to the applicant's qualifications for appointment and requested clinical privileges.
- B. The Medical Executive Committee shall do one of the following:
 - (1) make a written recommendation to the Board of Trustees to appoint the applicant and grant clinical privileges as requested;
 - (2) make a written recommendation to the Board of Trustees to appoint the applicant and grant clinical privileges with certain limitations, conditions, or restrictions on the initial appointment;
 - (3) defer the decision for a one month period to allow for additional research or information; or
 - (4) recommend denial of initial Staff appointment.
- C. Action by the Medical Executive Committee to defer the application for further consideration must be followed up within thirty (30) days with a recommendation for either provisional appointment with specified clinical privileges or for rejection for Staff appointment.
- D. In the event that the Medical Executive Committee's recommendation is adverse (12.3.2.B.3 and 12.3.2.B.4), the applicant shall be entitled to the procedural rights afforded under Article XXI, the Fair Hearing Plan. Neither the application nor the Medical Executive Committee's recommendation shall be forwarded to the Board until the applicant has exercised or has been deemed to have waived the right to a hearing. The adverse recommendation must state specifically the reasons for such recommendation or action with specific reference to the completed application and all other documentation considered. All information shall be forwarded to the office of the Chief Executive Officer

who shall promptly notify the applicant in writing, certified mail, return receipt requested, of his right to a hearing.

12.3.3. Approval of Application

- A. Applicants approved for privileges and/or appointment shall be notified in writing within one (1) week of approval by the Chief Executive Officer.
- B. The appropriate clinical and ancillary areas and medical staff are notified via memo of newly appointed applicants their staff status, and privileges granted.

12.4 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

- 12.4.1 Each individual who is granted staff appointment or clinical privileges or specified services shall be provisional for at least one (1) year, not to exceed two (2) years, and his performance shall be observed and evaluated by the Chairperson of the Department.
- 12.4.2 The Chairperson of the Department to which he is assigned shall review the application and information and present a written evaluation to the Medical Executive Committee as to the applicant's qualifications for appointment and requested clinical privileges.
- 12.4.3 If the appointee fails to be recommended at the end of the FPPE, his/her Staff appointment or particular clinical privileges, as applicable, shall automatically terminate. The appointee so affected shall be given special notice of such termination and shall be entitled to the procedural rights afforded in Article XXI of these Bylaws, the Fair Hearing Plan.

ARTICLE XIII - CLINICAL PRIVILEGES

13.1 GENERAL

- 13.1.1 Neither Medical Staff appointment or reappointment shall confer any clinical privileges or right to practice at the Hospital. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board. Some members of the Medical Staff may have Medical Staff Membership without clinical privileges.
- 13.1.2 The granting of clinical privileges shall carry with it acceptance of the obligations of such privileges including emergency service and other rotational obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act or other applicable requirements or standards.

13.1.3 The clinical privileges recommended to the Board shall be based upon consideration of the following:

- A. the applicant's ability to meet all current criteria for the requested clinical privileges;
- B. the applicant's education, training, experience, demonstrated current clinical competence and clinical judgment, references, utilization patterns, and ability to safely and competently perform the privileges requested;
- C. availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;
- D. adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
- E. the Hospital's available resources and personnel;
- F. any previously successful or pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;
- G. any information concerning professional review actions, the voluntary or involuntary termination of Medical Staff appointment or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
- H. other relevant information, including the written report and findings by the Department in which such privileges are sought; and
- I. if the requested procedure/privilege is new and/or requires establishing threshold criteria, a 90-day moratorium shall be placed on the process while such is established.

13.1.4 The reports of the Department Chair in which privileges are sought shall be forwarded to the Medical Executive Committee and processed as a part of the initial application for staff appointment and ultimately presented to the Board for approval.

13.1.5 Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.

13.2 CLINICAL PRIVILEGES FOR ORAL SURGEONS:

13.2.1 The scope and extent of surgical procedures that an Oral Surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

13.2.2 Oral Surgeons may be granted clinical privileges to perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient. However, if in the course of performing such history and physical an underlying health problem is discovered, the Oral Surgeon shall seek an appropriate medical consultation.

13.2 CLINICAL PRIVILEGES FOR PODIATRISTS AND DENTISTS:

- 13.3.1 The scope and extent of surgical procedures that a podiatrist or dentist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- 13.3.2 Dentists and podiatrists who perform surgical procedures shall be supervised the Chairman of Department of Surgery. All dentist and podiatry patients must receive a medical appraisal by a physician member of the Staff. Such physician medical staff member shall be responsible for the overall medical condition and care of such patient, and no surgical procedure shall be performed without such physician medical staff member's prior approval; however dentists are responsible for the portion of the H&P that relates to dentistry and podiatrists are responsible for the portion of the H&P that relates to podiatry.

13.4 CLINICAL PRIVILEGES FOR PSYCHOLOGISTS:

- 13.4.1 The scope and extent of privileges that a psychologist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

13.5 CLINICAL PRIVILEGES FOR LICENSED CLINICAL SOCIAL WORKERS AND LICENSED MARRIAGE AND FAMILY THERAPISTS:

- 13.5.1 The scope and extent of privileges a Licensed Clinical Social Worker or a Licensed Marriage and Family Therapist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

13.6 TEMPORARY CLINICAL PRIVILEGES

- 13.6.1 Temporary privileges shall not routinely be granted to practitioners. In certain situations, temporary privileges may be granted. Before temporary privileges are granted, the application must be processed in the same manner as an applicant requesting permanent privileges. The application and all relevant information is reviewed by the Chief of Staff who shall review the application to determine that it is complete and the practitioner is competent to practice in the hospital. The Chief of Staff may impose special requirements for consultation and reporting. The temporary privileges are then approved by the Chief Executive Officer or his designee for a specific time period, not to exceed ninety (90) days. Conditions which may constitute temporary privileges shall include the following:
- A. Upon the receipt of an application for Staff appointment that includes a specific request for temporary clinical privileges, in which case the granting of such privileges shall be for an initial period of thirty (30) days, with the ability to extend that period if necessary, not to exceed a total of ninety (90) days.
 - B. Upon receipt of a written request from a practitioner who is not an applicant for Staff membership, such request setting forth the specific temporary privileges

necessary for the care of one or more specific patients, temporary clinical privileges may be granted for the care of one or more specific patients and may not exceed ninety (90) days.

- C. Upon receipt of a written request for specific temporary privileges from an appropriately licensed practitioner of documented competence who is locum tenens for a member of the Staff, the grant of temporary privileges in such case to be for an initial period not to exceed thirty (30) days. Thereafter, such temporary privileges may be renewed for the period such locum tenens services may be required. The granting and exercise of such privileges shall be limited to treatment of the patients of such Medical Staff member and shall not automatically entitle such practitioner to admit patients to the hospital.

13.6.2 Termination of Temporary Privileges

- A. The Chief of Staff and CEO, upon the discovery of any information or the occurrence of any event that raises question about a practitioner's professional qualifications or ability to exercise any or all the temporary privilege granted, shall terminate all of such practitioner's temporary privileges. In the event of any such termination under this section, responsibility for the care of such practitioner's patients shall be assigned to an appropriate member of the Medical Staff by the Chief of Staff, with such assignment to take into consideration the desires of the patient when practicable.
- B. In the event a practitioner's request for temporary privileges is denied or in the event such temporary privileges are terminated or suspended, the affected practitioner shall not be entitled to any of the procedural rights provided under the Fair Hearing Plan.

13.7 EMERGENCY PRIVILEGES

In the event of an emergency that would result in serious harm to the patient or in which the life of the patient is in immediate danger, all Medical Staff members shall be authorized to do everything possible, within the scope of their licenses and regardless of Staff category, or scope of privileges, to save the patient from such harm or to save the patient's life. All persons who exercise such emergency privileges shall be obligated to summon all consultative assistance necessary and shall provide or arrange appropriate follow-up care.

13.8 DISASTER PRIVILEGES

Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization shall obtain for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a

state or federal agency (e.g. driver's license or passport) and at least one of the following:

- A. A current picture hospital ID card that clearly identifies professional designation
- B. A current license to practice
- C. Primary source verification of the license
- D. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- E. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- F. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

Primary source verification of licensure shall begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

The Medical Staff oversees the professional practice of volunteer licensed independent practitioners. The organization shall make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

13.9 TELEMEDICINE PRIVILEGES

13.9.1 All physicians who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so through one of the following mechanisms:

- A. may be fully privileged and credentialed according to Section 12.3 of Article XII.
- B. may use the credentialing and privileging information from the distant site if the distant site is a JOINT COMMISSION-accredited organization and the following requirements are met:

1. the practitioner is privileged at the distant site for those services to be provided at AMC;
 2. a method is established to provide evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement.
 3. the distant site evaluates the performance of services as part of the reappraisal conducted at the time of reappointment or renewal or revision of clinical privileges.
- C. shall go through the same approval process as outlined in Section 12.3 of Article XII.

ARTICLE XV - PROCEDURE FOR REAPPOINTMENT

15.1 COLLECTION AND VERIFICATION

15.1.2 At least three (3) months prior to the expiration of an individual's current period of appointment, the Medical Staff Office shall mail the individual the following:

Notification of the expiration date of Staff membership;
 Current Clinical Privileges or job description;
 A blank delineation of privileges form for his specialty;
 All documented education programs and hours for the preceding reappointment period;
 Reappointment application form.

15.1.3 The individual shall, providing he seeks reappointment, furnish the following:

- A. Completed reappointment application form which will contain the following:
- (1) Any information concerning training and education during the preceding appointment period.
 - (2) The name of any other healthcare facility where he has provided service during the preceding reappointment period.
 - (3) Membership, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations.
 - (4) Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration.
 - (5) Voluntary or involuntary termination of medical staff membership.
 - (6) Voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.
 - (7) Involvement in any professional liability action at a minimum, final judgments or settlements involving the individual are reported.
 - (8) Physical and Mental ability.

- B. Each Staff appointee who desires reappointment shall, at least sixty (60) days prior to such expiration date, send his reappointment packet to the Medical Staff Office. Failure to return the packet can result in automatic voluntary resignation at the expiration of the appointee's current term.
- C. In all cases, the Applicant shall have the burden of producing adequate information for proper evaluation of competence, character and other qualifications and, for resolving any doubts about such qualifications.
- D. In all cases, it shall be the responsibility of the applicant to furnish the hospital all information required, including that deriving from any individual, organization, facility or institution listed on the application.
- E. The decision to renew privileges is objective and evidence based. If the applicant has had no activity in the hospital during the past two years, he may not be eligible for renewal of privileges.

15.2 CREDENTIALING AND APPROVAL PROCESS

- 15.2.1 A. The Medical Staff Office shall process the reappointment application including, but not limited to the following:
 - (1) current licensure and/or certification as appropriate
 - (2) evidence of physical ability to perform the requested privileges
 - (3) NPDB query
 - (4) OIG query
 - (5) verification of insurance and claims history
 - (6) collection of Ongoing Professional Practice Evaluation (OPPE) data
 - B. If during the collection and processing of a particular individual's reappointment materials, there is any information that could be construed as derogatory in nature, the medical staff coordinator shall bring the information immediately to the attention of the Department Chairperson. If the Chairperson feels that consideration could be given to a recommendation that would deny reappointment, deny a requested change in Staff category or clinical privileges, or reduce clinical privileges, the Chairman shall notify the individual of the possible recommendation and ask him if he desires to meet with the MEC prior to any final recommendation. If he desires to meet, at such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.
- 15.2.2 When collection and verification is accomplished, the Department Chairperson shall review and evaluate all information, including but not limited to, results of PI activity. The reports of the Department Chair in which privileges are sought shall be forwarded

to the Medical Executive Committee and processed as a part of the reappointment application and ultimately presented to the Board for approval.

15.2.3. Approval for Reappointment

- A. Applicants approved for reappointment shall be notified in writing within one (1) week of approval by the Chief Executive Officer.
- B. The appropriate clinical and ancillary areas are notified via memo of reappointed applicants, their staff status, and privileges granted.

ARTICLE XVI - REQUESTS FOR MODIFICATION OF APPOINTMENT/CLINICAL PRIVILEGES

16.1 MODIFICATION OF PRIVILEGES

An individual may, either in connection with reappointment or at any other time, request modification of his Staff category, clinical privileges or specified services.

16.2 REQUEST FOR ADDITIONAL PRIVILEGES

If the request is for an additional procedure/privilege, the applicant shall request, in writing, to the Medical Staff Office, the procedure/privilege desired, and shall have the burden of providing the relevant training and competence necessary to perform the procedure/privilege requested. If the requested procedure/privilege is new and/or requires establishing threshold criteria, a moratorium of at least 90 days shall be placed on the process while such is established. Thereafter, the process for a request for additional privileges shall be the same as for initial clinical privileges.

16.3 FPPE – WHEN MODIFICATION OF PRIVILEGS ARE MADE

A change in or the granting of additional privileges to a current appointee shall go through an FPPE pursuant to Article XII, Section 4 of these Bylaws.

ARTICLE XVII LEAVE STATUS

17.1 VOLUNTARY LEAVE OF ABSENCE

A Staff appointee may obtain a voluntary leave of absence from the Staff by submitting written notice to the Chief of Staff and the CEO stating the exact period of time of the leave, which may not exceed one (1) year. The staff member must provide coverage for his/her patients during this leave.

17.2 TERMINATION OF LEAVE

At least sixty (30) days prior to the termination of the leave, the Staff appointee may request reinstatement of his privileges by submitting to the MEC a written notice to that

effect. The MEC shall make a recommendation to the Trustees concerning the reinstatement of the appointee's privileges. Failure to request reinstatement shall result in automatic termination of Staff appointment and privileges. A request for Staff appointment subsequently received from a Staff appointee so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

17.3 ACTIVITY DURING LEAVE OF ABSENCE

The Staff appointee shall submit a written summary of his relevant activities during the leave. Failure to provide a requested summary of relevant activities shall result in automatic termination of Staff appointment and privileges. If a leave of absence occurs with no medical activity for twelve (12) or more months, reinstated clinical privileges shall be considered provisional.

17.4 LEAVE OF ABSENCE FOR CONTINUING EDUCATION

If an appointee requests leave of absence status for the purpose of obtaining further medical training in his own or another field of practice, reinstatement will become automatic upon request for same. However, any new privileges requested will be acted upon and monitored as provisional.

17.5 LEAVE OF ABSENCE FOR MILITARY DUTY

Reinstatement will be automatic if leave of absence is for serving in an armed services commitment; however, the Staff member shall submit an account of relevant activity during the leave period.

17.6 LEAVE OF ABSENCE FOR MEDICAL REASONS

If an appointee requests a leave for medical reasons, the individual must submit a report from his or her attending physician indicating that the appointee is physically and/or mentally capable of resuming Hospital practice and performing the clinical privileges that he or she is requesting. The individual shall also provide such other information as may be requested by the Hospital at that time.

17.7 VACATIONS

During vacations or other "short" absences the appointee pledges to provide continuous medical care for his/her patients.

ARTICLE XVIII - CORRECTIVE ACTION

18.1 REPORTING REQUIREMENTS

A. General

Every member of the Medical Staff shall be required to report any direct knowledge that he may have concerning the commission or omission of any act by another member of the Staff or any other person directly involved in the care of patients that is or may constitute the conduct specified in Section 2 of this Article.

B. Initiating a Complaint or Corrective Action

Requests for corrective action may be initiated by any Department Director, by the Chairman of any committee of the Medical Staff, by any Member, or by any member of the Governing Body. The Chief of Staff shall receive the complaint, detailed and in writing. If the Chief of Staff determines that such request merits an initial investigation prior to its referral to the MEC, he shall refer the matter directly to the appropriate committee for preparation of an initial report to be made to the MEC.

18.2 CRITERIA

Corrective Action may be initiated concerning any Member if:

- A. The Member becomes physically or mentally impaired;
- B. If the activities or conduct of such Member are believed to be detrimental to patient safety or delivery of quality patient care;
- C. If the quality of patient care and/or safety is considered to be below the standards and aims of the Hospital and the Medical Staff;
- D. If the activities or conduct of such Member is considered to be disruptive to the operation of the Hospital; and/or
- E. If the activities or conduct of such Member is considered to be in violation of the Hospital Bylaws, the Policies and Procedures, these Bylaws, the Rules and Regulations or any departmental rules, policies and procedures.

18.3 INVESTIGATION

Whenever reliable information indicates that an individual may have exhibited acts, demeanor or conduct falling within the criteria specified in Section 2 of this Article, the MEC shall direct that an investigation be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate Staff office or Committee. The investigation shall be conducted in a prompt manner and a written report shall be prepared as soon thereafter as possible. The report may include recommendation for appropriate corrective action. The affected individual shall be notified by "special notice" that an investigation is being conducted and shall be given the opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. Interviews with such individuals may be conducted. Such investigation shall not constitute a hearing and the procedural rules with respect to hearing or appeals set forth in these Bylaws shall not be applicable. No

investigation shall be considered to preclude the MEC from taking any action as may be warranted by the circumstances or other incidents involving the individual under investigation.

18.4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible after the conclusion of the investigation, the Medical Executive Committee shall take action that may include but shall not be limited to the following:

- A. A determination that no corrective action need be taken.
- B. A determination to defer any corrective action for a reasonable time when circumstances warrant.
- C. The issuance of a letter of admonition, censure, reprimand or warning.
- D. A recommendation to the Board imposing terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including without limitation requirements for co-admissions, mandatory consultation or proctoring.
- E. A recommendation to the Board for the reduction, modification, suspension or revocation of clinical privileges.
- F. A recommendation to the Board for the reduction of membership status or the limitation of any practices directly related to the member's delivery of patient care.
- G. A recommendation to the Board for the suspension, revocation or probation of Medical Staff membership.

Should the MEC determine that a complaint is without merit, a report of the complaint, its investigation, and the reasons for the MEC's decision shall be submitted to the Governing Board. The Governing Board shall review the report and act, as it deems necessary and shall not be limited by the decision of the MEC.

18.5 SUMMARY SUSPENSION

- A. Criteria

Whenever an individual who has been granted clinical privileges displays conduct which necessitates that immediate action be taken to protect life or well being of any patient or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient or other person, the CEO, with the concurrence of the Chief of Staff, may summarily suspend the clinical privileges of such individual. Such summary suspension shall become effective immediately upon imposition, and "special notice" shall promptly be given to such individual of the summary suspension. Such member's patients shall promptly be assigned to another Staff member by the Chief of Staff. Such suspension shall be deemed an interim precautionary action and not a professional review action.

B. Medical Executive Committee

Not later than thirty (30) days after the imposition of such summary suspension, a meeting of the MEC shall be convened to review and consider the action.

Upon request of the MEC, the individual may attend the meeting and make a statement concerning the issues under investigation on such terms and conditions as the MEC may impose, provided, in no event, shall such meeting of the MEC, whether with or without the presence of such individual constitute a hearing within the meaning of the Fair Hearing Plan. The MEC shall modify, continue or terminate the summary suspension, and, in all such events, furnish written notice of its decision.

C. Procedural Rights

Following the MEC's decision, unless the MEC terminates the summary suspension within thirty (30) days after its imposition, the affected individual shall be entitled to the procedural rights provided in the Fair Hearing Plan. The terms of the primary suspension shall remain in effect pending a decision by the Board.

18.6 AUTOMATIC SUSPENSION

In the following instances, the individual's privileges and/or membership shall be subject to automatic suspension, which, action shall be final without a right to hearing or further review.

A. Revocation or Suspension of Licensure

Whenever an individual's license, certificate or other legal credential authorizing practice in the State of North Carolina is revoked or suspended, clinical privileges and, if the individual is a Staff member, Staff membership automatically shall be revoked as of the date such action becomes effective. Whenever an individual's license authorizing practice in the State of North Carolina is limited or restricted by the applicable licensing authority, any clinical privileges granted to the individual within the scope of such limitation or restriction automatically shall be limited or restricted in a similar manner as of the date such action becomes effective and throughout its duration.

B. Controlled Substance

Whenever an individual's DEA certificate is revoked, limited, voluntarily or involuntarily, or suspended, the individual automatically shall be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its duration. As soon as possible after such automatic suspension, the MEC shall convene to review and consider the facts under which the DEA number was revoked, limited or suspended. The

MEC may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

C. Lapse in Malpractice Coverage

Each practitioner granted clinical privileges or approved to render specified services in the Hospital shall continuously maintain in force professional liability insurance in an amount determined by the Board. Each practitioner shall immediately notify the Executive Committee of any change in such coverage. In the event of cancellation or reduction in coverage to less than the minimum amount specified by the Board, an automatic suspension in the form of withdrawal of admitting and other related privileges until coverage is reinstated shall be imposed.

D. Daily Professional Coverage

The active staff member fails to provide for the daily professional care of his/her patients, either personally or by another active staff member of the Hospital. Failure to meet this requirement and responsibility constitutes cause for automatic immediate suspension of active staff privileges. The Chief of Staff shall investigate the situation and either reinstate privileges or revoke privileges depending upon the circumstances involved. The Chief of Staff or Chief Executive Officer has the authority to call any member of the active staff to provide care for the patients of the physician who fails to meet his/her responsibility.

E. Failure to Apply for Reappointment

Each practitioner granted staff membership, clinical privileges or specified services must reapply every two years for continued clinical privileges, specified services and staff membership. Failure to reapply by the stated date on the reappointment form is cause for suspension.

F. Failure to Request Reinstatement after a Leave of Absence

Failure to request reinstatement from a leave of absence shall constitute a voluntary resignation of medical staff appointment and clinical privileges unless an exception is made by the Board.

G. Medical Records

Staff members shall be required to complete medical records within such reasonable time periods as are prescribed in the Medical Records Requirements Policy under the miscellaneous heading. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the Chief of Staff and CEO after notice of

delinquency for failure to complete medical records within such period. For the purpose of this subsection G, “related privileges” means voluntary surgery, assisting in surgery, consulting on hospital cases and providing professional services within the hospital for future patients. A member whose privileges have been suspended pursuant to this subsection G may admit obstetrical patients, if he has privileges in OB /Gyn may admit other patients in life-threatening situations. Such suspension shall continue until terminated by the Chief of Staff and CEO.

ARTICLE IXX - PROCEDURAL RIGHTS

19.1 INTERVIEWS

The Medical Executive Committee or the Board may grant an interview to an individual when it is considering adverse action as that term is defined in Section 1 of Article XXI of the Fair Hearing Plan, against such individual. The interview shall not be considered a hearing, shall be preliminary in nature and shall be conducted informally. The individual shall be informed of the general nature of the circumstance under consideration and may present relevant information. A summary record of such interview shall be made.

19.2 HEARING AND APPELLATE REVIEW

An adverse action, as that term is defined in Section of Article XXI of the Fair Hearing Plan, shall entitle the affected individual upon request to a hearing and appellate review in accordance with the provisions of the Fair Hearing Plan. All hearing and appellate reviews shall be conducted pursuant to the provisions of the Fair Hearing Plan. Only those adverse actions specifically enumerated in Section 1 of the Fair Hearing Plan shall give rise to such rights to a hearing or appellate review.

ARTICLE XX - CONFIDENTIALITY, IMMUNITY AND RELEASES

20.1 SPECIAL DEFINITIONS

For purposes of this Article, the following definitions shall apply:

- A. “Information” means record of proceedings, minutes interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications in written or oral form relating to any subject matter specified in Section 18.3 of this Article XVIII.
- B. “Practitioner” means a medical staff member or applicant and all individuals applying for or exercising clinical privileges at the Hospital.
- C. “Representatives” means the Board and any director or committee thereof; the CEO or his designee; the Medical Staff and any organization, officer, clinical unit, service, or committee thereof which, in connection with its credentialing

duties under these Bylaws, is a “medical review committee” under Chapter 131 E of the General Statutes of North Carolina and a “professional review Body” under the Health Care Quality Improvement Act of 1986; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or dissemination functions.

- D. “Third Parties” means both individuals and organizations providing information and Representatives.

20.2 AUTHORIZATION AND CONDITIONS

By submitting an application for Staff membership or by applying for or exercising clinical privileges at the Hospital, a practitioner:

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon Information bearing on his professional ability and qualifications.
- B. Agrees to be bound by the provisions of this Article XX and that he shall have no claim against any representative who acts in accordance with the provisions of this Article XX.

20.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative for the purpose of evaluation and improving the quality and efficiency of patient care, reducing morbidity and mortality and determining that healthcare services are professionally indicated and performed in compliance with applicable standard of care shall, to the fullest extent permitted by law, be confidential and privileges shall not be used in any ways except as provided herein or except as otherwise provided by law. Such confidentiality shall also extend to Information of the kind that may be produced by Third Parties. Information shall not become a part of a patient’s record or of the general Hospital records. The filing of reports under the Health Care Quality Improvement Act of 1986 shall not be deemed a breach of confidentiality.

20.4 IMMUNITY FROM LIABILITY

- A. Each practitioner agrees that no Representative shall be liable for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his duties as a Representative if such Representative acts in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.
- B. Each practitioner agrees that no Representative and no Third Party shall be liable for damages or other relief by reason of providing information to another Representative or to an appropriate state or federal regulatory agency concerning any Practitioner who is or has been an applicant to or a member of

the Staff or who did or does exercise clinical privileges or provide specific patient care services at the Hospital, provided that such Representative acts in good faith and without malice provided such information is reported in a factual manner and provided further that such information will not be disclosed to any other hospital, healthcare facility, organization or health professionals or individuals without that Practitioner's expressed written consent.

20.5 ACTIVITIES AND INFORMATION COVERED

- A. Activities: The confidentiality and immunity provided by this Article XX applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memorandums, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with any of the Hospital's activities, including but not limited to:
1. Applications for appointment or clinical privileges or services;
 2. Periodic reappraisals for reappointment or for clinical privileges or services;
 3. Corrective action;
 4. Hearings and appellate review;
 5. Peer review evaluations;
 6. Utilization reviews; and
 7. Other hospital and Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.
- B. Information: Information, as defined by this Article XX, may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability professional ethics or any other matter that might directly or indirectly affect patient care.

20.6 AUTHORIZATIONS

Each Practitioner shall, upon written request of the Hospital, execute general and specific authorizations in accordance with the tenor and import of this Article XX. Execution of such authorizations is not a prerequisite to the effectiveness of this Article XX.

20.7 CUMULATIVE AFFECT

Provisions in these Bylaws and in applications forms relating to authorization, confidentiality of information, or immunities from liability are in addition to the protections provided by law and not in limitation thereof.

ARTICLE XXI - INITIATION OF HEARING

21.1 RECOMMENDATIONS OR ACTIONS

The following recommendations or actions shall, if deemed adverse pursuant to Section 21.2 of this Plan, entitle the practitioner affected thereby to a hearing:

- A. Denial of initial Staff appointment.
- B. Denial of Staff reappointment.
- C. Suspension of Staff membership.
- D. Denial of requested advancement in Staff category.
- E. Reduction in Staff category.
- F. Limitation of admitting prerogatives.
- G. Denial of requested clinical privileges.
- H. Reduction in clinical privileges.
- I. Suspension of clinical privileges.
- J. Revocation of clinical privileges.
- K. Terms of probation.
- L. Requirement of consultation.

All such recommendations or actions shall be taken (i) in the reasonable belief that they were in the furtherance of quality health care, (ii) after a reasonable effort to obtain the facts underlying the matter, (iii) after adequate notice and hearing procedures and other procedures as set forth in this Fair Hearing Plan are afforded the affected individual, and (iv) in the reasonable belief that they were warranted by the facts known after such reasonable effort to obtain facts and after compliance with such procedures.

21.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 21.1 of this Article shall be deemed adverse only when it has been:

- A. Recommended by the Medical Executive Committee (MEC); or
- B. Taken by the Board contrary to a favorable recommendation by the MEC; or
- C. Taken by the Board on its own initiative without a prior recommendation by the MEC.

The issuance of a letter of admonition, censure, reprimand or warning, or the reduction of temporary privileges shall not be deemed adverse recommendation or action. In addition, automatic suspension under Section 18.6 of Article XVIII of the Bylaws shall not be considered an adverse recommendation or action.

Cessation of the application process shall not be a consideration for the Fair Hearing Plan.

21.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

The affected individual against whom an adverse action has been taken or recommended pursuant to Section 21.2 of this Article shall be given notice within three (3) business days of said action or recommendation. All notices that are required to be given pursuant to this Article XXI shall be provided either by personal delivery or by certified/registered mail, either of which will be deemed to be “special notice”. All mailed notices will be deemed to have been provided when the notice is deposited in the U.S. Mail. All notices to the affected individual shall be provided by the Hospital Administrator or his designee. The notice shall:

- A. State that an adverse action or recommendation has been proposed against the individual;
- B. Contain a concise statement of the practitioner’s alleged acts or omissions, a list by number of the specified or representative patient records in question and/or the other reason or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing; and
- C. State that the affected individual has the right to request a hearing within the time limit specified in Section 21.4 of this article and shall contain a summary of the individual’s rights at such hearing; and
- D. State that failure to request a hearing within the specified time period shall constitute a waiver of his rights to a hearing and to an appellate review on the matter.

21.4 REQUEST FOR HEARING

The affected individual shall have thirty (30) days after receipt of a notice pursuant to Section 21.3 of this Article to file a written request for hearing. Such request shall be delivered to the Administrator either in person or by certified or registered mail.

21.5 WAIVER BY FAILURE TO REQUEST A HEARING

In the event the affected individual fails to request a hearing within the time and in the manner specified in Section 21.4 of this Article, he shall have waived any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver shall constitute acceptance of the adverse action by the Board and shall become effective as a final decision.

21.6 PROCESS FOR ALLIED HEALTH PROFESSIONALS

The affected allied health professional shall follow the rules as outlined in Article XXIX, Section 29.9 entitled “Procedural Rights for Allied Health Professionals.”

ARTICLE XXII - HEARING REQUIREMENTS

22.1 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the Administrator shall deliver such request to the Chief of Staff. Within ten (10) days after receipt of such request, the Chief of Staff shall schedule and arrange for a hearing. The Hospital Administrator shall deliver notice to the affected individual, either in person or by “special notice”, stating the time, place and date of the hearing. The date of the hearing shall not be less than thirty (30) days after the affected individual receives such notice. The notice of the hearing shall also include a list of witnesses, if any, expected to testify at the hearing in support of the proposed action.

22.2 CONDUCT OF HEARING

The Chief of Staff shall determine whether the hearing shall be held before a hearing officer or a hearing committee. The hearing officer shall be appointed by the Chief of Staff pursuant to Section 22.3 of this Article. The hearing committee shall be appointed by the Chief of Staff pursuant to Section 22.4 of this Article.

22.3 APPOINTMENT OF HEARING OFFICER

In the event the hearing is to be held before a hearing officer, the hearing officer shall conduct the hearing pursuant to the provisions of Article XXIII hereof. The hearing officer may be a physician, attorney or other individual qualified to conduct the hearing. The hearing officer may be, but is not required to be a member of the medical staff. The hearing officer shall not be in direct economic competition with the affected individual.

22.4 APPOINTMENT OF AND SERVICE ON HEARING COMMITTEE

A. Appointment

In the event the hearing is to be held before a hearing committee, the hearing committee, which shall be appointed by the Chief of Staff, shall consist of at least three (3) members, one of whom shall be designated as chairman by the Chief of Staff. The members of the hearing committee may be, but are not required to be, members of the Medical Staff. The members of the hearing committee shall not be in direct economic competition with the affected individual.

A hearing occasioned by an adverse action of the board pursuant to Section 1.2, Subsections B or C shall be conducted by a hearing committee appointed by the Chairman of the Board and composed of five (5) persons. At least three (3) Medical Staff members shall be included on this committee when feasible. The members of the hearing committee shall not be in direct economic competition with the affected individual. One of the appointees to the committee shall be designated as chairman.

A majority of the hearing committee members must be present throughout the hearing and the committee's deliberations. If a member of the hearing committee is absent from any of the hearing, he shall not be permitted to participate in the committee's deliberations.

B. Service

An individual shall not be disqualified from serving on the hearing committee merely because he has heard of the case. However, an individual shall be disqualified from serving on the hearing committee if he participated in initiating or investigating the underlying matter which is the subject of the hearing. Moreover, no member of the hearing committee may be in direct economic competition with the affected individual. All members of the hearing committee shall be required to decide the case objectively and in good faith.

ARTICLE XXIII - HEARING PROCEDURE

23.1 FORFEITURE OF HEARING

Any individual who requests a hearing pursuant to this plan but fails to appear at the hearing without good cause, as determined by the hearing committee or hearing officer, shall forfeit his rights to such hearing and to any appellate review to which he might otherwise have been entitled.

23.2 DUTIES OF HEARING OFFICER

The hearing officer shall be the presiding officer of the hearing. He shall act to maintain decorum and to assure that all hearing participants have a reasonable opportunity to present relevant oral and documentary evidence. He shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

23.3 REPRESENTATION

The affected individual who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff or an attorney, and the MEC or the Board may appoint a member of the medical staff or an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation or action and to examine witnesses.

23.4 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to the following:

- A. Call and examine witnesses;

- B. Introduce any evidence, including exhibits, determined relevant by the hearing officer or hearing committee, regardless of its inadmissibility in a court of law;
- C. Question any witnesses on any matter relevant to the issues;
- D. Impeach any witness;
- E. Rebut any evidence;
- F. Submit a written statement at the close of the hearing.

23.5 PROCEDURE AND EVIDENCE

The hearing need not be conducted 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 admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to and during the hearing, be entitled to submit memoranda concerning any issues of law or fact and such memoranda shall become a part of the hearing record.

23.6 INFORMATION PERTINENT TO HEARING

In reaching a decision, the hearing officer or hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and any other information that is considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff for clinical privileges and/or any other matters to be determined by the hearing officer or hearing committee.

23.7 BURDEN OF PROOF

When the adverse recommendation or action listed in subsections A, D or G of Article XXI, Section 21.1 hereof is the basis for the hearing, the affected individual who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn therefrom are arbitrary, unreasonable or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the affected individual shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusion drawn there from are arbitrary, unreasonable or capricious.

23.8 RECORD OF HEARING

A record of the hearing shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee or hearing officer may select the method to be used for making the record, such as court

reporter, electronic recording unit, detailed transcription or accurate recordation method.

23.9 POSTPONEMENT

Request for postponement of a hearing may be granted by the hearing officer or the chairman of the hearing committee upon a showing of good cause.

23.10 RECESSES AND ADJOURNMENT

The hearing officer or hearing committee may recess the hearing and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of the presentation of all evidence and oral argument, the hearing shall be adjourned.

ARTICLE XXIV - REPORT OF HEARING OFFICER OR COMMITTEE AND FURTHER ACTION

24.1 REPORT

Within ten (10) business days after final adjournment of the hearing, the hearing officer or hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by the hearing officer or hearing committee, to the MEC or Board, depending on whose adverse recommendation or action occasioned the hearing. The report shall include a statement of the basis for such findings and recommendations. At the same time, a copy of the report shall be provided to the affected individual.

24.2 ACTION ON REPORT

Within twenty (20) days after receipt of the report, the MEC or the Board, as the case may be, shall consider the case based on the hearing committee report and shall affirm, modify or reverse its initial recommendation or action in the matter. The decision shall be in writing and shall include a statement as to its basis. The decision shall be transmitted, together with the hearing record, the report of the hearing officer or hearing committee and all other documentation considered, to the Hospital Administrator.

24.3 NOTICE AND EFFECT OF RESULT

A. Notice

The Administrator shall promptly deliver a copy of the decision of the MEC or the Board, as the case may be, along with a statement of the basis for the decision, –by special notice to the affected individual, the Chief of Staff and to the Board.

B. Effect of Result

1. In the case of a decision rendered by the Board, if such decision is favorable to the affected individual, such decision shall become the final decision of the Board and the matter shall be considered closed.
2. In the case of a decision rendered by the MEC, whether such decision is favorable or unfavorable to the affected individual, the Administrator shall forward it, together with all supporting documentation, to the Board for its final action. The Board shall take final action thereon by adopting or rejecting the MEC's decision, in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After the receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The Hospital administrator shall promptly send special notice to the affected individual informing him of each action taken pursuant to this subsection and shall provide copies of all actions, referrals or recommendation. A favorable determination shall become the final decision of the Board and the matter shall be considered closed. If the Board's action is adverse as defined in Article XXI hereof, the notice shall inform the affected individual off his right to request an appellate review by the Board as provided in 25.1 of Article XXV hereof.

ARTICLE XXV - INITIATION AND PREREQUISITES OF APPELLATE REVIEW

25.1 REQUEST FOR APPELLATE REVIEW

The affected individual shall have fourteen (14) business days after his receipt of any notice pursuant to Section 24.3 of Article XXIV hereof to file a written request for an appellate review. Such request shall be delivered to the Hospital by special notice and may include a request for a copy of the report and record of the hearing and all other material, favorable or unfavorable, that was considered in making the adverse decision.

25.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

In the event the affected individual fails to request an appellate review within the time and in the manner specified in Section 25.1 of this Article, he shall be deemed to have waived any right to such appellate review. Such waiver shall constitute acceptance of the decision and the case shall be closed.

25.3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Hospital administrator shall deliver such request to the Board. Within fourteen (14) days after receipt of such request, the Board shall schedule and arrange for an appellate review which shall be not less than forty-five (45) days nor more than ninety (90) days from the date of receipt of the appellate review request. At least thirty (30) days prior to the appellate review, the Administrator shall deliver special notice to the affected individual of the time, place and date of the appellate review. The time for the appellate review may be extended by the appellate review body upon request of the affected individual.

25.4 APPELLATE REVIEW BODY

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee of three (3) members of the Board, such committee members to be appointed by the Chairman of the Board. In the event a committee is appointed, one of its members shall be designated as chairman by the Chairman of the Board. No Board or committee member shall be in direct economic competition with the affected individual. A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Review Body is absent from any part of the proceedings, he shall not be permitted to participate in the deliberation or the decisions.

ARTICLE XXVI - NATURE OF PROCEEDINGS

26.1 NATURE OF PROCEEDINGS

The proceedings by the appellate review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing officer or hearing committee, the report and all subsequent results and actions thereon. The appellate review body shall also consider any written statements submitted pursuant to Section 26.2 of this Article and such other material as may be presented and accepted under Sections 26.4 and 26.5 of this Article.

26.2 WRITTEN STATEMENTS

The affected individual seeking the appellate review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees and his reasons for such disagreement with the request for appellate review submitted pursuant to Section 25.1 of Article XXV. This written statement may cover any matters raised at any step in the hearing process. A written statement in reply may also be submitted by the MEC to the affected individual by special notice. The appellate review body will be provided a copy of the affected individual's written statement and any written statement submitted by the MEC or the Board at the appellate review proceeding.

26.3 PRESIDING OFFICER

The Chairman of the appellate review body shall be presiding officer and shall conduct the appellate review. He shall determine the order of procedure during the review, make all required rulings and maintain decorum. The chairman shall be appointed by the Chairman of the Board.

26.4 ORAL STATEMENT

The Appellate Review Body shall allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

26.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matter or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

26.6 RECESS AND ADJOURNMENT

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, the appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of those deliberations, the appellate review shall be declared finally adjourned.

26.7 ACTION TAKEN

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action or, in its discretion, may refer the matter back to the hearing officer or hearing committee for further review and recommendation to be returned to it within thirty (30) days and in accordance with its instructions. Within thirty (30) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board as provided in this Section 26.7.

26.8 ADJOURNMENT

The appellate review body shall not be deemed to be concluded and adjourned until all of the procedural steps provided herein shall have been completed or waived.

ARTICLE XXVII - FINAL DECISION OF THE BOARD

27.1 BOARD ACTION

Within forty-five (45) days receipt of the appellate review body's recommendation, the Board shall direct the hospital administrator to render its final decision in the matter in writing and shall send notice thereof to the affected individual, to the Chief of Medical Staff and to the MEC.

ARTICLE XXVIII - GENERAL PROVISIONS

28.1 WAIVER

If at any time after receipt of notice of an adverse recommendation, action or results, the affected individual fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he shall be deemed to have consented to such adverse recommendation, action or result and to waived voluntarily all rights to which he might otherwise have been entitled with respect to the matter involved.

28.2 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no affected individual shall be entitled as a right to more than one (1) hearing and one (1) appellate review with respect to an adverse recommendation or action.

28.3 RELEASE

By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of Article XX, Section 4 in the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.

28.4 EXHAUSTION OF REMEDIES

The affected individual must exhaust the remedies afforded by this Fair Hearing Plan before resorting to any form of legal action.

28.5 AMENDMENT

The Fair Hearing Plan shall be considered a part of the Medical Staff Bylaws of Angel Medical Center and may be amended only in the manner provided for amendment of such Bylaws.

28.6 MEDICAL STAFF RESPONSIBILITY AND BOARD INITIATIVE

The principles stated in the Medical Staff and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical

Staff Bylaws and amendments thereto and the circumstances under which the Board may resort to its own initiative in accomplishing those functions shall apply as well to the formation, adoption and amendment to the Fair Hearing Plan.

ARTICLE XXIX – ALLIED HEALTH PROFESSIONALS

29.1 SCOPE AND OVERVIEW

- A. This article addresses those Allied Health Professionals (AHPs) who are permitted to provide services at the Hospital and its Facilities.
- B. Only those classes of AHPs that have been approved by the Board shall be permitted to provide services at the Hospital. The Board shall determine that there is a need for the services of a particular type of AHP and decide to permit those AHPs to provide services in the Hospital. The Board shall approve threshold criteria and/or scope of practice or delineated privileges prior to an AHP begins the application process.
- C. This article outlines the credentialing processes for AHPs, as well as the general practice parameters for these individuals. All AHPs who are permitted to provide services at the Hospital shall be classified in on of two categories, “Independent Practitioners” or “Dependent Practitioners.”
- D. The “Independent Practitioner” category shall include all those health professionals who are authorized to function independently in the Hospital. These individuals generally can bill for the services they provide and they require no formal or direct supervision by a physician.
- E. The “Dependent Practitioner” category shall embody all AHPs who are authorized to function in the Hospital only as employees of, or under direct supervision of, a member of the Medical Staff. The employing and/or supervising Medical Staff member shall remain fully responsible for the actions of the Dependent Practitioner in the Hospital.

29.2 GENERAL QUALIFICATIONS

Any AHP who applies to provide services at the Hospital as an Independent or Dependent practitioner shall:

- A. be covered by current, valid professional liability insurance in the amount of at least one (1) million dollars per claim and one (1) million dollars in the aggregate;
- B. never have been convicted of a felony or any crime related to fraud;
- C. be able to document his or her:

- (1) background, education, relevant training, experience, and current demonstrated clinical competence,
- (2) adherence to the ethics of his or her profession,
- (3) good reputation and character, and
- (4) ability to safely and competently perform the clinical functions and activities requested.

29.3 NO ENTITLEMENT TO MEDICAL STAFF APPOINTMENT

- A. AHPs who are applying to provide services at the Hospital shall not be eligible for appointment to the Medical Staff, or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.
- B. AHPs shall provide services at the Hospital at the discretion of the Board and thus may be denied clinical privileges or a scope of practice or have the same terminated by the Board.

29.4 DUTIES AND RESPONSIBILITIES

- A. work cooperatively with Medical Staff, other Allied Health Professionals, nurses and other Hospital personnel as outlined in the Code of Conduct Policy;
- B. conduct themselves consistent with the Hospital values which are respect, communication, teamwork, integrity, quality, and customer focus;
- C. be physically and mentally capable of providing safe competent care to patients;
- D. complete in a timely manner the medical record or other required records for all patients, as required by the Bylaws and the Medical Staff Rules and Regulations;
- E. abide by all Bylaws, Policies, and Rules and Regulations of the Medical Staff and Hospital;
- F. accurately represent himself to patient, family members and staff by wearing the Hospital's ID badge;
- G. provide to the Medical Staff Office, with or without request, new or updated information, as it occurs, that is pertinent to any question on the application form;
- H. agree that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. There shall be no entitlement to any hearing or appeal rights as set forth

in Article XXI. Procedural Rights for AHPs is outlined in Section 29.9 of this Article.

- I. authorize the release of all information necessary for an evaluation of the individual's qualifications for practice at the Hospital;
- J. extend immunity to the fullest extent permitted by law, to the Hospital, the Medical Staff, and all individuals acting by or for the Hospital and/or its Medical Staff for all matters relating to the individual's clinical activities at the Hospital;
- K. refrain from assuming responsibility for diagnoses or care of hospitalized patient for which he or she is not qualified or without adequate supervision;
- L. refrain from deceiving patients as to his or her status as an AHP;
- M. seek consultation whenever necessary; and
- N. participate in performance improvement and quality monitoring activities of the Hospital.

29.5 INFORMATION TO BE SUBMITTED WITH APPLICATION:

- A. Application forms shall be sent from the Medical Staff Office to those individuals who meet the general qualifications set forth in this article.
- B. The application form shall require detailed information concerning the applicant's professional qualifications, including:
 - (1) the names, addresses, and phone numbers three (3) individuals, one of whom is a peer of the same specialty, who have had recent experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's current professional competence and character;
 - (2) the names, address, and phone numbers of the department chiefs and/or supervising physician(s) at any and all hospitals or other institutions at which the applicant has worked or trained;
 - (3) a complete chronological listing of the applicant's professional and educational appointment, employment, and positions;
 - (4) information as to whether the applicant's permission to practice and/or affiliation have been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, or not renewed at any hospital or health care facility;
 - (5) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his or her application or resigned before a final decision was made;

- (6) information as to whether the applicant's license or certification to practice any profession in any state, or Drug Enforcement Administration Certification is , or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being challenged;
- (7) information as to whether the applicant's membership in any local, state, or national professional society is, or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being challenged;
- (8) information concerning the applicant's professional liability insurance coverage, including the name of the insurance company, the amount and classification of such coverage, whether said insurance policy covers the scope of practice the applicant is requesting , and a consent to the release of information from present and past professional liability insurance carriers;
- (9) information concerning the applicant's malpractice litigation experience, including information concerning any final judgments or settlements: (a) the substance of the allegations; (b) the findings; (c) the ultimate disposition; and (d) any additional information concerning such proceedings or actions as the Hospital may deem appropriate;
- (10) information concerning professional misconduct proceedings involving the applicant in this state or any state, which may be closed or still pending;
- (11) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, or any other government-sponsored program or any private or public medical insurance program;
- (12) current information regarding the applicant's ability to perform safely and competently the scope of practice requested;
- (13) information as to whether the applicant has ever been a defendant in a criminal action or convicted of a crime, including details about any such instance;
- (14) information regarding the citizenship and/or visa status of application;
- (15) CME information as required by their professional organization;
- (16) the applicant's signature; and
- (17) other such information as the Hospital may require.

29.6 SUBMISSION OF APPLICATION

- A. Completed applications shall be submitted to the Medical Staff Office. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with the primary sources as required, the Medical Staff Office shall transmit the completed application along with all supporting materials to a peer for review and the Medical Executive Committee for recommendation to the Board.

- B. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation.
- C. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed voluntarily withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

29.7 BURDEN OF PROVIDING INFORMATION

- A. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
- B. The applicant shall have the burden of proving that all the statements made and information given on the application are true and correct. Any misstatement, omission and/or misrepresentation on the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application, and no further processing shall occur. In the event the Independent Practitioner or Dependent Practitioner status has been granted prior to discovery of such misstatement, misrepresentation or omission, such discovery shall result in automatic relinquishment of the privilege to provide services in the hospital, functions and activities and resignation of Independent or Dependent Practitioner status.

29.8 RENEWAL OF PERMISSION TO PRACTICE

- A. Permission to practice in the Hospital is a courtesy extended by the Board and shall be granted for a period not to exceed two (2) years. Renewal of clinical privileges shall be granted only upon submission of a completed renewal application.
- B. Once an application for renewal of permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures for review and approval as the initial application.

29.9 PROCEDURAL RIGHT FOR ALLIED HEALTH PROFESSIONALS

- A. AHPs shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws for Medical Staff members.

- B. In the event an AHP is not granted permission to provide services in the Hospital, or permission to provide services is terminated, the AHP, and when applicable, his or her employing or supervising physician, shall have the right to appear personally before the Medical Executive Committee to discuss the adverse recommendation.
- C. If the AHP desires to meet with the Medical Executive Committee, he or she must make such a request in writing. Should the AHP request a meeting in a timely manner, he or she will be informed of the general nature of the information supporting the adverse recommendation at least ten (10) days prior to the scheduled meeting.
- D. At the meeting, the AHP and, when applicable, his or her employing or supervising physician, shall be invited to discuss the recommendation and the reasons supporting it. Such meeting shall not constitute a hearing and none of the procedural rules provided for in the Medical Staff Bylaws for Medical Staff members with respect to a hearing shall apply. However, minutes of the meeting shall be kept and shall be attached to the Medical Executive Committee's recommendation.
- E. The Medical Executive Committee shall forward its recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the recommendation, certified mail, return receipt requested, to the AHP.
- F. If the Medical Executive Committee's recommendation continues to be adverse, the affected individual shall have ten (10) days after notice of such recommendation to request that the recommendation be considered by the Board. Such a request must be in writing and must include a statement of the reasons, including specific facts, which justify further review. The request shall be delivered to the Chief Executive Officer either in person or by certified mail.
- G. If a written request for further review is not submitted within the ten (10) day time frame specified herein, the Medical Executive Committee's recommendation and supporting information shall be forwarded by the Chief Executive Officer to the Chairman of the Board for final action.
- H. If a timely request for further review is submitted, the Chief Executive Officer shall forward the Medical Executive Committee's recommendation, supporting information, and the request for Board consideration to the Board or, at the Board Chair's discretion, to a three (3) person ad hoc review panel.
- I. The Board Chair (or the ad hoc review panel) will consider the record upon which the adverse recommendation was made and may accept additional written information, provided the information is new and relevant.

- J. Upon completion of the review, the Board Chair (or ad hoc review panel) shall adopt the Medical Executive Committee's recommendation as the Board's final action, refer the matter for further review and recommendation, or make a decision on behalf of the Board. Such decision shall be deemed to constitute final action by the Board.

29.10 SUPERVISION BY EMPLOYING OR SUPERVISING PHYSICIAN

- A. Any activities permitted by the Board to be done at the Hospital by a Dependent Practitioner shall be done only under supervision of the physician employing or supervising that individual. Except as provided by law or Hospital policy, "supervision" shall not require the actual physical presence of the employing or supervising physician.
- B. Dependent Practitioners may function in the Hospital only so long as they remain employees of, or are supervised by, a physician currently appointed to the Medical Staff. Should the Medical Staff appointment or clinical privileges of the staff physician employing a Dependent Practitioner be revoked or terminated, the Dependent Practitioner's permission to provide services in the Hospital shall automatically terminate. If the Medical Staff appointment or clinical privileges of a physician supervising a Dependent Practitioner is resigned, revoked or terminated, the Medical Executive Committee may immediately recommend the termination of the Dependent Practitioner's permission to provide services in the Hospital, or may recommend that the Dependent Practitioner be permitted to arrange for supervision by another physician appointed to the Medical Staff. If a Dependent Practitioner is employed by the Hospital and loses permission to provide services, his employment shall also be immediately terminated.

29.11 QUESTIONS REGARDING AUTHORITY OF DEPENDENT PRACTITIONER

- A. Should any Medical Staff appointee or Hospital employee who is licensed or certified by the state have any questions regarding the clinical competence or authority of a Dependent Practitioner either to act or issue instructions outside the physical presence of the employing or supervising physician in a particular instance, such Medical Staff appointee or Hospital employee shall have the right to require that the Dependent Practitioner's employer or supervisor validate, either at the time or later, the instructions of the Dependent Practitioner. Any such act or instruction of the Dependent Practitioner shall be delayed until such time as the staff appointee or Hospital employee can be certain that the act is clearly in the scope of the Dependent Practitioner's activities permitted by the Board.
- B. Any question regarding the professional conduct of a Dependent Practitioner shall be reported to the Chief of Staff or Chief Executive Officer. At all times

the employing or supervising physician shall remain responsible for all acts of the Dependent Practitioner while at the Hospital.

29.12 RESPONSIBILITIES OF EMPLOYING OR SUPERVISING PHYSICIAN

- A. The number of Dependent Practitioners acting as employees or under the supervision of one (1) physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, and the Bylaws and policies of the Medical Staff and Board.

29.13 CLINICAL PRIVILEGES FOR INDEPENDENT PRACTITIONERS

- A. The scope and extent of privileges independent practitioners may perform at the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- B. Dentists and podiatrists who perform surgical procedures shall be supervised.