



Medical Staff Bylaws Medical Staff
Rules & Regulations
Medical Staff Fair Hearing Plan

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Date:

11/29/2023

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Reviewed Approved by the Medical Staff 11/29/23.
Reviewed Approved by Governing Board 2/22/2024.



Medical Staff

Bylaws

LifeBrite Community Hospital of Stokes
Medical Staff Bylaws

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BYLAWS
of the
MEDICAL STAFF
of
LIFEBRITE COMMUNITY HOSPITAL OF STOKES
DANBURY, NORTH CAROLINA

ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. PURPOSE

The purpose of this medical staff is to bring qualified physicians, dentists, and podiatrists as well as Mid-Level Providers (i.e.: APN, PA, CRNA, and LCSW) who practice at LifeBrite Community Hospital of Stokes ("Hospital") together into a cohesive body to promote good care and to offer advice, recommendations, and input to the Chief of Staff and the Governing Board. The medical staff provides supervision to all ancillary staff. Specific functions of the staff are outlined in the Rules and Regulations Manual (Part 1).

SECTION 2. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff of Hospital is a privilege which shall be extended only to professionally competent physicians, dentists, and podiatrists as well as Mid-Level Providers (i.e.: APN, PA, CRNA, and LCSW) who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the medical staff and Hospital.

SECTION 3. QUALIFICATIONS FOR MEMBERSHIP

A. Eligible candidates for appointments to the medical staff shall have evidence that the following qualifications have been met:

1. Successfully completed at least a two-year postgraduate training program in the specialty in which privileges are held or sought, which program was, at the time attended, accredited by the Accreditation Council of Graduate Medical Education, or the American Osteopathic Association, and can document experience and demonstrate competence that is determined by the Medical Staff Committee and approved by the committee to be equivalent to the description in this subsection. Candidate has received a certificate from the Education Commission of Foreign Graduates (ECFMG), if applicable; or
2. Completed an accredited program for Mid-Level Providers.
3. Demonstrated current competency: Have documented, current clinical competence and experience during the last 12 months for the requested privileges to include parameters of safe and effective patient care. Review of performance data prior to appointment, if available, and reappointment every 24 months thereafter (see Sec. 5C).

4. Adhere to professional ethics (as outlined by AMA, AOA, ADA or APMA) and comply with the code of conduct as outlined in the Professional Conduct Attestation provided by LifeBrite Community Hospital of Stokes. Mid-Levels practitioners must adhere to the ethical standards as set forth through their licensing agency and comply with the Code of Conduct outlined in the Professional Conduct Attestation through LifeBrite Community Hospital of Stokes.
 5. Have no health problems existent that could affect his or her ability to perform the privileges requested so as to protect the health and safety of patients.
 6. Primary verification of State professional license: AMA Master Profile, have a current NC MD, DO, DDS, DPM, CRNA, APN, PA, or LCSW licensure and current Federal Narcotics Registration Certificate (DEA), as applicable.
 7. Have professional liability insurance of a type and in the amount established by the Governing Board
 8. Have no OIG Medicare/Medicaid sanction or exclusions, any felony conviction, or other occurrences that would raise questions of undesirable conduct not consistent with the mission of the organization.
 9. Review of any professional liability actions. Review of database profiles through professional services (i.e.: AMA, AOA, NPDB, OIG Medicare/Medicaid Exclusions, State specific data banks)
 10. Receipt of professional references
 11. Primary verification of education
- B. No physicians, dentists, podiatrists or Mid-Level Providers (i.e.: APN, PA, CRNA, and LCSW) shall be entitled to membership on the medical staff or to practice privileges merely by virtue of licensure, membership in any organization, or privileges at any other healthcare organization. During the processing period, the medical staff must consider the hospital facilities; equipment needs as it relates to the capital outlay budget; technical staff salaries and supportive services which would be needed by the applicant and his patients; the patient need for the applicants skill and training as well as the geographic location of the applicant's home and office to the hospital. The Medical Staff as a whole develop and recommend criteria for clinical privileges that are relevant to the care provided in the organization.
- C. Physician Assistants and Nurse Practitioners:
1. It is the policy of LifeBrite Community Hospital of Stokes and its medical staff to employ nurse practitioners (NPs) and physician assistants (PAs) to perform medical acts following official approval from the North Carolina Medical Board and/or the Board of Nursing. The NP/PA may be employed by the hospital or by a member of the active or courtesy medical staff. As defined by the North Carolina Medical Board:
 - A nurse practitioner means a “currently licensed registered nurse approved to perform medical acts under an agreement with a licensed physician for ongoing supervision, consultation, collaboration, and evaluation of the medical acts performed.”
 - A physician assistant means “a person licensed by and registered with the Board to perform medical acts, tasks, or functions under the supervision of a physician licensed by

the Board, who performs tasks traditionally performed by the physician, and who has graduated from a physician assistant or surgeon assistant program accredited by the Commission on Accreditation of Allied Health Education Programs, or its predecessor or successor agencies.”

- A. The NP/PA shall at all times be licensed, approved and registered pursuant to the then applicable laws, rules, and regulations of the State of North Carolina and all boards, commissions and agencies thereof.
 - B. Each NP/PA shall have a practice agreement/arrangement with a designated primary supervising physician. The primary supervising physician shall at all times be totally responsible for the NP/PA’s performance, and all acts, omissions, tasks, and functions of the NP/PA within the hospital and its outpatient facilities/offices. Back-up supervising physicians provide coverage when the primary supervising physician is unavailable. Back-up supervising physicians are only responsible for the medical acts of the NP/PA when they are actively supervising the NP/PA. A list of back-up physicians for each NP/PA is maintained in the administrative office as well as at each practice site.
2. Application and Approval of Nurse Practitioners and Physician Assistants
- A. NP/PAs are credentialed by the medical staff and authorized privileges in the same manner as that used for physicians. All privileges granted by the facility or medical staff will conform to state law. The initial request of the NP/PA to perform certain medical acts, tasks, and functions within the hospital and/or its outpatient settings shall be submitted in writing to the medical staff through the president. In addition, the PA/NP shall submit the following information which is included in the Approval to Practice application required by the Board of Medical Examiners and/or Board of Nursing:
 - 1. Satisfactory evidence that the NP/PA has successfully completed an approved educational/training program recognized by the NC Board of Medical Examiners and/or the NC Board of Nursing.
 - 2. Verification that the NP/PA is currently licensed, approved and/or registered by the applicable board of the state of North Carolina and is in good standing.
 - 3. Verification that the NP/PA has a practice agreement with a designated primary supervising physician.
 - 4. A list of back-up supervising physicians if applicable.
 - 5. Two letters of recommendation from qualified individuals attesting that the NP/PA has been appropriately trained for those requested acts, tasks, and functions.
 - 6. Core privilege list.
 - B. The application and supporting documentation shall be reviewed by the president and presented to the medical staff at the next scheduled meeting. The designated primary supervising physician may be required to explain any matter pertaining to the application or its supporting documentation by letter and/or appearance before the medical staff.

After such review, the medical staff shall make a decision for approval and privilege. The application and supporting documentation will be presented to the board of trustees by the president or the president of the medical staff at the next scheduled board meeting.

- C. Approval granted to a NP/PA shall be for no more than 24 calendar months. Before reappointment can be granted, the NP/PA must submit a written reappointment application to the medical staff in the same manner as that used for physicians.
 - D. To maintain approval to practice, the NP/PA must maintain earn 100 hours of continuing education every two years. Documentation of continuing education will be maintained by the NP/PA at each practice site and made available upon request to the administrative office, medical staff and NC Medical and/or Nursing Boards.
 - E. The application and all supporting documentation shall become a part of the PA/NP's permanent record at the hospital, to be maintained in the administrative office.
 - F. In the event that the medical staff should deny or limit initial approval, reappointment, or the core privilege of the NP/PA, he/she shall be entitled to a hearing before the medical staff. Request for a hearing shall be in writing and directed to the president of the hospital. The president shall contact the president of the medical staff and schedule an agenda item at the next regularly scheduled meeting. Should this decision be adverse following the hearing, the NP/PA and/or employer and/or supervising physician may request a hearing before the Executive Committee of the board of trustees. This request should be made in writing to the president of the hospital within 30 days of the hearing at the medical staff meeting. If the matter is not resolved at the board level, the chairman will appoint a committee of 2 trustees and 2 physicians (not to include the member employer or supervising physician) to make a final decision within 30 days of the board of trustees hearing.
3. Performance of Medical Acts, Tasks, and Functions (NP/PA)
- A. Healthcare services delivered by NPs and PAs must be within the scope of each practitioner's authorized practice as defined by NC state law. The scope of practice and role of the NP or PA in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the supervising physician and the NP or PA and are determined, in large part, by the delegatory decisions made by the supervising physician. The practice guidelines describe supervisory arrangements, written prescribing privileges, medical treatments, tests, procedures, and a pre-determined plan for emergencies that define the NP/PA's scope of medical acts. A copy of these guidelines are annually signed by both NP/PA and their designated primary supervising physician shall be kept on file at all practice sites, and shall be available for inspection upon request by the NC Medical Board and/or the NC Board of Nursing. A NP or PA may only provide those medical services which:
 - he or she is competent to perform, as determined by the supervising physician,
 - are consistent with his/her education, training, and experience, and
 - are delegated in writing by the supervising physician

- B. The supervising physician is responsible for the supervision of the NP or PA in all settings and must be available for consultation with the NP or PA at all times either in person or through telecommunication. When the primary supervising physician is not available, back-up supervising physicians provide this coverage. A list of back-up physicians is maintained in each practitioner's file in the administrative office as well as at each practice site with the NP/PA practice guidelines. The NP/PA's approval to perform within the hospital, its outpatient facilities, and/or offices shall temporarily cease during any period of time that communication and consultation by and between the NP/PA and either the primary supervising physician or a designated back-up physician is not possible. For example, if the primary supervising physician is away on vacation and a back-up supervising physician is not available.
- C. The supervising physician is ultimately responsible for coordinating and managing the care of patients and ensuring the quality of health care provided to patients by each NP or PA. A process of on-going review of care provided by the NP/PA is established by the supervising physician and the NP/PA based on requirements by the NC Medical Board and/or NC Board of Nursing. Appropriate records of these reviews are maintained by the NP/PA at each practice site.
- D. In accordance with all the above criteria, the NP or PA may work in any setting within the hospital and its outpatient facilities or offices and perform any medical service as approved by their primary supervising physician. Nurses and ancillary staff receiving an order from a nurse practitioner or physician assistant for medications, tests, or treatments are authorized to perform that order in the same manner as if it were received from a licensed physician. All orders given or prescriptions written by the NP/PA shall be deemed to have been authorized by the physician approved by the board(s) as the supervisor of the NP/PA and such supervising physician shall be responsible for authorizing such order or prescription. Nurses verify or question orders from NP/PAs in the same manner as they would from a physician in the interest of patient health and safety. NP/PA orders should be in writing except in extreme emergencies.
- E. Entries to a patient's medical record shall be signed by the NP/PA and countersigned by the supervising physician in accordance with the standards dictated by the NC Board of Medical Examiners and the NC Board of Nursing. The supervising physician will review and sign a sample of records of patients cared for by the NP/PA every two weeks.
- F. Patients will be made clearly aware at all times whether they are being cared for by a physician or an NP or PA. Appropriate name badges will be worn.
- G. The NP/PA shall:
 - 1. Participate in the development, review, revising and implementation of written clinical policies for services provided by the Hospital.
 - 2. Participate in the periodic review of medical records in conjunction with the medical staff.
 - 3. Perform clinical services that are not being performed by a doctor or medicine or osteopathy in accordance with Hospital policies.

- (a) Refer those patients who require clinical services not provided by the CAH and arrange for the maintenance and transfer of medical records.
 - (b) Notify a Physician on the Hospital's clinical staff when a patient is admitted as an inpatient.
- 4. Discontinuation of Supervising Physician Arrangement or Termination of Approval (NP/PA)
 - A. If for any reason either the NP/PA or the supervising physician discontinues their NP/PA-supervising physician arrangement, the NP/PA and/or the supervising physician will notify the president of the medical staff and the administrative office immediately and the NP/PA's approval to practice is terminated. The NP/PA shall notify the appropriate Medical/Nursing Boards in writing.
 - B. The medical staff may recommend the termination of the approval of the NP/PA to perform within the hospital and outpatient settings and may recommend disciplinary action for the primary supervising physician or back-up supervising physician for any of the following:
 - 1. The NP/PA represented or knowingly permitted another to represent him/her as a licensed physician.
 - 2. The NP/PA performed medical acts without the supervision of the primary supervising physician or a designated back-up supervising physician.
 - 3. The NP/PA performed a medical act, task, or function not in keeping with the approval granted or performed below acceptable levels of competency.
 - 4. The NP/PA performed or participated in an act within the hospital or its outpatient settings of serious moral or ethical misbehavior.
 - 5. The NP/PA has no liability insurance coverage.
 - C. The chief of staff shall notify the NP/PA in writing of the general nature of the charge, accusation or complaint and shall provide the NP/PA with an opportunity to be heard by the medical staff as a whole. The burden shall be on the NP/PA and/or employer to establish that the charge, accusation, or complaint is unfounded. After review, the medical staff shall make a written recommendation. If the decision is to terminate the approval of the NP/PA to work within the hospital and/or outpatient settings, the termination becomes effective when ratified by decision of the governing body. The NP/PA and/or employer shall be afforded the right to a hearing and appellate review as provided for in Article XI.
 - D. If the NP/PA's license, approval or registration is rescinded, revoked or terminated by the State of NC or any board, commission or agency thereof, or if such approval, license or registration expires, the NP/PA's approval with the hospital is terminated.

SECTION 4. NONDISCRIMINATION

Hospital shall not discriminate in granting medical staff appointment and/or practice privileges on the basis of religion, race, color, national origin, age, gender, height, weight, familial status, marital status, or disability unrelated to the provision of patient care. Appointment may be denied if no need has been demonstrated for a particular medical specialty.

SECTION 5. CONDITIONS AND DURATION OF APPOINTMENT

- A. Initial appointments and reappointments to the medical staff shall be made by the Governing Board. The Governing Board shall act on appointments and reappointments only after there has been a recommendation from the Medical Staff Committee.
- B. Appointments to the medical staff shall be for no more than 24 calendar months.
- C. Reappointment to the Medical Staff requires review and analysis of performance data. This data is collected using the “Monthly Provider Scorecard” and presented every 24 months to The Medical Staff Committee. Recommendations to the Governing Body are made by the Medical Staff Committee only after thorough evaluation of data and any noted deviations from standards of practice. Performance data must include the following:
 - Use of Blood and Blood Products
 - Prescribing of Medications
 - Operative and Invasive Procedures
 - Moderate Sedation Outcomes
 - Appropriateness of Care
 - Utilization Data
 - Significant Deviations from Standards of Practice
 - Timely and Legible completion of Patient Medical Records
- D. The medical staff must act on any formal application for membership no later than 45 days after receipt of application and corresponding information from the administrator. The governing body must act on the recommendation of the medical staff within 90 days. Applicants will be notified when the medical staff membership is granted. The administrative assistant handles this correspondence.

An applicant to the medical staff has 90 days to submit requested information to the president or administrative assistant to complete the application process. If requested information is not received within the 90 day period, the application will be deemed NO APPLICATION. The applicant is responsible for submitting all documentation in a timely manner. If it is clear that an applicant is seeking information and it is not his fault that he has been unable to secure the information, the 90 days period may be extended for an additional period of time to be decided by the president or administrative assistant. Once the administrator or administrative assistant deems the application complete and verified, it will be submitted to the medical staff at their next regularly scheduled meeting.

SECTION 6. RESPONSIBILITIES OF EACH MEMBER

- A. Each staff member must provide appropriate, timely, and continuous care of his/her patients. He/She is not responsible for the actions of other staff members, Allied Health Professionals (unless under his/her supervision), or health system employees.
- B. Each staff member must participate, if assigned, in quality/performance improvement activities and in discharging other staff functions as may be required from time to time.
- C. Each staff member must participate in the coverage of the emergency service and other coverage programs as determined by the Medical Staff Committee and contractual arrangements.

- D. Each staff member must abide by the bylaws, rules and regulations and other policies and procedures of the health system and the medical staff.
- E. Each staff member must notify the Chief of Staff immediately upon the occurrence of any of the following:
 - 1. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of the staff member's professional license by any state licensing agency for reasons relating to the staff member's professional competence or professional conduct; or
 - 2. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of a staff member's practice privileges at any hospital or other healthcare institution that adversely affects his/her practice privileges for a period of more than 30 days.
- F. Medical Records: A staff member with privileges who, after warning of delinquency, fails to complete medical records within 10 days, in accordance with the rules may have privileges withheld. He/she may also be required to attend the next regular MSC meeting to discuss his/her reasons for said delinquency. The staff member shall be notified by the Chief of Staff by certified mail, return receipt requested, of the matter to be discussed and the time and location of the meeting. The staff member so affected shall be required to attend that meeting of the MSC. The MSC may then take corrective action appropriate to the facts involved, pursuant to Section E above.
 - 1. History and Physical is required to be a part of the patient chart within 24 hours of admission. If the H&P has been dictated, a note stating the date/time of dictation will be added to the record.
 - 2. Discharge Summaries are to be completed as soon after discharge as possible.
 - 3. All Patient Record documentation must be completed within 36 hours of discharge.
 - 4. Telephone orders are to be used infrequently and when used must be accepted only by personnel authorized by the medical staff and in accordance with Federal and State law.
 - 5. Verbal orders should be limited to urgent situations where immediate written or electronic communication is not feasible.
 - 6. Verbal orders must be signed or initialed by the prescribing practitioner and must be authenticated in accordance with Federal and State law. If there is not a State law that designates a specific timeframe for the authentication of verbal orders, the orders must be authenticated within 48 hours. Verbal orders and/or telephone orders in long term care shall be signed within 72 hours of dictation. Verbal orders shall only be dictated by approved members of the medical staff to registered nurses, registered pharmacists, licensed physical therapists, licensed respiratory therapists or CRNAs in the hospital and/or licensed practical nurses in the skilled facility.
 - 7. Verbal orders must be documented in the patient's medical record, and be reviewed and countersigned by the prescriber as soon as possible. It is acceptable for a covering physician to co-sign the verbal order of the ordering practitioner in the event that the

ordering practitioner is not available to sign the verbal order in the established timeframe such as over the weekend or an extended period of time.

- G. Elements that are to be included in any medication order (including all written, and verbal/telephone orders):
1. Name of patient
 2. Age and weight of patient, or other dose calculation requirements, when appropriate
 3. Date and time of the order
 4. Drug name
 5. Dosage form (e.g., tablets, capsules, inhalants)
 6. Exact strength or concentration
 7. Dose, frequency, and route
 8. Quantity and/or duration; when applicable
 9. Indications for use (including orders for PRN administration and/or multiple uses of medication);
 10. Specific instructions for use (i.e. more than one medication for same use such as a pain, nausea)
- H. Each staff member will be given reports that trend elements of F. 1-5 at the Medical Staff Committee meeting. A list of incomplete charts, past the 36 hour requirement, will be presented to the provider at the MSC meeting. The provider will have 10 days to complete the charts prior to initiating any disciplinary actions. Providers whose facilities hold meetings bi-monthly will receive monthly report of deficiencies.

SECTION 7. MEDICAL STAFF MEMBERS RIGHTS

- A. Each physician on the medical staff has the right to meet with the Medical Staff Committee. In the event a staff member is unable to resolve a difficulty working with, that physician may, upon presentation of a written notice to the Chief of Staff, meet with the Medical Staff Committee to discuss the issue.
- B. Any staff member has a right to a hearing/appeal pursuant to the institution's fair hearing plan in the event that any of the following actions are taken or recommended:
1. denial of initial staff appointment
 2. denial of reappointment
 3. revocation of staff appointment
 4. denial or restriction of requested practice privileges

5. reduction in practice privileges
6. revocation of practice privileges
7. individual application of, or individual changes in, mandatory concurring consultation requirement
8. suspension of staff appointment or practice privileges if such suspension is for more than 14 days

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE ACTIVE CATEGORY

Qualifications: Appointees to the active category must:

- A. Be involved in a minimum of 25 patient contacts per year (i.e. a patient contact is defined as an inpatient admission, consultation, or outpatient encounter) at Hospital.

In the event that an appointee to the active category does not meet the qualifications for reappointment to the active category, and if the appointee is otherwise abiding by all bylaws, rules, regulations, and policies of the staff, the appointee may be appointed to the courtesy category.

Prerogatives: Staff members appointed to the active category may

- A. Exercise such practice privileges as are granted by the Governing Board
- B. Vote on all matters presented by the medical staff and by the appropriate department and committee of which he/she is a member
- C. Hold office and sit on or be the chair of any committee, unless otherwise specified elsewhere in these bylaws.

Responsibilities: Staff members in the active category must

- A. Contribute to the organizational and administrative affairs of the medical staff
- B. Actively participate in recognized functions of the staff appointment including quality/performance improvement, on call coverage for the emergency service and other coverage programs, risk management and monitoring activities other staff functions as may be required from time to time
- C. Fulfill any meeting attendance requirements as established by the Medical Staff Committee. Will attend at least 50% of Medical Staff Committee meetings.
- D. Assist Hospital in the fulfillment of its mission
- E. Reside within 75 minutes of the hospital, in order to respond to patient care needs, in a timely manner, to maintain practice privileges. The expected time limit for responding to notification is to call within 15 minutes of initiation of the page. The physician should be able to arrive at the hospital within 75 minutes. If the physician does not respond by phone within 15 minutes of notification, their practice partner(s) will be contacted. If a practice partner is not available, the Chief of Staff will be notified. Providers that are assigned to the Emergency Department must

report on site within 30 minutes.

F. Successfully complete the clinical monitoring process.

Requirements: Licenses and professional liability insurance required

SECTION 2. THE COURTESY CATEGORY

Qualifications: The courtesy category is reserved for staff members who do not meet the eligibility requirements for the active category. Information related to competency will be obtained from other healthcare organizations and/or peer recommendations in regards to staff members with low or no activity who are needed to fulfill a specialty patient care need.

Prerogatives: Staff members in the courtesy category may

- A. Exercise such practice privileges as are granted by the Governing Board
- B. Attend meetings of the staff and department of which he/she is an appointee and any staff or health system education programs
- C. Not be eligible to vote
- D. Not hold office

Responsibilities: Staff members in the courtesy category must assist Hospital in the fulfillment of its mission.

The courtesy medical staff shall consist of those members of the medical and dental profession, eligible as herein provided by medical staff membership, who wish to attend private patients in the hospital, perform procedures/surgeries and who may reside outside Stokes County. Members of the courtesy staff may admit patients as beds are available. They shall be appointed in the same manner as other members and are eligible for hearing and appeal.

These staff members may be available in person or via telemedicine communication.

Requirements: Licenses and professional liability insurance required

SECTION 3. THE ADJUNCT CATEGORY

The Adjunct category is divided into two sub-categories:

A. ADJUNCT-PRACTICING

Definition: practicing in a non-hospital clinical setting, affiliation recognition for provider purposes

Prerogatives:

- 1. membership only, no hospital privileges
- 2. can attend department, committee and CME meetings
- 3. not eligible to vote
- 4. shall not hold office

Requirements: licenses and professional liability insurance required

If in the judgment of MSC, granting Adjunct status would adversely affect the functioning of the medical staff in delivering patient care, the category can be declared closed to an area of

practice.

B. ADJUNCT-NON PRACTICING

Definition: not practicing in a clinical setting, affiliation recognition for retirement from clinical practice and/or former hospital service/contribution

Prerogatives:

1. membership only
2. can attend department, committee and CME meetings
3. not eligible to vote
4. shall not hold office
5. no licensing or professional liability insurance requirements

SECTION 4: THE VISITING CATEGORY

Qualifications: A Staff Member:

- A. Reside within 75 minutes of the hospital, in order to respond to patient care needs, in a timely manner, to maintain practice privileges. The preferred priority of contacting a physician on call is first, pager and second, the answering service. The expected time limit for responding to a page is to call within 15 minutes of initiation of the page. The physician should arrive at the hospital within 75 minutes. If the physician does not respond by phone within 15 minutes of notification, their practice partner(s) will be contacted. If a practice partner is not available, the Chief of Staff will be notified. If the patient's clinical condition is at risk, the Emergency Department Provider will be alerted.
- B. Who has medical staff membership at another health care organization where he/she regularly participates in quality improvement activities comparable to those of the hospital.

Prerogatives: Visiting members have the following prerogatives:

- A. To co-admit patients with an Active or Courtesy staff member (who has completed monitoring) and exercise
- B. privileges subject to limitations set out in the policy manual;
- C. To attend but not vote at general medical staff and department meetings;
- D. To attend and vote at meetings of a division or committee which he/she is a member;
- E. Attend any staff or hospital education programs.

Responsibilities: Each visiting staff member shall provide, through the co-admitting member, for the daily care and supervision of each inpatient for who he/she is providing services; be available at the

hospital through the recovery period or have pre-arranged coverage with a staff member with privileges within the same specialty for outpatient procedures; and have an arrangement to respond to a post-operative emergency with a covering system staff member in the same specialty.

Requirements: Licenses and professional liability insurance required

SECTION 5. THE CRITICAL NEED PHYSICIANS CATEGORY/LOCUM TENENS

Qualifications:

- A. Primary verification of education
- B. Demonstration of current competency
- C. Primary verification of State professional license
- D. Receipt of professional references
- E. Receipt of data base profiles from AMA, AOA, NPDB, and OIG CMS/Medicaid exclusions

In order for health care organizations to successfully adapt and respond to major technical and procedural changes in healthcare, they must be able to quickly acquire physicians and their support staff who can provide services not provided by their current medical staff. Appointees to this category will be named by a committee composed of the Chief of Staff, and the Chief Executive Officer of the facility, with the approval of the Medical Staff Committee.

Prerogatives:

These physicians will be exempt from any geographic or “time to arrival at the hospital restrictions,” as stated in the Bylaws of the Medical Staff, LifeBrite Community Hospital of Stokes.

Responsibilities:

- A. Provide care for patients as stated in Article I., Section 6 of the Medical Staff Bylaws.
- B. Exceptions or modifications to Article I, Section 6 of the Bylaws of the Medical Staff may be made by specific contractual agreements made between LifeBrite Community Hospital of Stokes and critical need physicians.

Requirements: Licenses and professional liability insurance required

SECTION 6. TEMPORARY PRIVILEGES (*NOT TO EXCEED 120 DAYS*)

Qualifications:

- A. Primary verification of education
- B. Demonstration of current competency
- C. Primary verification of State professional license
- D. Receipt of professional references
- E. Receipt of data base profiles from AMA, AOA, NPDB, and OIG CMS/Medicaid exclusions.

Prerogatives:

- A. To admit patients and exercise privileges subject to limitations set forth by the MSC.

- B. To attend but not vote at general medical staff and department meetings;
- C. To attend and vote at meetings of a division or committee which he/she is a member.
- D. Attend any staff or hospital education programs.

SECTION 7. DISASTER PRIVILEGES

When the hospital disaster plan is activated, the decision to grant disaster privileges to a volunteer Eligible Licensed Independent Practitioner will be made on a case-by-case basis by the Hospital Administrator and Medical Staff, or two members of the active medical staff and after the receipt of “key identification” documents and the reviewing of provided documents. In the event of a disaster situation where the disaster plan has been activated and the hospital is unable to meet immediate patient needs, the Disaster Privileges for Volunteer Eligible Licensed Independent Practitioner (ELIP) policy in the Medical Staff policy and procedure manual will be followed.

SECTION 8. HONORARY CATEGORY

The honorary medical staff shall be appointed by the governing body on recommendation of the active medical staff and shall have no assigned duties, responsibilities or privileges. The purpose of honorary membership is to allow attendance at medical staff meetings for information and education.

ARTICLE III. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

Officers:

The officers of the medical staff shall be:

- A. Chief of Staff
- B. Vice Chief of Staff
- C. Secretary

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must be staff members in good standing of the active category, indicate a willingness and ability to serve, and have excellent administrative and communication skills

SECTION 3. ELECTION OF OFFICE

Nominations may be made by any active member of the Medical Staff Committee.

SECTION 4. TERM OF OFFICE

All officers serve a term of two years. Officers shall take office on the first day of the calendar year. An officer may be reelected to a position.

SECTION 5. VACANCIES OF OFFICE

Vacancies of office during the medical staff year shall be filled by the Medical Staff Committee.

SECTION 6. DUTIES OF OFFICERS

A. Chief of Staff:

1. The chief of staff shall have direct responsibility for the organization and the administration of the medical staff, in accordance with the terms of the medical staff bylaws, rules and regulations, adopted by the governing body. In all medico-administrative matters, he should act in coordination and cooperation with the president of the hospital in giving effect to the adopted policies of the governing body and for immediately reporting when a physician response is inappropriate and may result in harm to the patient.
2. The chief of staff shall regularly and at intervals stipulated by the board submit to it all reports relevant to an appraisal of the medical care provided in the hospital.
3. The chief of staff shall convey to the board recommendations of the medical staff with respect to appointments and reappointments to the medical staff, granting or restricting clinical privileges of individual physicians, disciplinary action and changes in the medical staff bylaws, rules and regulations.
4. The chief of staff shall call, preside at and be responsible for the agenda of all meetings of the medical staff.
5. The chief of staff shall be an ex officio member of all committees of the medical staff and may vote.
6. The chief of staff shall appoint all members of committees of the medical staff, services and related committees as required in the medical staff bylaws, rules and regulations.
7. The chief of staff shall be responsible for the enforcement of the medical staff rules and regulations, for implementation of action where necessary for non compliance, and for presentation to the medical staff those cases where disciplinary action may be required. He shall review minutes of each medical staff meeting.
8. The chief of staff shall be responsible for the educational activities of the medical staff, subject to the policies of the governing body, i.e. 60 Category 1 CME hours by the end of the current three-year cycle per North Carolina Medical Board Regulations. Education activities should relate to their core privileges; relate to the type and nature of care offered at the hospital.
9. The chief of staff shall present categorical and individual core privilege applications of other professional personnel as required by the bylaws of the medical staff.

10. The chief of staff shall attend quarterly meetings of the governing body as staff representative and any other meeting when an invitation is extended.

B. Vice Chief of Staff:

1. The vice chief of staff shall fulfill all duties of the chief of staff in his absence as specified in duties of the chief of staff.

C. Secretary:

1. The secretary shall be responsible for reviewing all documents relating to the medical staff which shall be maintained in the administrative office, for content, order and correctness.
2. The secretary shall thoroughly review medical staff applications to verify completeness of all information before the application is presented in order to assure quality and satisfy accountability.
3. The secretary shall fulfill the duties of the chief of staff or vice chief of staff if they are absent or for some unforeseeable reason cannot fulfill their duties.

SECTION 7. REMOVAL FROM OFFICE

The medical staff may remove from office any officer by petition of 25 percent of the active staff members and a subsequent 75 percent affirmative vote by ballot of the active staff and approval by the Medical Staff Committee and hospital Governing Board. Removal shall be for failure to conduct those responsibilities assigned within these bylaws or other policies and procedures of the medical staff; an automatic or summary suspension; or for conduct or statements damaging to the medical staff or health system, its goals, or programs.

ARTICLE IV. MEDICAL STAFF ORGANIZATION

SECTION 1. ORGANIZATION OF THE MEDICAL STAFF

The medical staff of Hospital shall be organized into clinical departments. Each clinical department will have a medical director with overall responsibility for the supervision and satisfactory discharge of assigned functions.

The clinical departments are (if applicable):

- A. Emergency Medicine/Ambulatory
- B. Laboratories
- C. Geropsychiatric
- D. Radiology
- E. Surgery/Anesthesia
- F. Skilled Nursing
- G. Physical Therapy
- H. Respiratory

SECTION 2. OPTIONAL CLINICAL SECTIONS

- A. The Medical Staff Committee may authorize the formation of a clinical section.
- B. The functions may include, but not be limited to:
 - 1. develop, implement, monitor quality/performance improvement activities;
 - 2. develop and recommend membership and privilege criteria for applicants;
 - 3. conduct continuing education, Morbidity and Mortality and Grand Rounds for the section;
 - 4. discuss clinical policies/protocols/equipment and supply needs;
 - 5. discuss specific issues as requested by the Department.

The clinical section shall establish its Rules and Regulations in accordance with Department guidelines which will determine the meeting frequency. The section shall submit minutes to the medical staff for review.

ARTICLE V. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

There shall be a Medical Staff Committee and such other standing and special committees as shall be, from time to time, established by the Medical Staff Committee. Those medical staff functions that require the participation of, rather than direct oversight by, the medical staff, may be fulfilled by a staff member on such hospital or health system committees as are established to perform such functions.

SECTION 2. MEDICAL STAFF COMMITTEE

COMPOSITION: Voting members of the Medical Staff Committee shall consist of the Chief of Staff and active medical staff. Only voting members will comprise the committee in session.

DUTIES: The duties of the Medical Staff Committee, under the direction of the chief of staff, shall be to:

- A. Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities; and recommend to the Governing Board specific programs and systems to implement quality and credentialing functions performed by the medical staff.
- B. Coordinate the activities of and policies adopted by the Governing Board.
- C. Submit recommendations to the Governing Board concerning all matters relating to appointments, reappointments, staff category, and practice privileges, corrective and disciplinary action of the medical staff.
- D. Account to the Governing Board and to the medical staff for the overall quality and efficiency of care within the hospital and participate in the health system performance improvement activities.
- E. Supervise, the peer review process on each staff member, incorporating monitoring of performance data in order to support oversight of clinical care quality.
- F. Take reasonable steps to encourage professionally ethical conduct and competent clinical

performance on the part of staff appointees including initiating investigations and initiating and pursuing correction action, when warranted.

- G. Make recommendations to the Governing Board on medico-administrative and patient care management matters.
- H. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital.
- I. Consistent with the mission and philosophy, the Medical Staff Committee shall participate in identifying community health needs, reviewing and setting hospital and health system strategic plans and goals, and implementing programs to meet those needs.
- J. Represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws.
- K. Formulate and recommend to the Governing Board, medical staff rules, policies, and procedures.
- L. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership may be terminated, and the mechanisms for fair hearing procedures.

SECTION 3. STAFF FUNCTIONS

The Medical Staff Committee has the responsibility of performing the duties, responsibilities, and functions as set forth by these bylaws. These duties are carried out with the assistance of the Performance Data Review.

ARTICLE VI. MEDICAL STAFF MEETINGS

SECTION 1. Frequency

- A. A minimum of 6 meetings will be held annually. Written notice of the meeting shall be sent to all staff members and conspicuously posted throughout the hospital's campuses.
- B. Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the medical staff. Votes may include absentee ballots requested in advance and presented at or before the meeting.
- C. Permanent records of the proceedings and actions shall be maintained and be ready for review.

SECTION 2. SPECIAL MEETINGS OF THE MEDICAL STAFF

- A. The Chief of Staff may call a special meeting of the medical staff at any time. The Chief of Staff shall call a special meeting within 20 days after receipt of a written request signed by not less than 10 percent of the active medical staff, or upon a resolution by the Medical Staff Committee. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall determine the time and place of any special meeting.
- B. Written or printed notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least seven (7) days before the date of such meeting. No business shall be transacted at

any special meeting, except that stated in the notice of such meeting.

SECTION 3. DEPARTMENT AND COMMITTEE MEETINGS

Department and Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold meetings as needed to carry out department business. The Departments shall develop and adopt rules and regulations. The Department shall specify meeting frequency and attendance requirements for the Department which may exceed and supersede general requirements, with the advice and consent of the Medical Staff Committee.

SECTION 5. QUORUM

A quorum is defined as:

- A. Medical Staff Committee: Fifty (50) percent of the voting members of the committee
- B. Departments: those present, with a minimum of three (3)
- C. Committee/section meetings: those present

SECTION 6. ROBERT'S RULES OF ORDER

When needed, the latest edition of Robert's Rules of Order shall prevail at all meetings of the general staff, Medical Staff Committee, and department meetings, except that the chair of any meeting may vote. The Chief of Staff, or designee, shall serve as parliamentarian at all general meetings of the medical staff.

SECTION 7. NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each staff member of the committee or department not less than three (3) days before the time of such meeting.

SECTION 8. ACTION OF DEPARTMENT/COMMITTEE

The affirmative vote upon a recommendation of a majority (defined as 50 percent rounded up to the next highest digit) of its members present at a meeting at which a quorum is present shall be the action of the department or committee. Such recommendation shall then be forwarded to the Medical Staff Committee for final action.

SECTION 9. RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except that they shall not vote or be counted in determining the existence of a quorum.

SECTION 10. MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The prepared minutes

shall be signed by the officer who presided at the meeting and copies thereof shall be submitted to the Medical Staff Committee or other designated committee for approval. A permanent file of the approved minutes of each meeting shall be maintained. The minutes will be submitted each quarter to the Governing Board with all applicable reports and any documents concerning Medical Staff Appointment.

ARTICLE VII. CORRECTIVE ACTION PROCEDURES

SECTION 1. ROUTINE CORRECTIVE ACTION

- A. Criteria for Initiation: Any officer of the medical staff or the HOSPITAL ADMINISTRATOR may initiate requests for corrective action for, but not limited to, the following:
 - 1. The activities or professional conduct of any staff member with privileges are or are reasonably probable of being:
 - a. Detrimental to patient safety
 - b. Detrimental to effective delivery of patient care;
 - c. Disruptive to hospital or system operations;
 - 2. Unethical practice;
 - 3. Institution of formal charges for, or conviction of, a felony or any other crime involving or affecting professional practice;
 - 4. Incompetency (to include mental, judgmental and physical);
 - 5. Violation of these bylaws or the rules or policy of the medical (including, but not limited to, falsification of application or credential documents, and failure to report a change in the professional liability insurance record within seven (7) days of said change);
 - 6. Failure to discharge basic responsibilities of staff membership as provided in Article I, Section 6;
 - 7. Failure to continuously meet the basic qualifications for staff membership described in Article I, Section 3.
 - 8. Institution of formal charges for, or conviction of, any crime involving medical practice or hospital activities;
 - 9. Unauthorized disclosure of hospital or medical staff information relating to patient care or professional review or hospital business declared to be confidential; or
 - 10. Violation of an agreement or memorandum of understanding between the staff member and the medical staff or hospital in lieu of other corrective action.
- B. Contact: If a staff member or hospital employee believes that corrective action of a staff member may be indicated, that person may contact the Chief of Staff or Administration.
- C. Requests and Notice: All requests for corrective action, in accordance with this section shall be in writing, submitted to the MSC and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff or designee shall inform the Hospital Administrator or designee to consider investigation.

- D. Special requirements: Whenever a pattern of suspected deviation by a staff member from standard clinical or professional practice is identified, the Chief of Staff or the applicable department or committee chair may require the staff member to meet with him/her or with a standing or ad hoc committee that is considering the matter. The staff member shall be given special written notice of the meeting at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved, and notification that the staff member's appearance is mandatory. Failure of the staff member to appear at any such conference after two notices, unless excused by the Medical Staff Committee upon showing good cause, shall result in an automatic suspension of practice privileges and ultimately termination of medical staff membership. Such termination shall not give rise to a fair hearing, but shall automatically be rescinded upon the staff member's participation in the previously referenced meeting.
- E. Investigation when Appropriate and Report: If an investigation is deemed necessary and appropriate. When so designated, the investigator (person or committee) shall promptly investigate the matter and within 45 days after the receipt of the designation, forward a written report of the investigation to the MSC. If the corrective action request was preceded by an investigation, a report of that investigation may be used in lieu of a subsequent investigation.
- F. MSC Action: Within 45 days following receipt of the request, the MSC shall take action upon the request. Action taken by the MSC may include without limitation:
1. Rejecting the request for corrective action with or without a warning letter or admonition;
 2. Recommending to the Board requirements of consultation other than administrative consultations (as specified in Section 4)
 3. Issuing a letter of reprimand;
 4. Imposing a probation without limitation of privileges;
 5. Recommending to the Board reduction, suspension or revocation of privileges;
 6. Recommending to the Board reduction of category or limitation of any prerogatives directly related to patient care; and
 7. Recommending suspension or revocation of medical staff membership;
 8. Recommending to the Board that other action be taken.
- G. Exercise or Waiver of Procedural Rights: Any recommendation or action taken pursuant to (2) through (8) (but not Section 2 or 4) will ordinarily be held in abeyance for a period of 30 days or the timely and effective exercise of procedural rights applicable to the action in the Fair Hearing Plan, whichever is longer. However, during such period, other actions including those described in Sections 2, 3, and 4 may still be taken, if appropriate. The MSC may, based on the outcome of any informal or formal hearing, revise its action or recommendation. Failure of the subject staff member to timely request and pursue exercise of procedural rights shall constitute acquiescence to an adverse action or recommendation as provided in the Fair Hearing Plan.
- H. Report to the Board and Board Action: All MSC actions and recommendations regarding a corrective action request shall be reported promptly to the Board. A rejection of a request for corrective action or the taking of actions specified in Section I (F) (3) and (4) shall not be final until affirmatively approved by the Board. If not approved by the Board, the Board may, after due consultation with MSC take any other action specified in Section I (F). As to any corrective

action taken or recommended by the MSC for which the staff member has timely and effectively pursued a formal hearing (basic or special), if applicable, Board action will await the outcome or waiver of the staff member's appeal. As to any corrective action taken or recommended by the MSC for which the staff member is not entitled to or has waived a formal hearing, the Board may expressly affirm, or after consultation with the MSC, reject (or rescind) such action or recommendation with such special directives to Administration and/or the MSC as it deems appropriate. Silence or non-action by the Board for 60 days after receipt of notice of MSC corrective action, without the pendency of hearing or appeal proceedings, shall constitute the Board's implied approval of same.

SECTION 2. SUMMARY ACTION

- A. Criteria and Initiation: Any two (2) of the Chiefs of Staff of a clinical department or designee in his/her absence, and the Hospital Administrator or designee in his/her absence, acting jointly, or the MSC acting alone will have the authority to summarily suspend or place conditions upon the exercise of all or any portion of the privileges of a staff member whenever:
1. The staff member's temporary or permanent mental or physical state is such that one or more patients under his/her care would be subject to imminent danger to their health as a result of his/her action or inaction if he/she is permitted to continue exercise privileges; or
 2. There is substantial evidence that the staff member has committed acts of an illegal or unethical nature while in the hospital or another which are of such gravity that, if proven, would justify revocation or permanent suspension of medical staff membership, privileges, professional licensure or prescribing authority; or
 3. There is substantial evidence of a gross dereliction of duty which relates to the assurance of a patient's well-being, or in the management of a patient, which, in the judgment of those having the authority to summarily act, indicates one or more patients under the present and/or future care of the staff member involved would be subject to imminent danger to their health, if he/she is permitted to continue to exercise privileges. (Unusually high frequencies of unexpected deaths or morbidity shall constitute sufficient ground to invoke this provision.); or
 4. There is substantial evidence of an act, omission or pattern by the staff member which either has the potential of materially damaging the system's or hospital's reputation, licensure status, or the ability to effectively function as a provider of services; or
 5. There is non-compliance with an agreement between the staff member and the MSC or board, where the agreement specifies non-compliance will result in suspension or where non-compliance places patient welfare at risk.

Such summary action shall become effective immediately upon imposition, and the Chief of Staff shall promptly give written notice of the suspension to the staff member.

- B. MSC Action: At the next regularly scheduled MSC meeting, but no later than 12 days following such summary action, the MSC shall review and consider the action to be taken. The MSC may impose a modification, continuation or termination of the terms of the summary action. If a MSC decision is other than to rescind the action in total within 14 days of imposition, the subject staff member may make a request to pursue further remedy through the MSC.

- C. Responsibilities: The medical coverage for the inpatients in the hospital of the staff member subject to emergency suspension shall be assigned by the Chief of Staff. As much as possible, the wishes of the respective patient(s) shall be considered in the selection.

SECTION 3. AUTOMATIC ACTION

Automatic suspension or limitation of privilege occurs when:

- A. A staff member whose license authorizing practice in the state is revoked or suspended or is convicted for a crime involving medical practice or hospital facilities, or is convicted of any felony, shall have his/her appointment and privileges immediately terminated; or
- B. If the matter involves conviction of a crime or if the license revocation or suspension is for one year or more, then the application process for reinstatement will be handled the same as an application of a new applicant; or
- C. If the license revocation or suspension is for less than one year, then the appointment shall be deemed to have lapsed. The application process for reinstatement will be the same as for reappointment, if the staff member applies within 30 days of the expiration or completion of the process that led to the automatic action. However, if the staff member does not timely apply, any subsequent application will be as a new applicant; or
- D. DEA certificate is revoked, suspended or limited; or
- E. There is failure to maintain a minimum level of professional liability insurance; or
- F. Medicare or Medicaid status has been terminated or revoked.

SECTION 4. ADMINISTRATIVE ACTION

- A. Circumstances: Administrative action shall be automatically imposed for any reasons enumerated in Section 3. Administrative action, under the provisions of this Section, may not constitute a reportable medical staff action in accordance with state and federal reporting requirements, as it is considered to be a non-disciplinary and non-professional review action for purposes of those reporting requirements.
- B. Prescribing Authority: A staff member whose authority to prescribe and administer is revoked or suspended shall immediately and automatically be divested of his/her right to prescribe medications covered by such authority. After such administrative action, the MSC at its next regularly scheduled meeting shall review and consider the facts under which the authority was revoked or suspended. The MSC may then take corrective action as is appropriate to the facts disclosed in its review.
- C. Medical Records: A staff member with privileges who, after warning of delinquency, fails to complete medical records within 10 days, in accordance with the rules may have privileges withheld. He/she may also be required to attend the next regular MSC meeting to discuss his/her reasons for said delinquency. The staff member shall be notified by the Chief of Staff by certified mail, return receipt requested, of the matter to be discussed and the time and location of the meeting. The staff member so affected shall be required to attend that meeting of the MSC. The MSC may then take corrective action appropriate to the facts involved, pursuant to Section 1 above.

- D. Administrative Consultations: The Chief of Staff, or Hospital Administrator, may initiate an administrative consultation requirement as to a particular patient, certain particular patients or all patients of a staff member, when it is determined that the interests of the hospital or the welfare of a patient or patients of a staff member require such action. Such consultation requirement may include proctoring, co-management or other conditions or limitations upon the practice.

Imposition of an administrative consultation requirement, in accordance with this provision, shall be communicated to the affected staff member immediately by written notification. The result of the administrative consultation shall be reported back to the Hospital Administrator. This information, if found to be outside accepted standards of care, will be conveyed to the MSC at its next regularly scheduled meeting for determination of an appropriate course of action, which may include corrective action pursuant to Section 1 above.

- E. Professional Liability Insurance: In the event that a staff member with privileges fails to:

1. Maintain in force professional liability insurance in prescribed amounts or maintain other proof of financial responsibility, in accordance with bylaws and policies of the medical staff and hospital; or
2. Secure a special exemption from those requirements specified in E1 from the MSC and Board; or
3. Report any change in the status of his/her professional liability insurance to the Chief of Staff within seven (7) days subsequent to the change; or
4. The privileges of the staff member shall be withheld until the requirement is met. While privileges are withheld, the staff member may not see, treat, consult with respect to, or admit a patient at the hospital. Privileges which are withheld for failure to comply with the financial responsibility requirements shall continue to be withheld until the requirement is satisfied.

- F. Technical Non-Compliance with Bylaws, Rules and Regulations or Other System Policies: In the event a staff member is found to have violated provisions of the bylaws, rules, or other system policy (written or unwritten) which does not directly or immediately involve patient well-being, the Chief of Staff, after consultation with the MSC or the board, are each empowered to issue a letter to the staff member giving notice of non-compliance and advising the staff member of the importance of future compliance. The staff member involved shall be required, within 30 days after receipt of such notice, to acknowledge in writing, its receipt, and to pledge he/she will heretofore comply with the policy involved, and provide any mitigating factors he/she feels are warranted. A copy of such notice of non-compliance and the staff member's response shall be placed in the file with respect to the staff member. Such notice may be considered, for two (2) reappointment periods after issuance, in any corrective action proceedings involving the staff member. If no further notices of non-compliance are issued within two (2) reappointment cycles for similar infractions, it will, at the request of the staff member, be permanently expunged from his/her medical staff review file.

- G. Suspension or Termination by Educational or Health Organizational Employer:

1. If the employment or privileges of a staff member are suspended by the staff member's educational or other health care organization employer for reasons that in the judgment of the Chief of Staff after consultation with the MSC or the board are related to competence, conduct or ethics, when such employer is an organization that has a formal contractual

arrangement with the hospital to provide clinical services, then upon notice to the hospital, the affected staff member shall be automatically placed on leave of absence. The ending of leave of such absence shall be preceded by the hospital and/or its medical staff conducting an investigation of the reasons for the suspension. If deemed appropriate, corrective action procedures may be instituted by the hospital and/or medical staff based upon those other facts.

2. If employment or privileges are terminated by the education or health care organization employer and employment by the other organization is a contractual condition of membership or the privileges in the hospital, then the membership or privileges (as the contract provides) of the staff member shall likewise be terminated. If that applies, medical staff membership at the hospital, if thereafter desired, may be obtained only by submitting an application and processing the manner specified for application for initial appointments, unless in their sole discretion, the board and MSC authorize a different procedure.
- H. Unavailability – Resignation: A staff member with privileges, unless exempted in advance by the MSC, or on an authorized leave of absence, who is not in the general vicinity of the hospital for more than 90 days or removes his/her office address and phone number from publication in the usual manner, shall be automatically deemed to have resigned from the medical staff without expression upon his/her professional conduct or competence.
- I. Failure to Meet Minimum Activity Requirements – Resignation: A staff member, not on an authorized leave of absence, who fails to meet minimum activity requirements established by the MSC for any one year shall be deemed to have resigned from the medical staff without reflection upon his/her professional conduct or competence. Exceptions may be made by the Chief of Staff and MSC to the foregoing on an individual or category-wide basis, if the staff member is a staff member of a category which does not involve privileges.
- J. Low or no activity members: Information related to competency will be obtained from other healthcare organizations and/or peer recommendations in regards to staff members with low or no activity who are needed to fulfill a specialty patient care need.

ARTICLE VIII. REVIEW, REVISION, ADOPTION, and AMENDMENT

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff Committee shall have the responsibility to formulate, review annually and recommend to the Governing Board medical staff bylaws, policies, and amendments thereto, which shall be effective when approved by the Governing Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. The Medical Staff Committee shall also be responsible for the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws. Neither the Governing Board nor the medical staff may unilaterally change the medical staff bylaws without first having a joint conference to consider the same.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT

All proposed amendments, whether originated by the Medical Staff Committee, another standing committee, or by a member of the active category of the staff, must be reviewed and discussed by the Medical Staff Committee prior to a Medical Staff Committee vote.

- A. Such amendment may be recommended to the hospital Governing Board by the Medical Staff Committee after a majority vote of the medical staff at a meeting at which a quorum is present.

Any amendment recommended by the Medical Staff Committee shall become effective only after approval by the Governing Board and the Corporate Strategic Team.

- B. The Medical Staff Committee may adopt such amendments to the bylaws as are, in the committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Governing Board and Corporate Strategic Team but must be approved by the Chief of Staff.

SECTION 3. INCORPORATED PROTOCOLS AND MANUALS

The Medical Staff Committee shall recommend to the Governing Board a credentials and Rules and Regulations Manual and other such rules/regulations as are necessary to further define the general policies contained in these bylaws. Upon adoption by the hospital Governing Board, the LifeBrite Community Hospital of Stokes Medical Staff Rules and Regulations Manual, the LifeBrite Community Hospital of Stokes Medical Staff Credentials Policy and Procedure Manual, the LifeBrite Community Hospital of Stokes Medical Staff Quality Policy and Procedure Manual, General Medical Staff Policy and Procedure Manual, and the Fair Hearing Plan for staff members and applicants shall be incorporated by reference and become part of these bylaws.

DEFINITIONS

1. **ALLIED HEALTH PROFESSIONAL** or **AHP** is an individual, not a member of the medical staff, who can provide specified patient care services within the scope of their professional skills and abilities under the supervision and direction of a physician appointee of the medical staff. AHPs degree of participation in patient care shall be per applicable state practice acts.
2. **CHIEF OF STAFF** means the chief officer of the medical staff.
3. **CHIEF OF SERVICE** (or his/her designee) means the staff member elected in accordance with these bylaws to serve as head of a service and/or department.
4. **DENTIST** means an individual with a DDS or DMD degree licensed to practice dentistry in (your state) other than oral and maxillofacial surgery.
5. **EMERGENCY** means any condition where serious or permanent harm or aggravation of injury or disease could result to a patient or where the life of a patient is in immediate danger and any delay in treatment could add to the danger. Further defined: "Emergent" means conditions are a potential threat to life, limb, or function, requiring rapid intervention or delegated acts; "Urgent" means conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.
6. **COMMITTEE** means the medical staff committee.
7. **GOVERNING BOARD** or Board means the Governing Board of LifeBrite Community Hospital of Stokes
8. **HOSPITAL** means LifeBrite Community Hospital of Stokes and shall include all current and future facilities and campuses.
9. **JOINT CONFERENCE COMMITTEE** is designated as a medical staff committee, chaired by the current Chief of Staff and is defined as a meeting between the representatives of the

Governing Board and the physician members of the Medical Staff Committee.

10. **MEDICAL STAFF** or **STAFF** means all (your state) licensed physicians, dentists, and podiatrists who are privileged to attend patients at the hospital.
11. **MEDICAL STAFF YEAR** means the period from January 1 to December 31 of each year.
12. **ORAL** or **MAXILLOFACIAL SURGERY** means an individual with a DDS or DMD degree who is board certified or board eligible to practice oral or maxillofacial surgery, whose credentials have been approved by the hospital Governing Board to perform such procedures.
13. **PHYSICIAN** means an individual with a MD degree or DO degree who is licensed to practice medicine in the State of (your state), School or college of podiatry approved by the (your state) State Board of Medical Examiners and who is currently licensed to practice podiatry in (your state).
14. **PRACTICE PRIVILEGES** means the permission granted to a staff member to render specific diagnostic, therapeutic, medical, dental, podiatry, or surgical services and an allied health professional to participate in the provision of certain patient care services.
15. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other health system and medical staff rules, regulations, or policies.
16. **CHIEF OF STAFF** (or his/her designee) means the chief officer appointed by the Governing Board to act on its behalf in the overall management of the hospital.
17. **SERVICE** means that group of staff members who have practice privileges in one of the general areas of the health system practice.
18. Any person named by title means that person or his/her designee.



Medical Staff Rules & Regulations

Reviewed/Approved by the Medical Staff 11/25/2019
Reviewed/Approved by the Governing Board 2/7/20

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LIFEBRITE COMMUNITY HOSPITAL OF STOKES MEDICAL STAFF RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE

1. Only practitioners granted Staff appointment and clinical privileges may admit patients to this Hospital except as provided in the Staff Bylaws and Rules and Regulations (except Temporary Privileges). Only individuals granted clinical privileges may treat patients at this Hospital. All practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital.

2. Admission exceptions:

- (a) The Hospital shall accept patients for care and treatment except as follows:

- 1) Obstetric cases
 - 2) Severe mental disorders
 - 3) Ophthalmology

(See the Hospital's written plan for the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the Hospital, or who suffer the results of alcoholism or drug abuse.)

- (b) Patients who are known to be suffering from drug abuse, alcoholism, and mental illness shall not be admitted unless proper safety precautions can be taken to safeguard the patient, other patients, and employees.

- (c) The Admitting Practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm, and to assure the protection of others whenever his or her patients might be a source of danger from any cause whatever.

3. Physician Responsibility:

- (a) A physician member-appointee of the Staff shall be responsible for the overall medical care of each patient in the Hospital. The attending practitioner shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner.

- (b) Whenever physician responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service specializing in the treatment of the disease which necessitated admission.

4. In the case of a patient requiring admission who has no practitioner, he or she shall be assigned to the practitioner on-call for the service to which the illness of the patient indicates assignment.
5. Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.
6. Emergency Admission:
 - (a) In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, (i) record a provisional diagnosis or valid reason for admission as soon as possible; and (ii) contact the acute care charge nurse to ascertain if there is a bed available. A copy of the emergency service record shall accompany the patient to the nursing unit.
 - (b) Practitioners shall be able to justify emergency admissions based on criteria developed by the Staff. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission. Violators of this rule shall be referred to the MEC for appropriate action.
7. Patient Choice and Physician Responsibility:
 - (a) A patient to be admitted on an emergency basis shall be given the opportunity to select an appointee of the Staff to be responsible for the patient while in the Hospital.
 - (b) If a dentist or podiatrist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient. This requirement does not apply to patients admitted to the service of a qualified Oral Surgeon, defined as an individual who has successfully completed a post-graduate program in Oral Surgery, accredited by a nationally recognized accrediting body, approved by the U.S. Office of Education.
 - (c) Where no such selection is made or where the selected practitioner does not assume responsibility for care of the patient for some reason, the on-call practitioner may assume responsibility for the patient.
 - (d) In no event shall a physician member of the staff be required to co-admit any patient.
8. Each appointee of the staff shall name another appointee of the staff as an alternate to be called to attend his or her patients in an emergency when the attending practitioner is not available. If a covering physician is not available, contact shall be made with the on-call physician member of the staff. In case the alternate is not available, the Chief of the Staff shall have the authority to assign the on-call practitioner or any other appointee of the staff to attend the patient. Failure of an appointee of the staff to meet these requirements may result in disciplinary action.

9. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

- (a) Emergency
- (b) Urgent
- (c) Pre-operative
- (d) Routine

The committee responsible for the Utilization Review functions shall review admissions that do not meet the established criteria for the above categories if there is a need to do so. Unjustified variations and recommended actions shall be reported to the MSC for appropriate action.

10. The patient shall not be transferred within the Hospital without the approval of the attending practitioner or consulting practitioner. The order of priority for the patient transfers shall be as follows:

- (a) Emergency service to appropriate nursing unit.
- (b) From temporary placement in a clinical service area to the appropriate service or nursing unit for the patient being transferred.
- (c) Geropsychiatric to emergency or appropriate nursing unit.

11. Admissions and discharges shall be in accordance with established criteria. Exceptions shall be approved by the unit or service medical director.

12. Practitioners shall abide by the Hospital's case management plan to include:

- (a) The appropriateness and medical necessity of admissions
- (b) Continued stay
- (c) Supportive services
- (d) Discharge planning

13. Discharge:

- (a) Patients shall be discharged from the Hospital only on the written or verbal order of the patient's attending practitioner. If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, a notation shall be made in the patient's medical record.
- (b) Practitioners shall, when practical, write discharge orders that will allow patients to be discharged from the Hospital by 11:00 a.m. on the day of discharge.

14. In the event of a Hospital patient death, the deceased shall be pronounced dead by a physician or two R.N.'s, one in a charge capacity, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician appointee of the Staff. Policies with respect to release of dead bodies shall conform to local law.

15. For the protection of patients, the Medical and Nursing Staffs, and the Hospital, certain principles are to be met in the care of the potentially any patient being admitted is known or

suspected to be suicidal in intent, placement shall be made in an area where appropriate observation facilities are available. Transfer to another institution may be required.

B. EMERGENCY SERVICES

1. Responsibility
 - (a) Appointees of the Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.
 - (b) The Chief of emergency services or the emergency service committee shall have the overall responsibility for emergency care.
2. Clinical core privileges shall be completed for all practitioners rendering emergency care in accordance with Staff and Hospital procedures.
3. A physician shall be on-call and immediately available for rendering emergency patient care 24 hours per day, seven (7) days per week.
4. Emergency service policies and procedures shall be approved by the Chief of emergency services or the emergency services committee, the Staff and the governing body.
5. If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency physician, either for observation or for further treatment, the patient shall be admitted in the name of the patient's practitioner or the practitioner on-call. If in the judgment of the emergency physician the patient's condition requires continuing practitioner attendance the emergency physician shall continue to accept responsibility for the patient until such time as an admission order has been received from the attending physician.
6. Except in cases where transfer to surgery is contraindicated in the judgment of the emergency physician, surgery shall not be performed in the emergency treatment area.
7. In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency physician, copies of the radiologist's report shall be made available and brought to the attention of the emergency physician, the patient's private practitioner and the patient.
8. An appropriate emergency service medical record shall be kept for every patient receiving emergency service. The emergency service medical record shall include:
 - (a) Adequate patient identification;
 - (b) Information concerning the time of the patient's arrival and by whom transported;
 - (c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital and history of allergies;
 - (d) Description of significant clinical, laboratory and x-ray findings;
 - (e) Diagnosis including condition of patient;
 - (f) Treatment given and plans for management;
 - (g) Condition of the patient on discharge or transfer; and
 - (h) Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.

9. Each patient's emergency medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy and a copy of the emergency service medical record shall accompany patients being admitted as an inpatient.
10. The emergency physician director or the emergency service committee shall coordinate the review of emergency service records with the Staff medical records committee.
11. The emergency physician director or the emergency service committee shall be responsible for monitoring the quality and appropriateness of patient care.
12. Patients with conditions whose definitive care is beyond the capabilities of this hospital shall be referred to the appropriate facility, when in the judgment of the attending practitioner the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.
13. The emergency physician director or the emergency service committee shall make certain that emergency service procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.
14. Qualified Medical Persons or Personnel ("QMP") – In addition to a physician, Qualified Medical Persons may perform medical screening examinations. Individuals in the following professional categories who have demonstrated current competency in the performance of medical screening examinations and who are functioning within the scope of his/her license and policies of the Hospital, have been approved by the Medical Executive Committee and the Hospital's Governing Board as Qualified Medical Personnel: Physician Assistants and Advanced Registered Nurse Practitioners.

C. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient.

This record shall include:

- (a) the patient's name, address, date of birth, and the name of any legally authorized representative;
- (b) the legal status of patients receiving mental health services;
- (c) emergency care provided to the patient prior to arrival, if any;
- (d) the record and findings of the patient's physical examination;
- (e) conclusions or impressions drawn from the medical history (including chief complaint; details of the present illness; relevant past, social and family histories appropriate to the patient's age; and an inventory of body systems); a summary of the patient's psychosocial needs, as appropriate to the patient's age and physical examination;
- (f) the diagnosis or diagnostic impression;
- (g) the reasons for admission or treatment;
- (h) the goals of treatment and the treatment plan;
- (i) evidence of known advance directives;
- (j) evidence informed consent, when required by hospital policy;
- (k) diagnostic and therapeutic orders, if any;

- (l) all diagnostic and therapeutic procedures and test results;
 - (m) all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
 - (n) progress notes made by the medical staff and other authorized individuals;
 - (o) all reassessments and any revisions of the treatment plan;
 - (p) the patient's response to care;
 - (q) clinical observations including results of therapy;
 - (r) nursing notes
 - (s) consultation reports;
 - (t) every medication ordered or prescribed for an inpatient;
 - (u) every medication dispensed to an ambulatory patient or an inpatient on discharge;
 - (v) every dose of medication administered and any adverse drug reactions;
 - (w) all relevant diagnoses established during the course of care;
 - (x) any referrals and communications made to external and internal care providers and to community agencies;
 - (y) conclusions at termination of hospitalization to include relevant diagnoses;
 - (z) discharge instructions to the patient and family; and
 - (aa) clinical resumes and discharge summaries, or a final progress note or transfer summary, and an autopsy report if applicable.
2. A complete admission history and physical examination shall be recorded within twenty-four hours of admission but prior to surgery. This report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history has been recorded and a physical examination performed within thirty days; a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by an appointee of the staff with privileges to perform H&P's. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded on the day of admission. This update must be on or attached to the H&P within 24 hours of admission or prior to surgery.
 3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient. If the history and physical have been dictated but not typed, a progress note entry by the surgeon stating the proposed operation and reason therefore, together with any general medical implications of the proposed surgery, shall be acceptable in lieu of the typed report.
 4. Patients being admitted for 24-48 hour observation will require H&P and discharge summary.
 5. Podiatry and dental members of the medical staff shall conform in general to the standards for the medical staff and complete a history related to dentistry or podiatry. An adequate medical survey, including history, physical exam and adequate laboratory studies if applicable, shall be performed by a physician member of the medical staff, a PA or NP privileged to do so on each patient prior to a dental or podiatry procedure within the

timeframes set by the medical staff members. The history and physical portion of the preoperative H&P may be completed by a CRNA privileged to do so. When the CRNA performs the preoperative H&P, the surgeon, podiatrist or dentist will complete the impression and plan portion of the H&P.

Indicated consultations shall be held in complicated cases. Surgical procedures performed under general anesthesia by a podiatry or dentist member of medical staff, shall be supervised by a surgeon member of the medical staff who shall be present in the hospital or surgery center during the performance of surgery. Qualified oral surgeons who have been granted privileges to perform a history or physical do not require another evaluation by an active member of the medical staff.

Dentists and podiatrist may provide treatment and perform invasive diagnostic or other procedures only within those areas of competence indicated by the scope of their core privileges.

6. Podiatry cases normally scheduled for an office setting may be performed in the outpatient facilities for the convenience of the patient and for the sterile environment. These cases would not require an anesthetist, H&P or supervising surgeon on the active staff.
7. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care. The patient's clinical problems shall be clearly identified in such notes and correlated with specific orders as well as treatment. The attending practitioner shall write progress notes at least daily or more often as appropriate to the case so as to reflect accurately the patient's course in the Hospital.
8. Practitioners shall be responsible for obtaining the patient's informed consent. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital policy. Both the patient and the physician shall sign the consent form affirming that the practitioner has personally informed the patient. Space shall be provided on the form for the practitioner to document what was explained to the patient and that the patient understood and agreed to the proposed treatment.
9. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.
10. Within 24 hours, the attending physician shall countersign all orders, the history and physical examination and pre-operative notes and consult and progress notes when they have been recorded by Allied Health Professional designee.
11. Approved diagnosis specific protocols will be used for all patients where applicable.
12. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written (or dictated) immediately following surgery. In addition, an operative progress note must be entered immediately post-procedure.

13. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
14. Final diagnosis shall be recorded in full, limiting abbreviations to those on the medical staff approved abbreviation list, and dated and signed by the responsible practitioner at the time of discharge of the patient. This will be deemed equally as important as the actual discharge order.
15. A discharge summary (clinical resume) shall be written or dictated on all medical records of hospitalized patients. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner. A final progress note may be substituted for the resume for patients with problems and interventions of a minor nature who require less than a 48 hour period of hospitalization.
16. The discharge summary for an acute level patient in the hospital may act as the admitting history and physical for an intermediate or skilled long term care or swing bed admission in the same institution. Patients being admitted to a long term care or swing bed from another institution must have a history and physical completed by the admitting physician.
17. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the medical records committee.
18. The attending practitioner shall complete the medical record at the time of the patient's discharge, to include progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at time of discharge, the medical record will be available in the Medical Record Department.
19. All records must be completed by 10 days post discharge. Any physician not completing his/her records will have all admitting, elective surgical and consulting privileges suspended. The only exception to this policy will be patients currently hospitalized under the practitioner's service, and unassigned patients admitted through the emergency room when the practitioner is on ER call. Physicians remaining delinquent for 30 days will be reported at the next Medical Executive Committee for further disciplinary action.
20. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
21. In the interest of patient safety, the use of abbreviations is discouraged. In addition, the Medical Staff will develop and maintain a list of acceptable abbreviations as well as an unacceptable abbreviation list.
22. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute for the purpose of appearance in court, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Hospital Administrator. In any case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.

Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Staff Executive Committee.

23. Free access to all medical records of all patients shall be afforded to appointees of the staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the staff before records can be studied. Subject to the discretion of the Hospital Administrator, former appointees of the staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
24. The use of rubber stamps within a patient's medical record shall be prohibited.

D. GENERAL CONDUCT OF CARE

1. All orders for treatment shall be in writing. At a minimum, orders are required for diagnostic and therapeutic procedures, operative and special procedures, all drugs and biologicals, blood and blood components, use of restraints/seclusion, laboratory testing, referrals and transfers, rehabilitation care, therapeutic diets, DNR, and admission. All verbal and telephone orders shall be read back to the practitioner and documented as such by the individual receiving the order. A verbal order shall be considered to be in writing if given to a registered nurse, respiratory therapist, physical therapist, registered pharmacist or other allied health professional, functioning within his or her sphere of competence and signed by the responsible practitioner.

LPN's are authorized to take verbal orders, with the following condition: Additional training must be provided or obtained, with written documentation or evidence of the specific additional training required.

All orders dictated over the telephone shall be dictated by the practitioner or their qualified designee and shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner.

The following potentially hazardous verbal orders must be authenticated by the physician within 24 hours of such order:

- (a) Do Not Resuscitate
- (b) Restraints requiring the order of a licensed independent practitioner

2. A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission.
3. The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.
4. For in-patients, all orders for patient care, including medications, must be re-written by physician after any surgical procedures

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. All drugs shall be provided through, or approved by, the Hospital pharmacy.
6. The Pharmacy and Therapeutics Committee will develop policies regarding appropriate automatic stop orders for classes of drugs that is consistent with current medical practice. Drugs not specifically outlined in this policy will have an automatic stop order of 30 days. If the practitioner desires to continue these medications, he must reorder them at the end of this period.
7. All medications brought into the hospital by a patient must be sent to the Pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the practitioner has prescribed.
 - (a) Medications brought into the hospital by a patient or his family will not be given to the patient during his hospital stay without the express authorization of the attending practitioner.
 - (b) All patient owned medications received by the facility are entered into the "Patient Own Medication Log", located on each patient care unit. Additional records are required for controlled substances as outlined in the "Patient Own Medication Pharmacy Policy". Completed logs are given to the pharmacy for storage.
 - (c) Medications shall be returned to the patient/family/caregiver at the time of discharge, transfer or death.
 - (d) Medications not given to the patient/family/caregiver, or those not accepted by the same, shall be given to the pharmacy, and so noted on the "Patient Own Medication Log". The pharmacy will retain the medication for up to 14 days. Medications may be picked up during normal business hours, with proper government issued identification. After 14 days, the pharmacy may dispose of medications in a legally appropriate manner. Records of these transactions are kept in the pharmacy.
8. Blood is always available in the laboratory for emergency transfusion. For routine transfusions, blood will be sent to the contracted facility for type and crossmatching. Turn a round time is minimal for transfusion process.
9. Respiratory Care will be administered according to the attending practitioner's orders. The practitioner can write an order for Respiratory Care to evaluate and treat. The Respiratory Care Practitioner (RCP) will evaluate the patient and write orders within the Respiratory Care Protocol. The patient will be assessed daily by the RCP to ensure the current therapy ordered meets the patient's needs. Based on the patient's outcome, therapy may be upgraded, maintained or discontinued per the Respiratory Care Protocol.
10. Standing orders and/or instruction sheets shall be instituted only after approval of the Medical Staff Committee. Such standing orders and/or instruction sheets shall be reviewed at least annually and revised as necessary. All standing orders and/or instruction sheets must

be signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.

11. The attending practitioner or their designated consultant is primarily responsible for requesting consultation when indicated or when mandated by Hospital policy, and for calling in a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.
12. Consultations shall be held, except in extreme emergencies, under the following conditions:
 - (a) when requested by the patient or his family
 - (b) when required by the policy of a special care unit

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

13. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she or he shall call this to the attention of her or his superior who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the attending practitioner, the Hospital Administrator, or the Chief of Staff, or the Chief of Service as appropriate. Where circumstances are such as to justify such action, the Chief of Staff may request a consultation.
14. The attending physician or appropriate consultant should attend his/her patient at the bedside on not less than a daily basis. The attending is responsible for seeing that such coverage is provided.
15. Availability of Consultation Services
 - (a) Qualified staff members in the hospital can be called upon for consultation within their area of expertise and, if they accept the patient, are expected to respond within twenty-four (24) hours or sooner if clinically indicated.
 - (b) Due to the limited availability of psychiatry, consults may be ordered for the next scheduled hospital day at the time of the consult request. This may fall outside the twenty-four (24) hour expectation. Urgent requests will be communicated by the physician at the time of consult.

E. DEPARTMENT OF SURGERY

1. Department of Surgery-General Department Rules-Reference is made to the Bylaws, Rules and Regulations of the Medical Staff of LifeBrite Facility, particularly to those portions pertaining to the Department of Surgery, its sections and officers, qualifications, and general privileges. The Department Chief will be elected in accordance with the Medical Staff Bylaws. To be eligible for privileges in the Department of Surgery and specialties falling within the Department, an applicant must have completed formal training required for

Board Certification within the specialty. The applicant must be Board Certified or have recently completed a residency which qualifies the applicant as an active candidate for certification.

2. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery.) In all other cases the responsible nurse shall verify that the required documentation is recorded in the medical record. The responsible nurse will notify the operating surgeon regarding needed documentation preferably no later than the night before surgery but prior to the surgical procedure. In no case shall the patient be taken from the pre-op holding area to the surgical suite until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.
3. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he or she may have his or her privilege to schedule surgery suspended or may be referred to the Executive Committee for action.
4. The anesthesiologist or CRNA is responsible for maintaining a complete anesthesia record to include evidence of pre-anesthetic evaluation and for writing a pre-anesthetic note in the medical record. The note shall indicate a choice of anesthesia and the surgical procedure anticipated.
5. The anesthesiologist or CRNA is responsible for post-anesthetic follow-up and for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care to include at least a description of the presence or absence of anesthesia-related complications.
6. If, in the opinion of the operating surgeon and/or the Chief of Surgery, there is in any surgical procedure where there is an undue hazard to life, a qualified medical assistant shall be present and scrubbed.
7. All supervision of recently credentialed staff will be at the discretion of the department and section.
8. A patient admitted for dental care is a dual responsibility of the dentist and physician appointee of the Staff.
 - (a) Dentist's responsibilities:
 - 1) A detailed dental history justifying hospital admission.
 - 2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
 - 3) A complete operative report, describing the findings and techniques.
 - 4) The dentist is totally responsible for the oral or dental care.
 - 5) Progress notes as are pertinent to the oral condition.
 - 6) Discharge summary.

- (b) Physician's responsibilities:
 - 1) Medical history pertinent to the patient's general health.
 - 2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - 3) Supervision of the patient's general health status while hospitalized.
 - 4) Physician is not responsible for any dental care or consequences thereof.
 - 5) Can be performed by a qualified oral surgeon.
- 9. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and physician appointee of the staff.
 - (a) Podiatrist's responsibilities:
 - 1) A detailed history justifying hospital admission.
 - 2) A detailed description of the examination of the feet and pre-operative diagnosis.
 - 3) A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination according to Hospital policy.
 - 4) Progress notes.
 - 5) The podiatrist is solely responsible for the care of the feet.
 - 6) Discharge summary (or summary statement).
 - (b) Physician's responsibilities:
 - 1) Medical history pertinent to the patient's general health.
 - 2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - 3) Supervision of the patient's general health status while hospitalized.
 - 4) Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.
- 10. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
- 11. All tissues and non-tissues removed surgically, or via instrumentation within the hospital shall be forwarded to the laboratory (unless the tissue is on the exceptions list for pathology per Hospital policy) where a pathologist shall make such examination as he or she feels necessary for diagnostic or identification purposes. An authenticated copy of each report shall be made part of the patient's permanent record.

Bullets or other foreign objects of legal importance which are removed shall be forwarded to the pathologist who shall describe them and hold them indefinitely or until authorities request the specimen. The authorized individual requesting the specimen must show proper photographic identification and sign the release form before the specimen is released.
- 12. The rules for scheduling of elective or non-emergency surgery will be as follows:

- (a) The schedule is available for posting of cases at all times.
- (b) The following information is required in order to post a case:
 - 1) The patient's full name
 - 2) Age
 - 3) Sex
 - 4) Surgery procedure
 - 5) Type of anesthesia
 - 6) Anesthesiologist or CRNA
 - 7) Operating surgeon
 - 8) Time and name of person posting the case
- (c) After the first time slots are filled, the order of cases will be based on the time of the cases posted, available operating room personnel, room cleaning, etc., as determined by the operating room manager.

13. For patients undergoing general anesthesia, the following are the minimum preoperative requirements recommended by the Department of Surgery:

- (a) Hemoglobin and Hematocrit done within seven (7) days of surgery.
- (b) All diabetics must have a fasting blood sugar performed the day of surgery.
- (c) EKG and chest x-ray within three (3) months of surgery:
 - 1) For all patients 50 and over
 - 2) For all patients with cardiopulmonary problems
 - 3) A repeat test to be done for all known patients with any previous significant abnormalities.
- (d) All patients on diuretics must have a potassium study performed within seven (7) days of surgery.
- (e) All fertile patients within childbearing years must have a pregnancy test performed.

The Department of Surgery recognizes that these are general guidelines for preoperative requirements and that the clinical presentation and patient history should be considered by the surgeon and anesthesiologist/CRNA in making the decision to perform these test.

14. CRNAs may be supervised by the following operating practitioners privileged to do so: orthopedic surgeon, general surgeon, plastic surgeon, urologist, gynecologist, ophthalmologist and gastroenterologist. These practitioners may supervise the CRNA using the following range of anesthesia: local, regional, spinal, epidural and general anesthesia.

15. CRNAs may be supervised by the following operating practitioners privileged to do so: podiatrist and dentist. These practitioners may supervise the CRNA using the following range of anesthesia: local, regional and monitored anesthesia care (MAC).

F. DEPARTMENT OF MEDICINE

- 1. Reference is made to the Bylaws, Rules & Regulations of the Medical Staff of LifeBrite Facility, particularly to those portions pertaining to the Department of Medicine, its sections and officers, qualifications, and general privileges. The Department Chief will be elected in accordance with the Medical Staff Bylaws.

2. To be eligible for privileges in the Department of Medicine and specialties falling within the Department, an applicant must be board certified in their area of practice with the exception of a candidate who:
 - (a) is a candidate in a residency program who is completing residency requirements; or
 - (b) has fully completed the residency requirements of said American Board; and
 - (c) who is deemed eligible and acceptable by that said American Board to take the usual examinations required of its candidates for membership.
3. All supervision of recently credentialed staff will be at the discretion of the department and section.

G. DISASTER PLAN

1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Staff and the Governing body.
2. The disaster plan should make provision within the Hospital for:
 - (a) Availability of adequate basic utilities and supplies, including water, food and essential medical and supportive materials;
 - (b) An efficient system of notifying and assigning personnel;
 - (c) Unified medical command under the direction of the Chief of Staff or his or her designated substitute.
 - (d) Conversion of all usable space into clearly defined areas of efficient triage, for patient observation and for immediate care;
 - (e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care; (f) A special disaster medical record, such as an appropriately designated tag, that accompanies the casualty as he or she is moved;
 - (f) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;
 - (g) Maintaining security in order to keep relatives and curious persons out of the triage area; and
 - (h) Pre-establishment of public relations liaison duties to a qualified individual.
3. All practitioners may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of Staff in the Hospital and the Hospital Administrator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of Staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief of Staff and the Hospital Administrator of the Hospital. In their absence, the Vice Chief of Staff and alternate in administration are next in line of authority respectively.
4. The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

H. RADIOLOGY

1. All radiologic services shall be directed by physician orders. Physicians must provide the necessary information for the reason the service is requested.
2. All images will be reviewed and an official interpretation rendered by a qualified physician. To be eligible for privileges in the Department of Radiology, an applicant must have completed formal training required for Board Certification within the specialty. The applicant must be Board Certified, or have recently completed a residency which qualifies the applicant as an active candidate for certification. Those reading mammograms must meet ACR certification requirements; those requesting privilege in invasive diagnostic procedures must provide evidence of appropriate training as suggested by ACR and demonstrate current competency.
3. Intravenous injection of contrast media shall be under the direction of a physician or midlevel provider.
4. Contrast media will not be injected by the radiologist or his designee unless or until another physician or midlevel provider is in the facility. If the radiologist does not feel comfortable about the possibility of a reaction, the attending physician shall be contacted by the radiologist.

I. AUTOPSY

1. No autopsy shall be performed without the written consent, on a Hospital Autopsy Permit form, of the next of kin or legal guardian of the deceased. All autopsies shall be performed by a pathologist to whom the attending may delegate the duty. Permission for autopsy shall be actively sought in a death following a surgical procedure as well as other criteria. Findings from autopsy are used as a source of clinical information in quality performance activities.
2. A stillborn fetus over twenty-eight (28) weeks gestation will require a stillborn certificate.
3. Medical examiners appointed by the state shall identify which DOA cases must have autopsy performed.
4. Criteria which will be considered by the medical staff include, but are not limited to:
 - (a) Unanticipated death;
 - (b) Death occurring while the patient is being treated under an experimental regimen;
 - (c) Intraoperative or intraprocedural death;
 - (d) Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
 - (e) Death where the cause is sufficiently obscure to delay completion of the death certificate;
 - (f) Death in infants/children with congenital malformations.

5. The attending physician generally seeks permission for and orders the autopsy. If not ordered by the attending, the Chief of Staff shall so inform him following a request for autopsy by two or more members of the staff.

J. CREDENTIALING

1. The active medical staff shall review qualifications of specialized professional personnel, specifically nurse anesthetists, respiratory therapists, physical therapists, Emergency Department nurses and x-ray technicians as spelled out in job performance standards.
2. Approval for special procedures as outlined in each departmental standard must be approved by the medical staff as well as approving specific individuals to perform special procedures.

K. CERTIFIED NURSE ANESTHESIST

1. Nurse anesthetists shall work under the direction of a staff surgeon, podiatrist or dentist, must be a graduate of an anesthesia school accredited by the American Association of Nurse Anesthetists; must have passed the AANA qualifying exam and be licensed to practice in the State of North Carolina. Must demonstrate competence in:
 - (a) intubation
 - (b) induction
 - (c) maintenance and management of anesthetic reactions and/or complications
 - (d) resuscitative care (CPR) and advanced life support (ACLS)
 - (e) all current anesthesia techniques
 - (f) pre and post operative consultation, evaluation and documentation
 - (g) ability to perform the history and physical section of the preoperative H&P
 - (h) monitoring techniques
 - (i) venipuncture techniques
 - (j) recovery room techniques and management
 - (k) ability to conduct in-service education to ancillary departments
 - (l) management and upkeep of anesthesia equipment
 - (m) proper documentation of anesthesia related activity

L. MISCELLANEOUS

1. The Infection Control Committee, through its Chairperson or practitioner members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors or personnel exists.
2. Policies and procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Staff and approved by its Executive Committee and the Governing body, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of

all current directives. Policies and Procedures referred to above, and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedure Manual of the Hospital.

3. The case management and quality improvement plans of this Hospital as approved by the Medical Executive Committee of the Staff and the Governing body shall be adhered to by all attending practitioners.



MEDICAL STAFF FAIR HEARING PLAN

Reviewed/Approved by the Medical Staff 11/25/2019
Reviewed/Approved by the Governing Board 2/7/2020

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LIFEBRITE COMMUNITY HOSPITAL OF STOKES

MEDICAL STAFF FAIR HEARING PLAN

ARTICLE I

APPLICATION OF REVIEW PROCEDURES

1.1 SCOPE AND DEFINITIONS

1.1-1 Scope

The procedures set forth in this Fair Hearing Plan are intended to be utilized with regard to certain types of disciplinary and administrative actions taken or about to be taken with regard to staff members and initial applicants who make a timely request for same.

1.1-2 Definitions

The following definitions shall apply to this Fair Hearing Plan, in addition to those set forth in the Medical Staff Bylaws which are incorporated by reference:

ADMINISTRATION means the executive and administrative organization of the Hospital.

AFFECTED PRACTITIONER means a member of the Medical Staff or Initial Applicant as to whom a recommendation was made or action taken.

BOARD means the Board of Directors of the Hospital.

BYLAWS mean the Bylaws of the Medical Staff.

INITIAL APPLICANT means a Physician, Dentist or Podiatrist making application for initial appointment to the Medical Staff.

SPECIAL NOTICE means written notification by registered mail or certified mail, return receipt requested or personal delivery by a Hospital employee designated by the President.

1.2 INFORMAL REVIEW AND NON-APPLICATION OF FORMAL (BASIC AND SPECIAL) HEARING

The basic and special hearing procedures specified in Articles II through VI of this Fair Hearing Plan do not apply to any of the following recommendations or actions:

- (a) removal from any committee for failure to fulfill the responsibilities of membership;
- (b) issuance of a written warning letter;
- (c) continuation of provisional staff category status when Medical Staff membership has been one year but, during which monitoring is incomplete, or withdrawal of Medical Staff membership and practice privileges of a provisional staff member based on insufficient activity upon which to base a judgment of his/her ability;
- (d) summary suspension, when rescinded within fourteen (14) days;
- (e) withholding of Practice Privileges on account of late filing of a reappointment application;
- (f) non-reappointment for failure to file a reappointment application;
- (g) a reduction of Practice Privileges which applies equally and generally to all of a class of Staff members of like or similar training, experience, and Medical Staff membership duration;
- (h) imposition of a consultation requirement of thirty (30) days or less without the pendency of hearing or appeal proceedings, or for the duration of hearing and appeal proceedings regarding Medical Staff membership or Practice Privileges, whichever is longer;
- (i) involuntary resignation of Medical Staff membership as a result of a failure to timely request reinstatement while on leave of absence;
- (j) termination of Medical Staff membership or Practice Privileges pursuant to the terms of a written contract;
- (k) removal from Medical Staff officer position by the Medical Staff or Board of Directors;
- (l) removal from a physician administrative officer or contract physician capacity by virtue of action by the Administration or Board of Directors or by contract operation or expiration;
- (m) denial of adjunct Staff category membership;

- (n) denial of transfer or appointment to a Medical Staff category which has fewer prerogatives and responsibilities than that to which an Affected Practitioner is appointed;
- (o) denial of an initial application to the Medical Staff by reason of material inaccuracies in the application, by reason of failure to submit a complete and accurate initial application (including all required attachments) or for any reason unrelated to competence or professional conduct of the Initial Applicant;
- (p) revocation of the Medical Staff membership and Practice Privileges of a member provisionally appointed by reason of insufficient activity upon which to base an evaluation of his/her ability;
- (q) expiration or revocation of temporary privileges; or
- (r) imposition of administrative action.

Although the formal (basic or special) hearing procedures delineated in this Fair Hearing Plan shall not apply to such recommendations or actions, any Affected Practitioner who believes he/she is aggrieved by any such action or recommendation of the Medical Staff Committee or Board of Directors may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reasons therefore. The statement shall be read or furnished to whichever body made the recommendation or took the action, and made a part of the Affected Practitioner's permanent file. The staff member may also request an opportunity to appear before the Medical Staff Committee or Board of Directors to informally discuss his/her position on the action, which request may be granted at the discretion of the Medical Staff Committee or Board of Directors. The Board of Directors may also, in its sole discretion, direct a basic or special hearing be held to review and make recommendations concerning the underlying matter at issue.

1.3 APPLICATION OF BASIC HEARING PROCEDURES

The basic hearing procedures as set forth in Article III of this Fair Hearing Plan shall apply to the following recommendations or actions:

- (a) automatic suspension of Medical Staff membership or Practice Privileges due to loss of licensure or governmentally authorized prescribing authority; or conviction of any felony, or any other crime arising out of professional practice;
- (b) denial of a request by an active or courtesy Staff member to obtain Practice Privileges which are not ordinarily possessed by Physicians, Dentists or Podiatrists of like training, experience, staff category and medical staff membership duration;

- (c) denial of a requested change in Medical Staff status (e.g. relief from night call) except where such denial is based upon the requesting Staff member not meeting departmental criteria which is a prerequisite for the requested change in Staff status;
- (d) issuance of a letter of reprimand without any reduction or limitation on the exercise of Practice Privileges;
- (e) imposition of a consultation requirement of more than thirty (30) days without the pendency of hearing or appeal proceedings, or for the duration of hearing and appeal proceedings regarding Medical Staff membership or Practice Privileges, whichever is longer, except for review procedures for a provisional Staff member; and
- (f) non-reappointment by reason of failure to document financial responsibility/ professional liability insurance requirement compliance. (However, a hearing based on this action shall be limited to the issue of whether financial responsibility compliance has been documented by the Staff member).
- (g) denial of reappointment or renewal of practice privileges based on failure to meet board certification or board eligibility requirements generally required of members in the same department with similar Practice Privileges;
- (h) summary or other suspension of membership or Practice Privileges for reasons unrelated to professional competence or professional conduct affecting care of patients except for failure to comply with requirements for timely completion of medical records resulting in withdrawal of Practice Privileges or involuntary resignation (for which the procedures of Section 1.2 apply);
- (i) suspension, termination of Practice Privileges, termination of membership or non-reappointment for failure to comply with a written agreement between the member and the Medical Staff Committee or the Board of Directors used in lieu of corrective action or alternative action and which provides for such suspension, termination of membership, and/or non-reappointment in the event of non-compliance (however, a hearing based on this action shall be limited to the issue of whether compliance with the agreement has been established by the member);
- (j) Suspension, termination of Practice Privileges, termination of membership or non-reappointment for recurrent failure to work cooperatively with others after disruptive practitioner or alternative action procedures have been undertaken and professional conduct or competence in the care of patients is not the basis for such action;
- (k) Such other recommendations or actions as the Medical Staff Committee or the Board of Directors may direct, in its discretion, after consultation with the other.

1.4 APPLICATION OF SPECIAL HEARING PROCEDURES

The special hearing procedures as set forth in Article IV of this Fair Hearing Plan shall apply to the following recommendations or actions:

- (a) non-reappointment, except for failure to timely submit a reappointment form, or to document financial responsibility, timely request reinstatement following an expiration of leave of absence; termination of a written contract with the member; failure to comply with a written agreement between the Medical Staff Executive Committee or Board of Directors and the member which provides for non-reappointment for failure to comply; or recurrent failure to work cooperatively with others after disruptive practitioner or alternative action procedures have been undertaken;
- (b) denial, involuntary reduction or suspension of Practice Privileges of an active, courtesy, or provisional Staff member which are ordinarily possessed by a Staff member of like or similar training or Medical Staff duration, for fifteen (15) days or more for reasons related to professional competence or professional conduct in the care of patients; provided, however, that the foregoing does not apply to a failure to comply with a written agreement between the Medical Staff Committee or Board of Directors and the member which provides for denial, involuntary reduction or suspension of Practice Privileges for failure to comply;
- (c) revocation or suspension of Medical Staff membership for more than 15 days except for failure to timely submit a reappointment application, or to document financial responsibility, or to timely request reinstatement following expiration of a leave of absence; resignation due to insufficient activity as a member on provisional status; expiration or termination of a written contract with the member; failure to comply with requirements for timely completion of medical records resulting in withdrawal of practice privileges or involuntary resignation; failure to comply with a written agreement between the Medical Staff Committee or the Board of Directors and the member which provides for revocation or suspension for failure to comply; recurrent failure to work cooperatively with others after disruptive practitioner or alternative action procedures have been undertaken; or any other ground which is not based upon professional competence or conduct in the care of patients;
- (d) denial of an initial application for appointment to the Medical Staff, except: by reason of the application being incomplete; by reason of the application containing material inaccuracies or omissions, or for any other reason unrelated to the competence or professional conduct in the care of patients of the Initial Applicant; and
- (e) such other recommendations or actions as the Medical Staff Committee or the Board of Directors may direct in its discretion, after consultation with the other.

ARTICLE II

ADVERSE RECOMMENDATION OR ACTION

2.1 WHEN ADVERSE

A recommendation or action listed in Section 1.3 or 1.4 shall be deemed adverse to the Affected Practitioner only when it is:

- (a) recommended or taken by the Medical Staff Committee;
- (b) proposed or taken by the Board of Directors contrary to a favorable recommendation by the Medical Staff Committee under circumstances where no prior right to hearing existed; or
- (c) proposed or taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Staff Committee.

2.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

An Affected Practitioner against whom adverse action is proposed or has been preliminarily taken pursuant to Section 2.1 shall promptly be given Special Notice of such proposed or preliminary action by the President. The Special Notice shall contain:

- (a) A statement of the recommendation made and the general reasons for it;
- (b) A statement that the Affected Practitioner has the right to request a hearing on the recommendation within thirty (30) days of his/her receipt of the notice;
- (c) A statement of the kind of hearing (basic or special) to which the Affected Practitioner is entitled; and
- (d) A copy of this Plan, unless it has already been provided to the Affected Practitioner.

2.3 REQUEST FOR ORIGINAL HEARING

An Affected Practitioner shall have thirty (30) days following receipt of the Special Notice pursuant to Section 2.2 to file a written request for a hearing. The request shall be made by writing delivered to the President either in person or by certified or registered mail.

2.4 WAIVER BY FAILURE TO REQUEST A HEARING

An Affected Practitioner who fails to request a formal hearing within the time and in the manner specified in Section 2.3 waives any right to such hearing and to any possible appellate review. When such waiver is in connection with:

- (a) a proposed or actual adverse action by the Board of Directors, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board of Directors.
- (b) an adverse recommendation or action by the Medical Staff Committee, it shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board of Directors. In this event, the Board of Directors shall consider the Medical Staff Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board of Directors shall review and consider the recommendation and supporting documentation of the Medical Staff Committee and may consider any other relevant information received from any source. The Board of Directors' action on the matter shall constitute the final decision of the Board of Directors.

The President shall promptly send the Affected Practitioner notice of each official action taken pursuant to this Section 2.4 and shall notify the Chief of Staff of each such action.

ARTICLE III

BASIC HEARING PROCEDURES

3.1 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the President shall deliver such request to the Chief of Staff or the Board of Directors, depending on the body whose recommendation or action prompted the request for hearing. The Chief of Staff or the Board of Directors, as appropriate, shall promptly schedule and arrange for a basic hearing. At least seven (7) days prior to the hearing date, the President shall notify the Affected Practitioner of the date, time and place of the commencement of the hearing by Special Notice. The hearing date should not be more than forty-five (45) days from the date of receipt of the request for hearing. A hearing for a Staff member who is under suspension then in effect shall ordinarily be held as soon as the arrangements and preparations for it may be reasonably made and requirements for same met. The notice may also furnish hearing rules, including time limits, prepared by the Chief of Staff or President, that take into account the anticipated nature and scope of the hearing, as well as the interests of both parties and the hearing committee.

3.2 STATEMENT OF REASON

If the reason(s) for the action or recommendation have not already been stated to the Affected Practitioner seeking a hearing, he/she may request that such reasons be provided in his/her request for hearing. Such a request for reasons shall be responded to by letter from the President, mailed or delivered to the Affected Practitioner at least three (3) days before the scheduled date for the hearing. The statement of reasons may be amended at any time, provided the Affected Practitioner is given a reasonably sufficient opportunity to prepare to meet any added reasons.

3.3 APPOINTMENTS OF HEARING COMMITTEE

3.3-1 By Medical Staff

A hearing occasioned by recommendation of the Medical Staff Executive Committee shall be conducted by:

- (a) a quorum of the Medical Staff Committee; or
- (b) a subcommittee of no less than three Physicians, Dentists, or Podiatrists, at least one of which must be a member of the Medical Staff Committee appointed by the Chief of Staff to conduct the hearing.

The Chief of Staff, who shall not be a member of the hearing committee, shall appoint a member of the hearing committee to serve as its chair. The President shall notify the Affected Practitioner of the hearing committee's composition.

3.3-2 By Board of Directors

A hearing occasioned by proposed or actual adverse action of the Board of Directors pursuant to Section 2.1(b) or 2.1(c) shall be conducted by a hearing committee appointed by the Board of Directors. This committee shall be composed of not less than three members, at least one of whom shall be a member of the Medical Staff. The Chairperson of the Board of Directors, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chair. The President shall notify the Affected Practitioner of the hearing committee's composition.

3.3-3 Service on Hearing Committee

A Medical Staff or Board member shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter at issue or because of knowledge of facts involved. In any event, all members of a hearing committee shall be required to

consider and decide the case with good faith objectivity.

3.4 APPEARANCE AND REPRESENTATION

3.4-1 Appearance of Staff member

The Affected Practitioner requesting the hearing must be present for the hearing; his/her failure to appear at the date and time set forth in the notice shall constitute a waiver of the right to a hearing.

3.4-2 Representation

At any Basic Hearing:

- (a) an Affected Practitioner shall represent him/herself.
- (b) if the hearing committee is the Medical Staff Committee or a subcommittee thereof, the Chief of Staff may, in his/her discretion, appoint him/herself or another Medical Staff member to be an advocate to represent the position adverse to the Affected Practitioner who requested the hearing.
- (c) if the hearing committee is appointed by the Board of Directors, the Chairperson of the Board of Directors may, in his/her discretion, appoint a Staff member or other person to be an advocate to represent the position adverse to the Affected Practitioner who requested the hearing.
- (d) no Affected Practitioner or advocate may participate in deliberations of the hearing committee.

3.5 HEARING CONDUCT AND EVIDENCE

3.5-1 Hearing Conduct

The chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the considerations of evidence. The presiding officer may also promulgate hearing rules, including reasonable time limits, pursuant to Section 5.4 of this Plan, which may modify any rules provided by the Chief of Staff or President under Section 3.1.

The hearing shall be conducted in such a manner that both the Affected Practitioner and the advocate, if any, has an opportunity to have his/her position fairly heard and considered. Members of the hearing body may ask questions of the person who requested the hearing and the representative of the position adverse to him/her, if any.

3.5-2

Evidence

The Affected Practitioner and the advocate, if any, may submit to the hearing body for consideration:

- (a) written statements, letters and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Hospital regarding the Affected Practitioner; and
- (b) oral statements by the Affected Practitioner and the advocate, if any; and/or
- (c) only when deemed essential to a meaningful hearing, the presiding officer may, in his/her discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules; unless, so authorized, neither the Affected Practitioner nor the advocate (if any) shall have a right to formally present witnesses, or cross-examine witnesses in person.

Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

3.6 BURDEN OF PROOF

The Affected Practitioner shall have the burden of proof and must demonstrate that the action or recommendation is:

- (a) arbitrary;
- (b) capricious; and/or
- (c) based on inaccurate or insufficient information through no fault of the Affected Practitioner.

3.7 RECORDING OF HEARING

The hearing shall be recorded by minutes prepared by a recording secretary selected by the President, which minutes shall be subject to approval and amendment by the hearing committee. Other means of recording (e.g., electronic tape or court stenographer) shall be used only at the request or with the consent of the hearing committee.

3.8 RECOMMENDATION

3.8-1 Notice

Within thirty (30) days after completion of the hearing, the hearing committee shall meet, deliberate, and then issue its report in writing to the President. The report shall be submitted by the President to the Chief of Staff or Board of Directors, as appropriate, and to the Affected Practitioner by Special Notice.

3.8-2 Action on Recommendation

- (a) If the hearing committee was a subcommittee of the Medical Staff Committee, its report shall be submitted to the Medical Staff Committee for consideration. Thereafter, the Medical Staff Committee shall make its final recommendation, subject to approval by the Board of Directors.
- (b) If the hearing committee was the Medical Staff Committee, its report shall become the final recommendation of the Medical Staff Committee, subject to Board of Directors action.
- (c) If the hearing committee was a committee appointed on behalf of the Board of Directors, its report shall become its final recommendation, subject to Board of Directors action. If timely requested, final Board of Directors action may be subject to reconsideration on appeal.

3.9 APPEAL

If, following a basic hearing pursuant to this Article, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be the sole grounds for appeal, he/she may, within fifteen (15) days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefore to the President. If such an appeal is filed, the hearing committee or a representative thereof may submit a written response in opposition within fifteen (15) days

after the appeal is received. The appeal shall be considered by the Board of Directors which shall, within forty-five (45) days after receipt of the appeal, take one of the following actions:

- (a) refer the matter back for further review or supplemental findings; if this is done, the hearing committee or the Medical Staff Committee, as applicable, shall respond in writing to the Board of Directors request within fifteen (15) days of request, and the Board of Directors shall then take the actions in (b), (c), or (d) below within thirty (30) days after receipt of the response; or
- (b) uphold the recommendation of the hearing committee and take final action accordingly; or
- (c) reverse the recommendation of the hearing committee, with or without the requirement that further hearings be conducted by the hearing body;
- (d) reverse the recommendation and require a special hearing be held in accordance with the provisions of Article IV of this Fair Hearing Plan.

The President shall advise in writing the staff member appealing, by Special Notice of the outcome of the appeal.

3.10 RELEASE

By requesting an informal hearing or appellate review under this Fair Hearing Plan, the Affected Practitioner agrees to be bound by the provisions of the Bylaws, this Fair Hearing Plan the rules and policies of the Medical Staff in all matters relating thereto.

ARTICLE IV

SPECIAL HEARING PROCEDURES

4.1 NOTICE OF TIME AND PLACE FOR HEARING

4.1-1 Scheduling and Notice of Hearing

Upon the receipt of a timely and proper request for a special hearing, the President shall promptly schedule and arrange for a special hearing. The President by Special Notice shall notify the Affected Practitioner of the time, place, and date of the hearing and the proposed composition of the hearing

committee. The hearing date shall ordinarily be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing.

4.1-2 Shortened Time Limit for Hearing

A hearing for a Staff member who is under suspension then in effect may be held in less than thirty (30) days after the request is made, provided such Staff member's request for the hearing includes a specific request that the hearing be held in less than thirty (30) days; in the event such a special request for a shorter period is made by a Staff member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to Section 4.1-3 below.

4.1-3 Lengthened Time Limit for Hearing

If pursuant to Section 4.3 the Affected Practitioner objects to the composition of an ad hoc hearing committee, or a determination is made that a hearing officer who is not a member of the Medical Staff of the Hospital shall conduct the hearing, the sixty (60) day maximum limitation shall be deemed waived by the Affected Practitioner. In such event, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and the requirements for same met. The President shall give written notice of the new scheduled date, time, and place of the hearing to the Affected Practitioner, hearing committee or officer, and the Chief of Staff or Board of Directors, once the questioning and objection processes are complete and the hearing committee or officer has been finally selected.

4.2 STATEMENT OF CHARGES AND LIST OF WITNESSES

4.2-1 Statement of Charges and List of Witnesses of Medical Staff Executive Committee or Board of Directors

The notice of hearing required by Section 4.1 shall also contain, as applicable, a concise statement of the alleged acts or omissions of the Affected Practitioner, and/or a list by number of the specific or representative patient charts in question and/or other reasons or subject matter forming the basis for the adverse recommendations or action which is the subject of the hearing.

The notice of hearing shall also include a list of witnesses, if any, that the body which took or proposed the adverse action (or its designated representative) believes will be called as witnesses to testify in support of its position at the time of the hearing.

4.2-2 Response and List of Witnesses of Affected Practitioner

At least fourteen days (14) before the scheduled date of the hearing, the Affected Practitioner shall provide his/her written response to the statement of charges and a list of witnesses, if any, which may or will be called as witnesses in support of his/her position at the time of the hearing.

4.2-3 Amendments

The statement of charges, the response, or a list of witnesses may be amended at any time by the party furnishing it, provided that the opposite party is given a reasonable period in which to prepare to meet the substance of the amendments to the statement of charges or the response, or the substance of testimony of additional witnesses. For the purpose of this provision, a time period of one week or more, shall be presumed to be a "reasonable period". The permissibility of a shorter period of notice shall be subject to the discretion of the presiding officer for the hearing.

4.3 APPOINTMENTS OF HEARING COMMITTEE

4.3-1 By Medical Staff

A special hearing occasioned by recommendation of the Medical Staff Committee pursuant to Section 2.1(a) shall generally be conducted by an ad hoc committee composed of no less than three and no more than five Physicians, Dentists, or Podiatrists appointed by the Chief of Staff, who may or may not also be members of the Medical Staff or the Medical Staff Committee.

The Chief of Staff, who shall not be a hearing committee member, shall appoint the presiding officer of the hearing committee who may, but need not be a Physician, Dentist, or Podiatrist; an attorney may be appointed as a hearing officer but if this is done, while the attorney may participate in committee deliberations and assist in the preparation of the hearing committee report, he/she shall not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the procedures of Sections 4.3-3, 4.3-4, 4.3-5 and 4.3-6.

4.3-2 By Board of Directors

A hearing occasioned by adverse action of the Board of Directors shall be conducted by a hearing committee of three or more persons appointed by the Chairperson of the Board of Directors, at least one of which must be a Physician, Dentist or Podiatrist, who may but is not required to be a Staff member and at least one of which must be a Board of Directors member. One of the appointees to the hearing committee shall be designated as presiding

officer. The appointments are subject to the procedures of Sections 4.3-3, 4.3-4, 4.3-5 and 4.3-6.

4.3-3 Service on Hearing Committee

A Staff member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter and issue because of knowledge of the facts involved, or because of participation in an earlier disciplinary hearing involving the same Affected Practitioner. However, if after objection timely submitted in accordance with Section 4.3-4, the President, in his/her good faith discretion, determines that there is reasonable evidence to support the conclusion that a proposed member of an ad hoc hearing committee is either in direct economic competition with the Affected Practitioner, or could not decide the matter with good faith objectivity, the proposed member of the ad hoc hearing committee shall be removed and, except as provided in Section 4.3-6, replaced before the hearing.

4.3-4 Notice of Appointment to Hearing Committee

Within seven (7) days after the Affected Practitioner is given notice of those who are proposed to serve on the hearing committee, such Affected Practitioner shall be entitled to submit reasonable written questions (except in extraordinary circumstances only of the “short answer” type) of not more than ten (10) in number limited to the issues of direct economic competition or bias to all or any one or more of the proposed hearing committee members through the President. The President shall, in his/her good faith discretion, determine whether questions are unreasonable or irrelevant to the issues of direct economic competition or bias, and shall strike such questions which are unreasonable or irrelevant. The questions, except those which are deemed by the President to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then submit his/her response(s) within thirty (30) days to the President. The President shall in turn forward the answers on a prompt basis to the Affected Practitioner.

4.3-5 Objections to Proposed Hearing Committee Members

Within seven (7) days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in Section 4.3-4 was elected by the Affected Practitioner, seven (7) days after his/her receipt of the responses to the written questions, the Affected Practitioner shall be entitled to submit his/her written objections, if any, to those proposed members of the hearing committee which he/she believes are in direct economic competition with him/her or are so biased against him/her as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the President who shall determine in his/her good faith discretion

as to whether or not the objections are meritorious.

- (a) If none of the objections are deemed to be meritorious by the President, he/she shall so advise the Affected Practitioner who requested the hearing, in writing, and the hearing committee shall be constituted in the manner proposed.
- (b) If the President determines that the objections to any or all of the hearing committee membership have substance, he/she shall confer with the Chief of Staff or the Chairperson of the Board of Directors, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.
 - (i) If the Chief of Staff or Chairperson of the Board of Directors believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the hearing committee, the process set forth in Section 4.3-4 and this Section 4.3-5 regarding written questions and objections, shall be repeated as necessary until an appropriate hearing committee can be constituted.
 - (ii) If, however, the Chief of Staff or Chairperson of the Board of Directors believe that there is no person available at the Hospital or in the community, who meets the committee membership requirements for participation on a hearing committee, the requirements of Section 4.3-1 and 4.3-2 shall not apply.

4.3-6

Alternate Hearing Officer

If by reason of objections to proposed membership which are determined to be valid by the President, a hearing committee of at least three (3) volunteer persons as provided in Section 4.3-1 or 4.3-2 cannot be constituted, the President shall be empowered to appoint a single person to serve as hearing officer (who may, but need not be a staff member) where:

- (a) in the good faith discretion of the President, such person is not in direct economic competition with, and has no known bias towards the affected staff member or initial applicant;
- (b) the President has consulted with the Affected Practitioner regarding the appointment of such person(s) and the President has, in his/her good faith discretion, taken into account the legitimate objections, or preferences of the Affected Practitioner as well as the availability of a qualified person to serve as hearing officer; and

- (c) as a part of the appointment process, in lieu of consultation provided in (b) above, the President may, in his/her sole discretion, provide the Affected Practitioner with a list, by name, of two (2) or more prospective hearing officers from which one person may be appointed by the President to serve as hearing officer. If submitted, the Affected Practitioner may submit objections and the reasons in writing to the President within seven (7) days of receiving the list. If objections are timely made and meritorious in the judgment of the President, this process may be repeated until a mutually satisfactory hearing officer can be selected or the procedures of (b) above utilized.

4.3-7 Notice of Appointment

Notice of the appointment of a hearing officer shall be promptly given to the Affected Practitioner who requested the hearing. Such notice shall include the estimated fee and expenses of the hearing officer, if any.

- (a) If a fee and expenses are required by the hearing officer for his/her services as such, the cost will be equally borne by the Hospital and the Affected Practitioner and advance of one-half the estimated costs shall be sent to the hearing officer by the Affected Practitioner within 14 days from notice of his/her appointment.
- (b) If, and only if, the Affected Practitioner can demonstrate such poverty that he/she is unable to pay his/her portion of the hearing officer's fee, if any, the entire fee for the hearing officer shall be borne by the Hospital. Before the Affected Practitioner may be relieved of his/her obligation to pay half of the fee and expenses for such hearing officer on the basis of poverty, the Affected Practitioner must provide the financial information which the President deems necessary to document that a level of poverty exists. This information may include, but is not necessarily limited to income tax returns for the preceding two years, financial statements of net worth prepared by his/her Certified Public Accountant, and a Statement of Assets under oath.

4.3-8 Substituted Reference to Hearing Officer

If a hearing officer is appointed instead of a hearing committee, all references in this Article to the "hearing committee" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly indicate otherwise.

4.3-9 Waiver of Rights

If the Affected Practitioner fails, within seven (7) days after notice, to submit written questions or objections to proposed members of the hearing committee or to a proposed alternate hearing officer, he/she shall be deemed

to have waived his/her right to such submission. Further, a failure of the Affected Practitioner to timely submit financial information upon request to the President necessary to establish a claim of poverty with regard to payment of the hearing officer, shall constitute a waiver of any right to have the Hospital pay the full amount of a hearing officer's fee. The failure to timely submit one-half of the estimated fees and expenses of a hearing officer, if one is appointed, shall be deemed to be a waiver of the right to any hearing, unless an exception based on poverty is granted. In addition, the failure of the Affected Practitioner to pay his/her share of the finally determined fees after the hearing, shall result in the withholding of any practice privileges he/she holds or is granted until such obligation is paid.

4.4 PERSONAL PRESENCE

The personal presence at the hearing of the Affected Practitioner shall be required. An Affected Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights or review in the same manner and with the same consequence as provided in Sections 2.4 and 5.2.

4.5 PRESIDING OFFICER

The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings, procedure actions and the consideration of evidence. If the hearing is conducted by a single hearing officer as provided in Section 4.3-6, he/she shall serve as the presiding officer.

4.6 REPRESENTATION

The Affected Practitioner shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society. The Medical Staff Committee or Board of Directors, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation or action who shall be referred to as "advocate". The advocate may present evidence but, even if a member of the Medical Staff Committee or the Board of Directors, shall not participate in deliberations or vote on the matter at issue. Representation of either party by an attorney at law shall be governed by the provisions of Section 5.1.

4.7 RIGHTS OF PARTIES

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

- (a) call and examine witnesses and cross-examine witnesses called by the other party;
- (b) introduce exhibits and present other relevant evidence;
- (c) question witnesses on matters relevant to the issues;

- (d) rebut any evidence; and
- (e) impeach any witness.

If the Affected Practitioner does not testify, he/she may be called and examined as if under cross-examination.

4.8 PROCEDURE AND EVIDENCE

The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. The hearing shall not, without the consent of the hearing committee or as required by the Chief of Staff or the Board of Directors for good cause shown, extend beyond twelve (12) hours of in person hearing and presentation (six hours allocated to each party). If there is a perceived need to present more than can reasonably be presented within the allotted time, the matter shall be submitted to the hearing officer prior to the issuance of supplemental hearing rules under 5.4 so that alternative procedures (e.g., depositions and abstracts) can be authorized and timely used. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, at the close of if specifically requested and authorized by the presiding officer, within seven (7) days of the hearing, be entitled to submit a memorandum concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required, to order that oral evidence be only taken on oath or affirmation.

4.9 MATTERS CONSIDERED

In addition to relevant evidence to matters formally presented at the hearing, the hearing committee or officer is entitled to review any material or information on file in the Hospital and all other information which may be considered pertinent to applications for appointments or reappointments to the Medical Staff and/or requests for Practice Privileges. To facilitate the efficiency of the hearing, subject medical charts, investigative reports, pertinent correspondence, committee minutes and the statement of charges shall be furnished to the hearing committee or officer by the President. The Affected Practitioner must so be advised of same so that he/she may, if desired, challenge their relevancy at the hearing. The hearing committee or officer shall be entitled to conduct independent review, research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Practitioner is aware of such, and has the opportunity to rebut any information so gathered.

4.10 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Affected Practitioner shall be responsible for supporting a challenge to the adverse recommendation or action by providing evidence that the grounds are not supported by the evidence or that the conclusions

drawn therefrom are arbitrary or capricious.

4.11 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any person or group that may later be called upon to review the record and render a recommendation or decision in the matter. If the President and the Affected Practitioner cannot agree on a method, the presiding officer shall select the method to be used for making the record, (such as a court reporter, electronic recording unit or detailed transcription). The Affected Practitioner shall be entitled to obtain a copy of the record upon payment of the reasonable charges associated with the preparation of same. If the Affected Practitioner elects an alternate method of recording, he/she shall bear the cost thereof.

4.12 POSTPONEMENT

Requests for postponement of a hearing shall be granted by the presiding officer only upon a showing of good cause.

4.13 RECESSES AND ADJOURNMENT

The hearing committee or officer may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed and finally adjourned. Within thirty (30) days thereafter, the hearing committee or officer shall conduct its deliberations outside the presence of any other person.

4.14 HEARING REPORT

Within 30 days after final adjournment of the special hearing, the hearing committee or officer shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the President. The President in turn shall submit the report to the body whose adverse recommendation or action occasioned the hearing with copies to the Affected Practitioner and the advocate.

4.15 ACTION ON HEARING REPORT

Within 30 days after receipt (or finalization, if a committee of the whole was involved) of the report of the special hearing committee or officer, the Medical Staff Committee or the Board of Directors, as the case may be, shall consider the same and affirm, modify or reverse its prior recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee or officer and all other documentation considered, to the President.

4.16 NOTICE AND EFFECT OF RESULT

4.16-1 Notice

The President shall promptly send a copy of the result to the Affected Practitioner by Special Notice, to the Chief of Staff, and to the Board of Directors.

4.16-2 Effect of the Result Adopted by the Medical Staff Committee

The Medical Staff Committee's recommendation pursuant to Section 4.15, relative to the Affected Practitioner, shall be promptly forwarded by the President, together with all supporting documentation, to the Board of Directors for its final action.

4.16-3 Initial Board of Directors Action on Recommendation from the Medical Staff Executive Committee

The Board of Directors shall take action thereon by adopting or rejecting the Medical Staff Committee's report in whole or in part, or by referring the matter back to the Medical Staff Committee for further consideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Directors shall take action.

4.16-4 Effect of a Favorable Action by the Board of Directors

Favorable action by the Board of Directors, pursuant to Section 4.15, whether it be to support a favorable result adopted by the Medical Staff Committee or to reverse an unfavorable result adopted by the Medical Staff Committee, is the final decision of the Board of Directors and no appeal may be taken therefrom.

4.16-5 Effect of an Unfavorable Action by the Board of Directors

If in accordance with Section 4.16-3 (after the Medical Staff Committee's recommendations) or Section 4.15 (after Board of Directors level hearing) the Board of Directors contemplates taking action which would be adverse to the Affected Practitioner in any of the respects listed in Sections 1.3 and 1.4, the Affected Practitioner shall be informed by Special Notice of that fact and his/her right to request appellate review by the Board of Directors as provided in Section 4.17 of this Fair Hearing Plan.

4.17 REQUEST FOR APPELLATE REVIEW

An Affected Practitioner shall have 10 days following receipt of a notice pursuant to Section 4.16-5 to file a written request for an appellate review. Such request shall be delivered to the President either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, evidence which was considered in making the adverse action or result.

4.18 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

An Affected Practitioner who fails to request an appellate review within the time and in the manner specified in Section 4.17 waives any right to such review. Such waiver shall have the same force and effect as that provided in Sections 2.4 and Section 5.2 of this Fair Hearing Plan.

4.19 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the President shall deliver such request to the Board of Directors. The Board of Directors shall schedule and arrange for an appellate review which shall be not more than 45 days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Staff member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made. The President shall send the Affected Practitioner notice of the time, place and date of the review. The time for the appellate review may be extended by the Board of Directors for good cause.

4.20 APPELLATE REVIEW BODY

The Board of Directors shall be the appellate review body; one Board of Directors member shall be designated as chairperson of the appellate review proceedings.

4.21 NATURE OF APPELLATE REVIEW PROCEEDINGS

The appellate review proceedings of the Board of Directors shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The Board of Directors shall also consider the written statements as may be presented and accepted under this Article.

4.22 WRITTEN STATEMENTS

The Affected Practitioner shall submit a written statement detailing the findings, conclusions and procedural matters with which he/she disagrees, and the reason for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Board of Directors through the President at least five days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Staff Committee, or if Board of Directors action is being appealed, the advocate. If submitted, the President shall provide a copy thereof to the staff member or initial applicant at least two (2) days prior to the scheduled date of the appellate review.

4.23 PRESIDING OFFICER

The chairperson of the appellate review shall be presiding officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

4.24 ORAL STATEMENT

The Board of Directors in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put by any member of the Board of Directors.

4.25 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Subject to Section 5.3 below, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in his/her record shall be introduced at the appellate review only under unusual circumstances. The Board of Directors in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

4.26 RECESSES AND ADJOURNMENT

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

4.27 ACTION TAKEN BY BOARD OF DIRECTORS ON APPEAL

The Board of Directors may affirm, modify or reverse the adverse result or action taken by the hearing committee or officer pursuant to Section 4.15 or 4.16, or, in its discretion, may refer the matter back to the hearing committee or officer or the Board of Directors Quality Committee for further review and recommendation(s). Said recommendation(s) shall be returned within 45 days and within 15 days after receipt of such recommendation(s), the Board of Directors shall make its final decision.

4.28 FINAL BOARD OF DIRECTORS ACTION AFTER APPELLATE REVIEW

Unless the matter is referred back to a hearing committee, hearing officer, or Board of Directors Quality Committee, pursuant to Section 4.27, within 15 days after the conclusion of the appellate review, including referrals back to the hearing committee, hearing officer, or Board of Directors Quality Committee, the Board of Directors shall render its decision in the matter in writing and shall send notice thereof to the Affected Practitioner by Special Notice, to the Chief of Staff, and to the Medical Staff Committee.

ARTICLE V

GENERAL PROVISIONS APPLICABLE TO BASIC AND SPECIAL HEARINGS

5.1 ATTORNEYS

5.1-1 The Parties

- (a) Basic Hearings: If the Affected Practitioner desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Article III of this Fair Hearing Plan, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole

discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Practitioner to be so represented, the Medical Staff Committee or the Board of Directors may also be represented by an attorney at the hearing.

- (b) Special Hearings: If the Affected Practitioner desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Article IV of this Fair Hearing Plan, the request for such hearing or appellate review must so state. The Affected Practitioner shall have an unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Practitioner chooses to be so represented, the Medical Staff Committee or the Board of Directors may also be represented by an attorney at the hearing.

Notwithstanding the foregoing, however, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the presiding officer.

For any matter under review, an Affected Practitioner may request that any notices and information directed to him/her be sent to his/her attorney. The request will be honored only if the Affected Practitioner makes the request in writing to the President and both the Affected Practitioner and his/her attorney agree in writing that if confidential peer/professional review and Hospital business information is provided to them, they shall maintain its confidentiality and not re-disclose the information without the written consent of the President.

5.1-2 The Hearing or Appellate Review Body or Administrator

A hearing committee or appellate review body may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s).

5.2 WAIVER

If at any time after receipt of Special Notice of an adverse recommendation, action or result, an Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, the Affected Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

5.3 INDEPENDENT CONSULTANTS

At any stage of hearing proceedings, a hearing committee or the Board of Directors may retain an independent consultant, who may or may not be a member of the medical staff. The consultant may be provided with medical records, films, slides, reports, or such other materials he/she and the requesting body may deem appropriate for his/her review. The consultant shall present a written or oral report to the requesting body which shall be made available to all the parties. A consultant so elected should not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence which may be considered.

5.4 SUPPLEMENTAL HEARING RULES

The presiding officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Fair Hearing Plan. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Fair Hearing Plan. The supplemental rules may set forth order of presenting evidence and oral statements as well as time limits for presentations and presentation of the in-person aspects of the hearing. In this respect, the hearing rules may require that certain testimony be taken in deposition format and submitted to the hearing committee in the form of transcript, videotape and/or abstracts of relevant testimony. When feasible, the presiding officer may at his/her discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the parties (or their representatives) to meet and propose rules subject to his/her approval. When such rules are promulgated by the presiding officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered and, when deemed meritorious, amendments shall be made in the rules to address the objections.

5.5 NUMBER OF REVIEWS

Notwithstanding any other provision of the Bylaws or of this Fair Hearing Plan, no Affected Practitioner shall ever be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action. Further, the Medical Staff Committee and the Board of Directors need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Affected Practitioner, unless there is clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

5.6 RELEASE

By requesting a hearing or appellate review under this Fair Hearing Plan, an Affected Practitioner agrees to be bound by the provisions of the Bylaws, this Fair Hearing Plan, and the Rules established for hearing, in all matters relating thereto.

5.7 Time Limit Modification

Any procedural rule or time limit specified in this Fair Hearing Plan may be modified or waived by agreement between the presiding officer of the hearing committee and the Affected Practitioner or the duly authorized designee of any of them. The Board of Directors or the presiding officer at a hearing may, in its/his/her discretion, grant an extension of any time limits when required for fundamental fairness to any party. A request by an Affected Practitioner for a hearing for an extension of any time limits, which is granted, waives any right to insist upon the Hospital or Medical Staff complying with the time limits specified herein.

5.8 BOARD OF DIRECTORS QUALITY COMMITTEE REVIEW

If at any time during the Board of Directors' consideration and review of a recommendation or action with respect to an Affected Practitioner, the Board of Directors deems it necessary or advisable, the Board of Directors may refer the matter to the Board of Directors Quality Committee for review and comment.

Within fifteen (15) days of its receipt of a matter referred to it by the Board of Directors pursuant to the provisions of this Fair Hearing Plan, the Board of Directors Quality Committee shall convene and consider this matter and submit its written recommendations to the Board of Directors. The composition of the Board of Directors Quality Committee is as set forth in the Hospital Bylaws.

5.9 GOOD FAITH - ALTERNATIVE SPECIAL NOTICE

5.9-1 Good Faith

In addition to those duties imposed in the Bylaws, it shall be the duty of each Affected Practitioner to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Fair Hearing Plan without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the Board of Directors that an Affected Practitioner is not acting or has not acted in good faith with regard to the hearing process of this Fair Hearing Plan, the hearing committee, hearing officer or Board of Directors may limit or deem waived the Affected Practitioner's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.

5.9-2 Alternative Mailing

If, in attempting to give Special Notice, either postal authorities, despite reasonable efforts, are unable to deliver or obtain signature on a return receipt for registered or certified mail, or a representative of the Hospital, despite reasonable efforts is unable to make personal delivery, at the designated place of mail delivery for the Affected Practitioner, such Special Notice may alternatively given by regular mail mailed at least five days before any deadline to the last home address and last office address provided by the Affected Practitioner to Administration.

5.9-3 Time Limits - Constructive Receipt

For the purpose of time limits of this Fair Hearing Plan, if the foregoing mailing procedure of Section 5.9-2 is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authorities or personal delivery by Hospital personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Practitioner, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption may be overcome only by a clear and convincing showing to the presiding officer that the failure to make delivery or sign a receipt, was due to error, neglect, or unreasonable delay, of the postal authorities or Hospital representatives, and not the Affected Practitioner.

5.9-4 Designated Place of Mail Delivery

The designated place of mail delivery shall be the office address last provided by an Affected Practitioner to Administration and any person who signs a receipt for mail there shall be deemed as authorized by the staff member to do so. In the event of his/her absence, each Affected Practitioner shall either:

(a) authorize his/her office staff members to receive and sign receipts for mail on his/her behalf or, alternatively, (b) if his/her office shall be closed for more than two successive business days or he/she does not wish his/her office staff authorized to receive and sign a receipt for mail on his/her behalf, he/she must designate in a writing sent by certified mail to the President, the name and address of an alternate designated place of delivery (e.g., a law or accounting firm) and a statement that any person who receives and signs for mail there is authorized to do so on his/her behalf.

5.9-5 Purpose - Good Faith

The purpose of the foregoing provisions of Sections 5.9-2, 5.9-3 and 5.9-4 are to assure reasonable efforts to give required notices and proceed forward with

requested hearings are not thwarted or delayed by refusal to accept delivery, refusal to sign receipts, office closure, absence from the community, or the bad faith on the part of an Affected Practitioner.

5.10 CONSOLIDATION

If two or more hearings and/or appeals with respect to the same Affected Practitioner are proceeding simultaneously, (e.g., summary suspension and non-reappointment), the Board of Directors, at the request of the Affected Practitioner, the President, Chief of Staff, or the Medical Staff Committee, may order the two proceedings consolidated into a single hearing or appeal. In this respect, the Board of Directors shall have the authority to suspend or modify time limits and take whatever action most reasonably and fairly to all concerned to accommodate the consolidation.

5.11 HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

Those actions or recommendations which entitle an Affected Practitioner to a special hearing pursuant to Article IV, are those matters the Hospital and Medical Staff reasonably believe represent "professional review action" and "professional review activity" which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Fair Hearing Plan that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of Section 412 of the Act.

ARTICLE VI:

AMENDMENT AND APPLICATION

6.1 AMENDMENT

This Fair Hearing Plan may be amended or repealed, in whole or in part, in the manner set forth in the Medical Staff Bylaws.

6.2 APPLICATION

Any matter subject to review or hearing pursuant to the Medical Staff Bylaws after adoption of this Fair Hearing Plan by the Board of Directors shall be governed by its terms; the prior Fair Hearing Plan shall be deemed superseded by the terms of this Fair Hearing Plan.

The foregoing Fair Hearing Plan to the Bylaws of the Medical Staff was adopted by members of the Active category of the Medical Staff of the Hospital on the 26th day of September, 2013.