

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
RANDOLPH HOSPITAL**

CREDENTIALS POLICY

Effective October 1, 2009

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) "ALLIED HEALTH PROFESSIONAL" means a health care practitioner other than a physician, dentist, podiatrist, or oral surgeon who is authorized to provide patient care services in the Hospital.
- (2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (3) "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner, an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.
- (4) "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner, an Allied Health Professional who provides a medical level of care or performs surgical tasks (i.e., Advanced Practice Registered Nurse ("APRN"), Physician Assistant ("PA")) consistent with the clinical privileges granted, but who is required by law and/or the Hospital to exercise those clinical privileges under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision or collaborative agreement. Category II practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in the AHP Policy (e.g., moonlighting residents).
- (5) The AHP "CATEGORY III PRACTITIONER" means a Dependent Practitioner, an Allied Health Professional who is permitted by law or the Hospital to function only under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. All aspects of the clinical practice of Category III practitioners at the Hospital shall be handled by the Hospital's Human Resources Department in accordance with applicable human resources policies and procedures, and the provisions of this Policy shall specifically not apply. Hereinafter, as used in this Policy, the term "Allied Health Professional" shall mean Category I and Category II practitioners only.
- (6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to a practitioner to render specific patient care services, for which the Medical Staff leaders and Board have developed (i) eligibility and other

credentialing criteria, (ii) ongoing professional practice evaluation review criteria, and (iii) focused professional practice evaluation review criteria.

- (7) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leaders and Board to require closely related skills and experience.
- (8) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.
- (9) "DAYS" means calendar days.
- (10) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (11) "EXECUTIVE SESSION" is a meeting of a Medical Staff committee or department which only the voting Medical Staff members may attend, along with senior Hospital management. Executive Sessions may be called by the presiding officer, and are intended to be utilized to discuss peer review issues, personnel issues, or any other issue requiring confidentiality.
- (12) "HOSPITAL" means Randolph Hospital.
- (13) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.
- (14) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (15) "MEDICAL STAFF LEADER" means any Medical Staff officer, service line chair, and committee chair.
- (16) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (17) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (18) "ORAL OR MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has successfully completed an accredited post-graduate training program in oral and maxillofacial surgery.

- (19) "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (20) "PATIENT CONTACT" includes any admission, assumption of care, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests, or for non-diagnostic treatments or procedures.
- (21) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals by the Board or President/CEO, as applicable, to exercise a scope of practice and/or clinical privileges.
- (22) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (23) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (24) "PRESIDENT/CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (25) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (26) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (27) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II practitioner and to accept full responsibility for the actions of the Category II practitioner while he or she is practicing in the Hospital.
- (28) "SUPERVISION" means the supervision of (or collaboration with) a Category II practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general – Supervising Physician is available by telephone; direct – Supervising Physician is physically on the Hospital campus; or personal – Supervising Physician is present in the room) shall be determined at the time each Category II practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

- (29) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment and who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

- (1) Unless otherwise provided, when a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a medical staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders shall perform the function personally or delegate it to another appropriate individual.

1.D. GOVERNING LAWS

The Medical Staff Bylaws, Policies, Rules and Regulations and related documents have been drafted in accordance with relevant federal and North Carolina laws and shall be interpreted in accordance with those laws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, and podiatrists must:

- (a) have a current, unrestricted license to practice in North Carolina and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) demonstrate that they understand, and can satisfy, the specific response time requirements for their specialty as may be recommended by the MEC and approved by the Board;
- (d) have (or can provide formal documentation evidencing the process of obtaining) current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital, which shall be a minimum of \$1 million per incident and \$3 million aggregate;
- (e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (h) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (i) agree to fulfill all responsibilities regarding emergency call;

- (j) have or agree to make coverage arrangements with other members of the Medical Staff for those times when they are unavailable for their private patients;
- (k) have successfully completed:*
 - (1) a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in a specialty in which the applicant seeks clinical privileges;
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (l) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS") or the AOA, the American Association of Oral and Maxillofacial Surgery or the ADA, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and*
- (m) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.*

* These requirements shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. These requirements are not applicable to existing Medical Staff members at the Hospital. Existing Medical Staff members shall be grandfathered and shall be governed by the residency training and board certification requirements in effect at the time of their initial appointments.

2.A.2. Waiver of Threshold Eligibility Criteria:

- (a) Any individual who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The individual requesting

the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant service line chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation shall be forwarded to the MEC. Any recommendation to grant a waiver must include the basis for such.
- (c) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.
- (d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.
- (e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (f) An application for appointment that does not satisfy an eligibility criterion shall not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

The following factors shall be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability and willingness to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams;

- (e) ability to safely and competently perform the clinical privileges requested; and
- (f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (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 hospital or health care facility;
- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment or reappointment on the basis of gender, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility (if a Medical Staff member becomes unavailable for any reason, the service line chair or the Chief of Staff shall assign to another member of the Medical Staff, and that member must accept, responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician);
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

- (c) to participate in Medical Staff affairs through committee service, participation in quality improvement and peer review activities, and by performing such other reasonable duties and responsibilities as may be assigned by the Medical Staff Leaders;
- (d) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients;
- (e) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;
- (f) to also comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;
- (g) to inform the President/CEO and the Chief of Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:
 - changes in licensure status or professional liability insurance coverage;
 - the filing of a professional liability lawsuit against the practitioner;
 - changes in the practitioner's Medical Staff status at any other hospital;
 - indictment, conviction, or a plea of guilty or no contest in any criminal matter;
 - exclusion or preclusion from participation in Medicare or any sanctions imposed; and
 - any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving while impaired ("DWI") (Any DWI incident shall be reviewed by the Chief of Staff and the President/CEO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they shall forward the matter for further review under the practitioner health policy or this Credentials Policy.);
- (h) to immediately submit to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership;

- (i) to appear for personal interviews in regard to an application for initial appointment or reappointment, if requested;
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (l) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (m) to seek consultation whenever necessary;
- (n) to complete in a timely manner all medical and other required records, containing all information required by the Hospital as set forth in the Medical Staff Rules and Regulations and any applicable policies pertaining to medical records;
- (o) to participate in an Organized Health Care Arrangement with the Hospital, to abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;
- (p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (q) to promptly pay any applicable dues, and/or assessments;
- (r) to maintain an active e-mail address with the Medical Staff Office;
- (s) to satisfy continuing medical education requirements; and
- (t) that any misstatement in, or omission from, the application, as determined by the Chief of Staff and the President/CEO, shall cause the credentialing process for an application to be stopped. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges shall be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal in accordance with Article 7 of this Policy. Applicants shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee shall review the individual's response and provide a recommendation to the MEC. The MEC shall recommend to the Board whether the application should be processed further, whereupon the Board shall make the final decision. The possible reinstatement of an existing Medical Staff member who automatically relinquishes appointment and privileges shall be reviewed in accordance with Section 6.E.2(g) of this Policy.

2.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications.
- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended,

modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

- (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (5) a copy of a government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

- (a) whether or not appointment or clinical privileges are granted;
- (b) throughout the term of any appointment or reappointment period and thereafter;
- (c) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (d) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.

(1) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(2) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(3) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/ facility, and any licensure or regulatory matter.

(4) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(5) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Application:

- (a) Applications for appointment shall be in writing and shall be on forms approved by the Board, upon recommendation by the MEC and Credentials Committee.
- (b) An individual seeking initial appointment shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee if applicable.
- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

3.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available

sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

- (b) Additional references may be sought from any person having knowledge of the applicant's qualifications by the service line chair, a Credentials Committee representative, a member of the MEC, the Chief of Staff, and/or the President/CEO.
- (c) An interview(s) with the applicant may be conducted. The purpose of the interview(s) is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview(s) may be conducted by a combination of any of the following: the service line chair, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, and/or the President/CEO.

3.A.4. Service Line Chair Procedure:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chair of each service line in which the applicant seeks clinical privileges. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The service line chair shall be available to the Credentials Committee, MEC, and the Board to answer any questions that may be raised with respect to that chairman's report and findings.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant service line chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the service line chair, or any member of the service line, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's Health Status Confirmation form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an

examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the President/CEO, explaining the reasons for the delay.

3.A.6. Medical Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendation of the Credentials Committee, as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board through the Chief of Staff.
- (c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC shall forward its recommendation to the President/CEO, who shall promptly send special notice to the applicant. The President/CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

- (1) a current or previously successful challenge to any license or registration;
- (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
- (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the President/CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board, favorable or unfavorable, to grant, deny, revise or revoke appointment and/or clinical privileges, shall be signed by the President/CEO, disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. PROVISIONAL STATUS

3.B.1. Nature of Provisional Period:

Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

3.B.2. Focused Professional Practice Evaluation:

During the provisional period, the individual's exercise of the relevant clinical privileges will be evaluated by the chair of the service line in which the individual has clinical privileges and/or by a physician(s) designated by the Credentials Committee. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other physicians and Hospital employees. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

3.B.3. Duration of Provisional Period:

- (a) The duration of the provisional period for initial appointment and privileges will be from 12 to 24 months, as recommended by the Credentials Committee.
- (b) The duration of the provisional period for all other initial grants of privileges will be as recommended by the Credentials Committee.

3.B.4. Duties During Provisional Period:

- (a) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the service line chair and/or by other designated physicians.
- (b) A new member of the Medical Staff shall automatically relinquish his or her appointment and privileges at the end of the provisional period if that new member fails, during the provisional period, to:
 - (1) participate in the required number of surgical cases and/or demonstrate satisfactory involvement in disease management pertinent to the individual's specialty;
 - (2) cooperate with the monitoring and review conditions; or
 - (3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

- (c) If a member of the Medical Staff who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The individual may not reapply for the privileges in question for two years.
- (d) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to a hearing and appeal.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.
- (d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria.
- (e) The clinical privileges recommended to the Board will be based upon consideration of the following:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
 - (5) availability of qualified staff members to provide coverage of the individual's private patients in case of the applicant's illness or unavailability;

- (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (f) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
 - (g) The report of the chair of the service line in which privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

- (a) Scope. This section applies to all requests for modification of clinical privileges (increases and relinquishments) during the term of appointment, resignation from the Medical Staff, and waivers of eligibility criteria for privileges.
- (b) Submitting a Request. Requests for privilege modifications and waivers must be submitted in writing to the Medical Staff Office.
- (c) Waivers.
 - (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
 - (2) If the individual is requesting a waiver of the requirement that each member apply for the full core privileges in his or her specialty, the

request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

- (3) By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall arrange for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, arrange for the patient's transfer.
- (4) Requests for waivers in this section will be processed in the same manner as requests for waivers of appointment criteria, as described in Article 2, and will consider the factors outlined in Paragraph (f).

(d) Increased Privileges.

- (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria.
- (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(e) Resignation and Relinquishment of Privileges.

- (1) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation. After consulting with the Chief of Staff, the President/CEO will act on the resignation request.
- (2) Relinquishment of Individual Privileges. A request to resign any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(f) Factors for Consideration.

The Medical Staff leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification or waiver related to privileges:

- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
- (2) whether sufficient notice has been given to provide the smooth transition of patient care services;
- (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
- (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have upon them;
- (5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the emergency department;
- (6) any perceived inequities in modifications or waivers being provided to some, but not others;
- (7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and
- (8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges, nor to a hearing or other process if a modification or waiver is not granted.

4.B. OTHER PRIVILEGING ISSUES

4.B.1. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.
- (b) The Credentials Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.
- (c) If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee shall conduct research and may consult with experts, both those on the Hospital's Medical Staff and those outside the Hospital, and develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the procedure or service;
 - (2) the criteria and/or indications for when the procedure or service is appropriate;
 - (3) the manner of addressing the most common complications that may arise; and
 - (4) the extent of focused monitoring and supervision that should occur if the privileges are granted.
- (d) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.
- (e) After receiving the recommendations from the Credentials Committee and the MEC, the Board shall make a determination as to whether the new procedure or

service will be offered to patients. If the Board determines to offer the procedure or service, it shall then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

4.B.2. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., service line chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (c) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent of focused monitoring and supervision that should occur if privileges would be granted;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (d) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for

final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

- (e) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.B.3. Clinical Privileges After Age 67:

- (a) Individuals who desire to exercise clinical privileges after the age of 67 must apply for reappointment on a yearly basis.
- (b) As part of the annual reappointment process, these members shall be required to have a physical and mental health assessment performed by a physician who is acceptable to the Credentials Committee. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.
- (c) If the Committee determines that there are issues in any of these areas and/or other concern areas, the Committee shall determine what next steps are to be taken to address the concerns raised. The Committee may meet with the individual to discuss these concerns and to try to determine what collegial and voluntary steps, such as a voluntary restructuring of privileges, further monitoring, or focused review (as examples only), can be taken.

4.B.4. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Dentists and oral surgeons must arrange for physician members of the Medical Staff to perform and record initial medical histories and physical examinations of patients before dental surgery shall be performed. Updates to the initial history and physical examination further assessing the medical risks of the procedure on the patient may be performed by dentists and oral surgeons who are deemed qualified to do so by the Credentials Committee and MEC, as long as the initial history and physical was completed in accordance with this Section.
- (c) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and

consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.B.5. Clinical Privileges for Podiatrists:

- (a) The scope and extent of surgical procedures that a podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Podiatrists must arrange for physician members of the Medical Staff to perform and record initial medical histories and physical examinations of patients before podiatric surgery shall be performed. Updates to the initial history and physical examination further assessing the medical risks of the procedure on the patient may be performed by podiatrists who are deemed qualified to do so by the Credentials Committee and MEC, as long as the initial history and physical was completed in accordance with this Section.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.B.6. Physicians in Training:

Physicians in training shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the MEC or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.B.7. Temporary Clinical Privileges:

- (a) Applicants. Temporary privileges may be granted by the President/CEO, upon receipt of a report from the relevant service line chair, a favorable recommendation of the Credentials Committee, and recommendation by the Chief of Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the MEC and Board. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested and current professional liability coverage; compliance with privileges criteria; and

consideration of information from the Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he/she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility. Temporary privileges in this situation shall be granted for a maximum period of 120 consecutive days.

- (b) Non-Applicants. Temporary privileges may also be granted to non-applicants by the President/CEO, upon recommendation of the Chief of Staff and the relevant service line chair, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:
- (1) the care of a specific patient; or
 - (2) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure, current competence, current professional liability coverage acceptable to the Hospital, results of a query to the National Practitioner Data Bank, and results of any criminal background check. The granting of clinical privileges in these situations shall not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the President/CEO and the Chief of Staff.

- (c) Locum Tenens. The President/CEO may grant temporary admitting and clinical privileges to an individual serving as a locum tenens for a member of the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in paragraph (b), except for the following: (i) the locum tenens physician must also file a complete application, and (ii) the time periods for the grant of privileges are different. The individual serving as a locum tenens may exercise privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the date they are granted. Individuals who wish to exercise locum tenens temporary privileges longer than 120 days during any 24-month period must submit applications requesting full Medical Staff membership.
- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.
- (e) Supervision Requirements. In exercising temporary privileges, the individual shall act under the supervision of the service line chair. Special requirements of

supervision and reporting may be imposed on any individual granted temporary clinical privileges.

(f) Termination of Temporary Clinical Privileges.

- (1) The President/CEO may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the service line chair, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
- (2) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the President/CEO, the service line chair, or the Chief of Staff may immediately terminate all temporary privileges. The service line chair or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (3) The granting of temporary privileges is a courtesy and may be terminated for any reason.
- (4) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.B.8. Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate service line chair, the Credentials Committee, and the MEC.
- (b) Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.
- (c) Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.
- (d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by the

applicant's primary hospital/group, provided that hospital/group is accredited by the Joint Commission.

- (e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.
- (f) Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of service line status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the service line chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President/CEO or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

- (b) A volunteer's license may be verified in any of the following ways:
 - (i) current Hospital picture ID card that clearly identifies the individual's professional designation;
 - (ii) current license to practice;
 - (iii) primary source verification of the license;
 - (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or
 - (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.
- (3) Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records;
- (b) completed all continuing medical education requirements (Evidence of 50 hours of documented Category I CME relevant to current practice is required at the time of biennial reappointment. Because of the discrepancy between the Hospital reappointment cycle and the State Board cycle, Category I CME earned during the last six months of the previous reappointment period may be counted toward the required 50 hours, provided it has not been considered during the previous reappointment. Copies of actual certificates or official letters are required.);
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application shall be considered complete and processed further; and
- (f) paid the reappointment processing fee (if applicable).

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy shall be considered. Additionally, the following factors shall be evaluated as part of the reappointment process:

- (a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
- (b) participation in Medical Staff duties, including committee assignments and call responsibilities (both for private patients and for the Emergency Department), consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.
- (b) Failure to submit a complete application at least two months prior to the expiration of the member's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff leadership.
- (c) Reappointment shall be for a period of not more than two years.
- (d) Except as provided below, if an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.
- (e) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to

meet on-call coverage requirements, or denying the community access to needed medical services, the President/CEO shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the President/CEO shall consult with the chair of the applicable service line, the Chair of the Credentials Committee, and/or the Chief of Staff. The temporary clinical privileges shall be only for a period not to exceed 120 days.

- (f) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (g) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

- (a) The Medical Staff Office shall forward the application to the relevant service line chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) If it becomes apparent to the Credentials Committee or the MEC that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee shall notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.
- (b) In addition, in the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a

conditional reappointment for a period of less than two years may be granted pending the completion of that process.

- (c) Reappointments may also be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

5.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff leaders (and Hospital management if requested by the Medical Staff leaders), beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.
- (3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:
 - (a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records; and
 - (b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (4) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual shall have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.
- (6) The relevant Medical Staff leader(s), in conjunction with the President/CEO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation plan). Medical Staff leaders may also direct these matters to the MEC for further action.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the Professional Practice Evaluation Plan. Matters that cannot be appropriately resolved through collegial intervention or through the Professional Practice Evaluation Plan shall be referred to the MEC for its review in accordance with Section 6.C below.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial or peer review efforts have not resolved an issue, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
 - (3) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter may be referred to the Chief of Staff, the chair of the service line, the chair of a standing committee, or the President/CEO.
- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff member, the matter shall be referred to the Chief of Staff, the chair of the service line, the chair of a standing committee, or the President/CEO for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the MEC.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.C.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy, practitioner health policy, professional practice evaluation plan), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.
- (b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The Chief of Staff shall keep the President/CEO fully informed of all action taken in connection with an investigation.

6.C.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the MEC shall investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).
- (b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that
 - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
 - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

- (c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
 - (1) relevant literature and clinical practice guidelines, as appropriate;
 - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
 - (3) any information or explanations provided by the individual under review.

6.C.4. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring or consultation;
 - (5) recommend additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the President/CEO, who shall promptly inform the individual by special notice. The President/CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the President/CEO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.D.1. Grounds for Precautionary Suspension or Restriction:

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the Chief of Staff, the chair of a clinical service line, the President/CEO, or the MEC shall each have the authority to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges.
- (b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction. Precautionary suspensions are not reportable to the National Practitioner Data Bank but are, however, reportable to the North Carolina Medical Board even though the matter has not been finally determined.
- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO and the Chief of Staff, and shall remain in effect unless it is modified by the President/CEO or MEC.
- (e) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.D.2. Medical Executive Committee Procedure:

- (a) The MEC shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.D.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
- (b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the service line chair, the MEC, and the President/CEO in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT

6.E.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. The Hospital is required to report individuals to the North Carolina Medical Board who automatically relinquish their clinical privileges for medical record delinquencies three times in one calendar year. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff.

6.E.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below or failure to satisfy any of the threshold eligibility criteria set forth in this Policy must be promptly reported to the President/CEO and the Chief of Staff by the Medical Staff member.

- (b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following administrative events occur:
- (1) Licensure: Revocation, expiration, suspension, or the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the \$1 million per incident and \$3 million per aggregate minimum required by the Hospital or cease to be in effect, in whole or in part.
 - (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
 - (5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.
- (c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this Policy. An automatic relinquishment for any of the reasons set forth in this Section is not reportable to the National Practitioner Data Bank or to the North Carolina Medical Board.
- (d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. The Chief of Staff shall notify the individual that patients have been appropriately reassigned. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment shall be deemed permanent.
- (e) Failure to resolve the underlying matter leading to an individual's clinical privileges being automatically relinquished in accordance with paragraphs (b)(1), (b)(2) or (b)(3) above, within 90 days of the date of relinquishment shall result in automatic resignation from the Medical Staff.
- (f) Upon an individual's clinical privileges being automatically relinquished, the Chief of Staff shall assign to another individual with appropriate clinical

privileges responsibility for care of the that individual's hospitalized patients. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

- (g) Requests for reinstatement shall be reviewed by the relevant service line chair, the Chair of the Credentials Committee, the Chief of Staff, and the President/CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment and/or clinical privileges, in response to a written request from the Credentials Committee, the MEC, a Professional Practice Evaluation Committee, the President/CEO, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment shall continue in effect until the information is provided to the satisfaction of the requesting party.

6.E.4. Failure to Attend Special Conference:

- (a) Whenever there is a concern regarding clinical practice or professional conduct involving any individual, the service line chair or the Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
- (c) Failure of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.F. LEAVES OF ABSENCE

- (1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President/CEO. The request must state the

beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

- (2) Except for maternity leaves, members of the Medical Staff must report to the President/CEO any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the President/CEO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence.
- (3) The President/CEO shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the President/CEO shall consult with the Chief of Staff and the relevant service line chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (4) During the leave of absence, the individual shall not exercise any clinical privileges at the Hospital. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.
- (5) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant service line chair, the Chair of the Credentials Committee, the Chief of Staff, and the President/CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume patient care activities without first waiting for regularly scheduled Credentials, MEC, and Board meetings. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (6) If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. The privacy of the information contained in the report will be maintained in strict confidence by the Medical Staff leadership who are involved in the review of the matter.

- (7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the President/CEO, in consultation with the Chief of Staff. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (8) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply for reappointment.
- (9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) issuance of a letter of guidance, counsel, warning, or reprimand;

- (b) imposition of conditions, monitoring, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) denial of a request for leave of absence or an extension of a leave;
- (h) determination that an application is incomplete;
- (i) determination that an application shall not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The President/CEO shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the President/CEO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The President/CEO, after consulting with the Chief of Staff, shall schedule the hearing and provide, by special notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

The President/CEO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members and may include any combination of:

- (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).
 - (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
 - (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
 - (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
 - (5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.
 - (6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- (b) Presiding Officer:
- (1) The President/CEO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
 - (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence;

- (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
 - (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
 - (4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- (c) Hearing Officer:
- (1) When the underlying matter involves issues of professional conduct only (as opposed to issues of clinical competence), as an alternative to a Hearing Panel, the President/CEO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.
 - (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, shall be made in writing, within ten days of receipt of notice, to the President/CEO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The President/CEO shall rule on the objection and give notice to the parties. The President/CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.6. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the MEC;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the MEC's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.C.4. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.5. Stipulations:

The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.6. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (i) a pre-hearing statement that either party may choose to submit; (ii) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (iii) stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel, who may call, examine, and cross-examine witnesses and present the case;
 - (5) to submit a written statement at the close of the hearing; and
 - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. An audio recording shall also be made of the hearing. The cost of creating these records shall be borne by the Hospital. A copy of the stenographer's transcript shall be provided to the individual who requested the hearing. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to be Present:

The hearing sessions shall be restricted to those individuals involved in the proceeding, the Chief of Staff, and the President/CEO. In addition, administrative personnel may be present as requested by the President/CEO or the Chief of Staff.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President/CEO on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the President/CEO. The President/CEO shall send by special notice a copy of the report to the individual who requested the hearing. The President/CEO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

- (a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the President/CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Bylaws of the Hospital or Medical Staff during the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chairman of the Board shall determine whether the grounds for appeal have been met; if so, the Chairman shall schedule and arrange for the appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Chairman of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board. The Review Panel shall not include individuals who have actively participated in the matter at any previous level.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel and Review Panel. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.
- (c) The Board shall render its final decision in writing, including specific reasons, and shall send special notice thereof to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFLICTS OF INTEREST

8.A.1. General Principles:

- (a) All those involved in credentialing and peer review activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, and to protect the integrity of the review process and the individual with the potential conflict.
- (b) It is also essential that peers participate in credentialing and peer review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

8.A.2. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

8.A.3. Employment or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not in and of itself preclude an individual from participating in credentialing and peer review activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

8.A.4. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

- (a) membership in the same group practice;
- (b) having a direct or indirect financial relationship;
- (c) being a direct competitor;
- (d) close friendship;
- (e) a history of personal conflict;

- (f) personal involvement in the care of a patient which is subject to review;
- (g) raising the concern that triggered the review; or
- (h) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

8.A.5. Guidelines for Participation in Credentialing and Peer Review Activities:

When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

- (a) Individual Reviewers. An Interested Member may participate as an individual reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:
 - Participation in the review of applications for appointment, reappointment, clinical privileges because of the Credentials Committee's and MEC's subsequent review of credentialing matters; and
 - Participation as case reviewers in peer review because of a Professional Practice Evaluation Committee's subsequent review of peer review matters.
- (b) Credentials Committee or Professional Practice Evaluation Committee Member. An Interested Member may participate as a member of these Committees because these Committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested member in a particular situation, in accordance with the rules for recusal outlined below. It is expected that a member of any of these committees (Credentials or a Professional Practice Evaluation Committee) will inform the committee chairperson if the individual meets the criteria for an Interested Member as defined in 8.A.4.
- (c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may provide information to and answer questions posed by the ad hoc investigating committee.
- (d) Medical Executive Committee. An Interested Member shall be recused and may not participate as a member of the MEC when the MEC is considering a

recommendation that could adversely affect the clinical privileges of a practitioner subject to the rules for recusal outlined below.

8.A.6. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

- (a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria; and
- (b) serve on the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but
- (c) shall recuse him/herself, or be recused, if that individual serves on the MEC at the time the MEC is considering its final recommendation to the Board regarding the criteria.

8.A.7. Rules for Recusal:

- (a) When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair shall consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee or would skew the recommendation or determination of the committee.
- (b) Any Interested Member who is recused from participating in a committee meeting must leave the meeting room prior to the committee's final deliberation and determination but may answer questions and provide input before leaving.
- (c) Any recusal shall be documented in the committee's minutes.
- (d) Whenever possible, an actual or potential conflict should be brought to the attention of the Chief of Staff or committee chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

8.A.8. Other Considerations:

- (a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the

situations noted in the paragraphs above, may call the conflict of interest to the attention of Chief of Staff (or to the Chief of Staff-Elect if the Chief of Staff is the person with the potential conflict), or the applicable service line chair or committee chair. The Chief of Staff or the applicable service line chair or committee chair shall make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

- (b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff leaders, guided by this Article.
- (c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities;
- (2) when the disclosures are authorized by a Medical Staff or Hospital policy; or
- (3) when the disclosures are authorized, in writing, by the President/CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

9.B. PEER REVIEW PROTECTION

- (1) All credentialing and peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by "Medical Review Committees" in accordance with N.C. Gen. Stat. §90-21.22A and N.C. Gen. Stats. §§131E *et seq.* Medical review committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Hospital committees;
 - (b) all service lines;
 - (c) hearing panels;
 - (d) the Board and its committees; and
 - (e) any individual acting for or on behalf of any such entity, including but not limited to service line chairs, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by medical review committees are confidential and covered by the provisions of N.C. Gen. Stat. §90-21.22A and N.C. Gen. Stats. §§131E *et seq.*

- (2) All medical review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments shall also be provided to all members of the Medical Staff at least 14 days prior to the MEC meeting and any member of the Medical Staff may submit written comments to the MEC. No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

This Policy is adopted, and made effective as of October 1, 2009, upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on July 16, 2009:

Chief of Staff

Approved by the Board on July 28, 2009:

Chair, Board of Directors

Revision Dates: