Medical Staff Bylaws

Novant Health Medical Park Hospital

11/30/2022

NOVANT HEALTH

OVERVIEW

These are the medical staff bylaws for the medical staff of Novant Health Medical Park Hospital. The bylaws explain the rights of the medical staff; the qualifications for medical staff members and advanced practice providers; and the basic steps in the appointment, reappointment and clinical privileging processes. They also describe how the medical staff governs itself and how it is organized by medical staff category and clinical departments. Finally, the bylaws address how the medical staff reviews and investigates clinical competence and professional behavior concerns and the procedures used for hearings and appeals.

Organization of the bylaws

The bylaws are organized into the following articles:

Important concepts

- Only physicians, oral surgeons, podiatrists and general dentists who meet the qualifications in these bylaws are eligible to be members of the medical staff. Others, such as certified registered nurse anesthetists (CRNAs), certified nurse midwives (CRNAs), clinical pharmacist practitioners (CPPs), nurse practitioner (NPs) and physician assistants (PAs), may hold clinical privileges, but they are not eligible to be members of the medical staff.

- Being granted membership on the medical staff means the same thing as being appointed or reappointed to the medical staff.
- When the word "practitioner" is used, it refers both to members of the medical staff and to those individuals who hold clinical privileges but are not members, such as CRNAs, CNMs, CPPs, NPs and PAs.
- It is a privilege to serve on the medical staff and to exercise clinical privileges. Members and those holding clinical privileges are afforded important rights but also must fulfill certain obligations and responsibilities such as providing quality care to patients and treating all patients, visitors and members of the healthcare team with respect, courtesy, and dignity.
- Terms of membership and clinical privileges cannot be for longer than two years, but they may be for two years or less. Members and those holding clinical privileges must apply for reappointment and renewal of clinical privileges at least every two years.
- Whenever the hospital president deems it appropriate, he/she may delegate the performance of duties to a designee, and all references to the hospital president include his/her designee.
- References to a "clinical department" or "department" also include "specialty sections" unless the context clearly requires otherwise.
- Words used in these bylaws are to be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are used for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.
- Medical staff bylaws address, at a high level, how the medical staff governs itself. Rules & regulations address, in more detail, how the medical staff practices at the hospital (such as how the medical staff requests consults, when the medical staff may request to be exempt from unassigned patient call, etc). Policies address, in greater detail, a particular topic (such as how to administer blood, etc).
- An abbreviated table of contents follows this overview. Detailed tables of contents are included at the beginning of each article.
- Adoption and approval dates for these bylaws are listed on Appendix 6 on page A-6.

TABLE OF CONTENTS

This is an abbreviated table of contents. Detailed tables of contents are included at the beginning of each article.

ARTICLE I - GOVERNANCE

Article I describes how the medical staff governs itself. It explains how the medical staff nominates and elects its officers and clinical department chairpersons, and it describes how the medical staff, clinical departments and medical staff committees meet and take action. Finally, Article I outlines the processes used to adopt and approve the medical staff's governing documents, which are these bylaws, rules & regulations and policies.

ARTICLE I – GOVERNANCE
Table of Contents

ARTICLE I – GOVERNANCE

Section 1-1. Officers of the Medical Staff

The officers of the medical staff are the chief of staff and vice-chief of staff. The immediate past chief of staff is *not* a medical staff officer, but he/she serves as a voting member of the MEC and may offer advice and guidance to the chief of staff, vice-chief of staff and other medical staff leaders when needed. Department and section chairpersons also are *not* medical staff officers (*see* section 1-2, A, on page 10 for information about department and section chairpersons).

The officers of the medical staff are the chief of staff and vice-chief of staff.

- Section 1-1, C, on page 5 explains how medical staff officers are nominated and elected or selected.

A. Qualifications for medical staff officers

A medical staff officer must:

1. be an active medical staff member in good standing;
2. be board certified;
3. have been a member of the active medical staff for at least two consecutive years;
4. have served for at least one year either as a clinical department chairperson or as a member of the credentials committee, a quality committee or a clinical improvement committee; and
5. be able to perform successfully the responsibilities of the office.

B. Terms for medical staff officers

Officers serve for two-year terms, beginning on May 1st, unless they resign or are removed from office before the end of their term (*see* section 1-1, E, on page 8 for how to fill a vacancy and section 1-1, F, on page 8 for how to remove a medical staff officer). Officers cannot hold more than one medical staff office at the same time.

Officers serve for two-year terms, beginning on May 1st.

C. Nomination and election of medical staff officers

The nomination and election process for medical staff officers is explained below.

1. Chief of staff

   There is no nomination or election for chief of staff. The vice-chief of staff *automatically* becomes the chief of staff at the end of the term, unless the chief of staff succeeds himself or herself.

2. Vice-chief of staff

   a. Nominations of qualified candidates for vice-chief of staff

      Nominations of qualified candidates for vice-chief of staff may be made by the nominating committee and by the medical staff, as explained below.

      i. Nominating committee

      The nominating committee nominates one *qualified* candidate for vice-chief of staff every other year (*see* section 1-1, A, on page 5 for medical staff officer qualifications). The nominating committee is composed of the chief of staff, vice-chief of staff, one or two past chiefs of staff (if available), the chief clinical officer (CCO) and the hospital president. The CCO and hospital president are non-voting members. The candidate's name is included in a medical staff meeting notice, which is emailed to voting medical staff members at least 14 days before the medical staff meeting (*see* section 1-4 on page 25 for medical staff meetings).

      The nominating committee nominates one qualified candidate for vice-chief of staff, and the candidate's name is emailed to the voting members of the medical staff at least 14 days before a medical staff meeting.

      Members of the medical staff may nominate additional qualified candidates but must submit their names, and meet the other requirements in Section 1-1, B, 2, a, ii, to the medical staff office at least 3 business days before the medical staff meeting.

      ii. Nominations from the medical staff

      Members of the medical staff also may nominate *qualified* candidates for vice-chief of staff (*see* section 1-1, A, on page 5 for medical staff officer qualifications). These nominations must:

      - be in writing;
      - be signed by at least 10% of the voting members of the medical staff (*see* section 1-4, B, on page 26 for who the voting members of the medical staff are);
      - include a statement from the candidate that he/she is willing to serve as vice-chief of staff; and
      - be submitted to the medical staff office at least three *business* days before the medical staff meeting.

b. Elections for vice-chief of staff

An unopposed candidate for vice-chief of staff is elected automatically, and no voting is necessary. Opposed candidates are voted on by the voting members of the medical staff either at a medical staff meeting *or* by ballot, as determined by the MEC. If voting occurs at a medical staff meeting, nominations will ***not*** be accepted from the floor. The candidate who receives a majority vote is elected. If no candidate receives a majority vote, there will be successive voting, and the name of the candidate who receives the fewest votes will be omitted from each successive slate until a candidate receives a majority vote. The election of the vice-chief of staff is effective when ratified by the Board of Trustees.

Unopposed candidates for vice-chief of staff are elected automatically, and no voting is needed.

Opposed candidates are voted on either at a medical staff meeting or by ballot; if voting occurs at a medical staff meeting, no nominations will be accepted from the floor. The candidate who receives a majority of the votes cast is elected.

D. Duties of medical staff officers

1. Chief of staff duties

The chief of staff serves as a member of the Board of Trustees; coordinates the medical staff's activities and concerns with hospital administration, nursing and other patient care departments; represents the medical staff's views and needs to the Board of Trustees and hospital administration; enforces the medical staff's bylaws, rules & regulations and policies; calls, sets the agenda and presides at medical staff meetings; serves as the MEC chairperson and as a non-voting member of all other medical staff committees; acts on behalf of the MEC to consider and resolve issues that occur between MEC meetings when the MEC executive committee cannot meet; and has general supervision over all the professional work of the hospital. The chief of staff may also perform any duty of any department chairperson or medical staff committee chairperson if the chairperson is not available or otherwise fails to perform their duties.

The chief of staff may perform the duties of any department chairperson or medical staff committee chairperson when the chairperson is not available or otherwise fails to perform his/her duties.

2. Vice-chief of staff duties

The vice-chief of staff serves as the MEC vice-chairperson; fulfills the chief of staff's duties in his/her absence; and performs any other duties that may be assigned by the chief of staff, the MEC or the Board of Trustees.

E. Vacancies in a medical staff officer position

If there is a vacancy in a medical staff officer position, the MEC appoints a *qualified* medical staff member to serve the remainder of the term (*see* section 1-1, A, on page 5 for medical staff officer qualifications). The Board of Trustees must ratify the appointment, and the appointed medical staff officer has the full authority of the office between MEC appointment and Board of Trustees ratification.

F. Removal of a medical staff officer

1. Grounds for removing a medical staff officer

A medical staff officer may be removed by either the MEC or the medical staff *only* for the following grounds:

a. not performing the duties of the medical staff office (*see* section 1-1, D, on page 7 for the duties of medical staff officers);

b. not maintaining the qualifications for officers (*see* section 1-1, A, on page 5 for the qualifications of medical staff officers); or

c. exhibiting behavior or conduct that is lower than the standards of the medical staff or hospital or that is disruptive to the orderly operations of the medical staff or hospital.

The MEC or the medical staff may remove a medical staff officer – but only for the grounds listed in section 1-1, F, 1.

At least a 2/3 vote of all the voting members of the MEC or at least a 2/3 vote of all the voting members of the medical staff is required to remove a medical staff officer.

Voting must occur at either an MEC meeting or a medical staff meeting. Voting by proxy or ballot is not allowed.

2. Removal process

When one or more the grounds to remove an officer listed above in section 1-1, F, 1, exist, the MEC or the medical staff may remove the medical staff officer by following the process set out below. The medical staff officer's removal is effective when it is approved by the Board of Trustees.

a. Removal of medical staff officers by the MEC

At least a two-thirds (2/3) vote of ***all the voting members of the MEC*** is required to remove a medical staff officer (*see* section 1-3, A, 3, b, on page 19 and Appendix 3 on page A-3 for the voting members of the MEC). MEC members must vote to remove a medical staff officer at an MEC meeting; *they cannot vote by proxy or by ballot to remove a medical staff officer*. The medical staff officer must be notified in writing at least 10 days before the meeting at which removal will be considered and be given an opportunity to speak before any vote is taken.

b. Removal of medical staff officers by the medical staff

Members of the medical staff also may remove a medical staff officer. In order to do this, a removal petition that is signed by at least 50% of the voting members of the medical staff must be presented to the MEC (*see* section 1-4, B, on page 26 for the voting members of the medical staff). If a petition meets these requirements, the MEC chairperson will schedule a medical staff meeting per section 1-4, A, on page 25 to discuss the issue and, if appropriate, vote on removal. The officer must be given an opportunity to speak before any vote is taken. At least a two-thirds (2/3) vote of ***all voting members of the medical staff*** is needed to remove the officer. Voting members of the medical staff must vote to remove a medical staff officer at a medical staff meeting; *they cannot vote by proxy or ballot to remove a medical staff officer*.

Section 1-2. Clinical Departments and Sections

In this section, and throughout the bylaws, all references to a "department" also include a "section," unless the context clearly requires otherwise.

- Appendix 2 on page A-2 contains a list of departments and their sections, if any.
- Table 1 on page 15 describes how departments meet and take action, and Appendix A-1 on page A-1 describes how departments, medical staff committees and the medical staff meet and take action.
- Section 1-2, A, 3, on page 11 explains how department chairpersons are nominated and elected.

Each practitioner is assigned to one clinical department, or to a specialty section within a department, by the Board of Trustees based on the MEC's recommendation. Practitioners may hold clinical privileges in other clinical departments as well. Practitioners who exercise clinical privileges within a clinical department are subject to its rules and regulations and to the authority of its chairperson.

If departments need to be created, combined or eliminated, the MEC will consider the following in making a recommendation on the matter to the Board of Trustees: whether the discipline is a boarded discipline, the number of practitioners involved, the evolving scope of clinical services, and the needs of the medical staff to oversee the quality of patient care.

A. Department and section chairpersons

Each clinical department must have a chairperson. A specialty section within a department may have a chairperson but is *not* required to have one.

Each department must have a chairperson. A section within a department may have a chairperson but is not required to have one.

1. Qualifications for chairpersons

A clinical department chairperson must be:

a. an active medical staff member in good standing (a chairperson does not have to be on the active medical staff for those departments that do not have any, or only a few, active members because they are largely outpatient based, such as family practice and pediatrics);
b. board certified in the specialty they are to lead;
c. on the active staff for at least two consecutive years (or one year when needed);
d. a medical staff member of the clinical department or section he/she is to lead; and
e. able successfully to perform the responsibilities of the position.

2. Terms for chairpersons

Chairpersons serve for two- year terms, beginning on May 1st, unless they resign or are removed before the end of their term. There are no term limits, but a medical staff

Chairpersons serve two-year terms, beginning on May 1st.

member who is on the medical staff of more than one Novant Health hospital may only serve as chairperson for one hospital during a term.

3. Nomination and election of chairpersons

The nomination and election process for department chairpersons is explained below.

a. Nominations of qualified candidates for chairpersons

i. Nominating committee

The nominating committee works with the current chairperson to nominate one *qualified* candidate for each clinical department or specialty section chairperson position that is open (*see* section 1-2, A, 1, on page 10 for department chairperson qualifications). The nominating committee is composed of the chief of staff, vice-chief of staff, one or two past chiefs of staff (if available), the CCO and the hospital president. The CCO and hospital president are non-voting members. The candidate's name is emailed to the voting members of the department at least 14 days before a medical staff meeting or department meeting, depending upon where voting will occur.

The nominating committee works with the current department chairperson to nominate one qualified candidate for chairperson, and the candidate's name is emailed to the voting members of the medical staff at least 14 days before a medical staff or department meeting.

Medical staff members of the department may nominate additional qualified candidates but must submit their names, and meet the other requirements in section 1-2, A, 3, a, ii, to the medical staff office at least 3 business days before the medical staff or department meeting.

ii. Nominations from the medical staff members of the department

Voting members of the department also may nominate qualified candidates for chairperson (*see* section 1-2, A, 1, on page 10 for department chairperson qualifications). These nominations must:

- be in writing;
- be signed by at least 10% of the voting members of the department;
- include a statement from the candidate that he/she is willing to serve as chairperson; and
- be submitted to the medical staff office at least 3 *business* days before the medical staff or department meeting.

4. Elections for department chairpersons

Unopposed candidates for chairperson are elected automatically, and *no voting is necessary*. Opposed candidates are voted on by the voting members of the department either at a department meeting (*see* section 1-2, B, on page 14 for department meetings and section 1-2, B, 2, on page 15 for the voting members of the department) or a medical staff meeting (*see* section 1-4, on page 25 for medical staff meetings). Nominations will ***not*** be accepted from the floor during the meeting. The candidate who receives a majority vote is elected. If no candidate receives a majority vote, there will be successive voting, and the name of the candidate who receives the fewest votes will be omitted from each successive slate until a candidate receives a majority vote. A department chairperson's election must be ratified by the Board of Trustees.

Unopposed candidates for department chairperson are elected automatically, and no voting is needed. Opposed candidates are voted on either at a medical staff meeting or a department meeting. Nominations will not be accepted from the floor. The candidate who receives a majority of the votes cast is elected.

5. Duties of chairpersons

Clinical department and specialty section chairpersons are responsible for:

a. clinically related activities of the department or section;
b. administratively related activities of the department or section, unless otherwise provided by the hospital;
c. continuing surveillance of the professional performance of all practitioners in the department or section who have delineated clinical privileges, regardless of whether or not the practitioners are members of the department;
d. recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department or section;
e. recommending clinical privileges for each applicant and member of the department or section;
f. assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department, section or the organization;
g. integrating the department, section or service into the primary functions of the organization;
h. coordinating and integrating interdepartmental/ sectional and intradepartmental/ sectional services;
i. developing and implementing policies and procedures that guide and support the provision of care, treatment, and services;

j. recommending a sufficient number of qualified and competent persons to provide care, treatment, and services;
k. determining the qualifications and competence of department, section or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
l. continuously assessing and improving the quality of care, treatment, and services;
m. maintaining quality control programs, as appropriate;
n. providing orientation and continuing education to all persons in the department or section;
o. recommending space and other resources as needed by the department or service;
p. developing a separate, unassigned patient call schedule for each specialty and subspecialty within the department to meet community need, as required by the medical staff's rules & regulations;
q. monitoring compliance with medical staff and hospital policies and procedures; and
r. making regular reports on the department's activities to the credentials committee.

6. Vacancies in a chairperson position

If there is a vacancy in a chairperson position, the MEC appoints a *qualified* medical staff member to serve the remainder of the term (*see* section 1-2, A, 1, on page 10 for chairperson qualifications). The Board of Trustees must ratify the appointment, and the appointed chairperson has the full authority of the position between MEC appointment and Board of Trustees ratification.

7. Removal of a chairperson

a. Grounds for removing a chairperson

A chairperson may be removed by either the MEC or the medical staff members assigned to the department *only* for the following grounds:

i. not performing the chairperson's duties (*see* section 1-2, A, 5, on page 12 for chairperson duties);
ii. not maintaining the qualifications for chairpersons (*see* section 1-2, A, 1, on page 10 for chairperson qualifications); or
iii. exhibiting behavior or conduct that is lower than the standards of the medical staff or hospital or that is disruptive to the orderly operations of the medical staff or hospital.

b. Removal process

When one of more the grounds listed above exist, the MEC or the medical staff members assigned to the department may remove a chairperson by following the

process set out below. The chairperson's removal is effective when it is approved by the Board of Trustees.

i. Removal of chairpersons by the MEC

At least a two-thirds (2/3) vote of ***all the voting members of the MEC*** is required to remove a chairperson (*see* section 1-3, A, 3, b, on page 19 and Appendix 3 on page A-3 for the voting members of the MEC). MEC members must vote to remove a chairperson at an MEC meeting; *they cannot vote by proxy or by ballot to remove a chairperson*. The chairperson must be notified in writing at least 10 days before the meeting at which removal will be considered and be given an opportunity to speak before any vote is taken.

The MEC or the medical staff members assigned to a department may remove the department's chairperson – but only for the grounds listed in section 1-2, A, 7, a.

At least a 2/3 vote of all the voting members of the MEC or at least a 2/3 vote of all the voting members of the department is required to remove the chairperson. Voting must occur at either an MEC meeting or a department meeting.

Voting by proxy or ballot is not allowed.

ii. Removal of chairpersons by the medical staff assigned to the department

Members of the medical staff assigned to the department also may remove the chairperson. In order to do this, a removal petition that is signed by at least 50% of the voting members of the department must be presented to the MEC (see section 1-2, B, 2, on page 15 for the voting members of the department). If a petition meets these requirements, the MEC chairperson will schedule a department meeting to discuss the issue and, if appropriate, vote on removal. The chairperson must be given an opportunity to speak before any vote is taken. At least a two-thirds (2/3) vote of ***all voting members of the department*** is needed to remove the chairperson. Voting members of the department must vote to remove a chairperson at a department meeting; *they cannot vote by proxy or ballot to remove a chairperson*.

B. Department meetings and taking action

Departments meet and take action as explained below. *See* Appendix 1 on page A-1 for an illustration of how medical staff committees, clinical departments and the medical staff meet and take action.

Table 1. How departments meet and take action

Meeting frequency	As often as needed to perform their functions, as determined by the chairperson
Meeting notice	May be given in any manner determined appropriate by the chairperson
Quorum	Whichever is greater: - At least 10% of the voting members of the department; *or* - That number of voting members of the department present at a meeting, but there must be at least 2.
Who may vote	Chairperson and active medical staff members assigned to the department. If, however, the department is made up of only affiliate medical staff members, then the chairperson and the affiliate staff members assigned to the department have the right to vote.
Voting method	May vote during a meeting with a quorum *or* by ballot, as determined by the chairperson If voting by ballot, voting members of the department must have at least 5 days to return ballots and at least 10% of ballots must be returned.
Proxy voting	Proxy voting is not allowed for department meetings
Votes needed to pass an issue	At least a majority of those votes cast (exception – at least a 2/3 vote of all voting members of the department is needed to remove the chairperson)

1. Department meeting frequency and notice

Departments meet as often as needed to perform their functions; meeting notices may be given in any manner determined appropriate by the chairperson. The department chairperson may allow, but is not required to allow, members of the department to participate in a meeting by conference call or by other similar methods that allow everyone to communicate with one another. Participating in a meeting this way constitutes personal attendance at the meeting.

2. Attendance and right to vote at department meetings

All practitioners are encouraged to attend meetings of the department to which they have been assigned, but only the chairperson and active medical staff members of the department have the right to vote. When, however, a department does not have any, or only a few, active members because the specialty is largely outpatient based, such as family practice and pediatrics, the voting members of the department are the chairperson and the affiliate medical staff members assigned to the department.

3. Taking action

Departments may take action on matters either during a department meeting when a quorum is present *or* by ballot, as determined by the chairperson. To be passed, the issue or question must receive a majority of those votes cast, except for removal of a department chairperson which requires at least a 2/3 vote of all voting members of the

department (*see* section 1-2, A, 7, on page 13 for removing a chairperson). All actions taken apply to all practitioners assigned to the department, including those who did not attend the meeting or vote.

Departments may take action either during a department meeting when a quorum is present or by ballot. Proxy voting is not allowed. A majority of votes cast is needed to pass an issue (except for removing a department chairperson which requires at least a 2/3 vote of all voting members of the department).

a. Taking action during a department meeting

Departments may take action during a meeting if there is a quorum. A quorum is ***whichever is greater***:

i. 10% of the voting members of the department; ***or***

ii. That number of voting members of the department who are present at the meeting, but there must be at least two members present.

When voting during a department meeting, once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting. Voting by proxy is ***not*** allowed during department meetings.

b. Taking action by ballot without a department meeting

Departments may take action on a matter without meeting by electronic or written ballot. The issue or question to be decided must be emailed to the voting members of the department, along with directions for returning ballots. Voting members of the department must have at least five days to return ballots, and at least 10% of ballots must be returned.

Voting members of the department must have at least 5 days to return ballots and at least 10% of ballots must be returned.

Section 1-3. Medical Staff Committees

The medical staff performs many of its functions through standing and ad hoc committees.

- Table 2 on page 18 describes how the MEC meets and takes action, and Appendix 2 on page A-2 describes the membership of the MEC.
- Table 3 on page 21 describes how the credentials committee meets and takes action.
- Table 4 on page 23 describes how all other medical staff committees meet and take action.
- Appendix 1 on page A-1 illustrates how medical staff committees, clinical departments and the medical staff meet and take action.

A. Medical executive committee

The MEC is a standing medical staff committee. The medical staff has delegated broad authority to the MEC to oversee the operations of the medical staff. The medical staff may modify this authority by following the process for amending the bylaws in section 1-5, A, on page 29.

1. Membership on the MEC

The MEC must include physician members; other practitioners also may be members as determined by the medical staff, but a majority of the MEC's membership and voting membership must be physicians. *See* Appendix 3 on page A-3 for the members of the MEC and section 1-3, A, 3, b, on page 19 for voting members of the MEC. The chief of staff serves as the chairperson of the MEC, and the vice-chief of staff serves as the vice-chairperson of the MEC.

A majority of the MEC's members, and its voting members, must be physicians (MDs/DOs).

The chief of staff serves as the chairperson of MEC, and the vice-chief serves as the vice-chairperson.

a. Terms for MEC members

MEC members serve for a period of two years or until a successor is appointed, unless they resign or are removed from the committee before the end of their term.

b. Filling vacancies on the MEC

Vacancies on the MEC are filled in the same manner in which the original appointment was made.

c. Removing MEC members

Voting MEC members may be removed by the chief of staff or the MEC chairperson when good cause is demonstrated, such as excessive absence. Non-voting MEC members may only be removed by the hospital president.

2. Duties of the MEC

The MEC acts on behalf of the medical staff between medical staff meetings, within the scope of its responsibilities as defined by the medical staff; makes recommendations directly to the Board of Trustees on medical staff membership, the structure of the medical staff, the process used to review credentials and delineate clinical privileges, the delineation of privileges for each practitioner privileged through the medical staff process; and its review of, and actions on, reports from medical staff committees, clinical departments and other assigned group activities; requests evaluations of those privileged through the medical staff process when there is doubt about the ability to perform the privileges requested; requests professional reviews and investigations and collegial action or corrective action, as needed; implements hospital policies that affect the medical staff; enforces the medical staff bylaws, rules & regulations and policies; adopts and amends medical staff rules & regulations and policies as necessary to implement the general principles in these bylaws; and assists the hospital in maintaining its accreditation status and informs the medical staff of applicable accreditation and regulatory requirements affecting the hospital.

3. MEC meetings and taking action

The MEC meets and takes action as explained below. *See* Appendix 1 on page A-1 for an illustration of how medical staff committees, clinical departments and the medical staff meet and take action.

Table 2. How the MEC meets and takes action

Meeting frequency	As often as needed to perform their functions, as determined by the chief of staff (who serves as the MEC chairperson)
Meeting notice	May be given in any manner determined appropriate by the chief of staff
Quorum	At least a majority of voting MEC members present at a meeting
Who may vote	All MEC members may vote, except the CCO, hospital president, CNO, pharmacy representative and the medical staff office manager
Voting method	May vote during a meeting with a quorum *or* by ballot, as determined by the chief of staff (but cannot vote by ballot to remove a medical staff officer or department chairperson). If voting by ballot, members must have at least 5 days to return ballots and at least a majority of ballots must be returned.
Proxy voting	Proxy voting is *not* allowed for the full MEC, but the MEC's executive committee may vote by proxy.
Votes needed to pass an issue	At least a majority of those votes cast (exception – at least a 2/3 vote of all voting MEC members is needed to remove a medical staff officer or department chairperson)

a. MEC meeting frequency and notice

The MEC meets as often as needed to perform its duties, and meeting notices may be given in any manner determined appropriate by the chairperson. The chairperson may allow, but is not required to allow, committee members to participate in a meeting by conference call or by other similar methods that allow everyone to communicate with one another. Participation in a meeting in this manner constitutes personal attendance at the meeting. The MEC makes written summaries of pertinent actions available to the medical staff after each meeting.

b. Attendance and right to vote

All MEC members should attend MEC meetings. All MEC members have the right to vote, *except* the CCO, hospital president, chief nursing officer, pharmacy representative and the medical staff office manager.

All MEC members have the right to vote, except the CCO, hospital president, chief nursing officer, pharmacy representative and the medical staff office manager.

c. Taking action

The MEC may take action either during an MEC meeting at which a quorum is present *or* by ballot, as determined by the MEC chairperson. To be passed, the issue or question must receive a majority of those votes cast, except that removal of a medical staff officer or a department chairperson requires at least a 2/3 vote of all voting members of the MEC. All actions taken apply to all practitioners.

The MEC may take action either during an MEC meeting when a quorum is present or by ballot. A majority of votes is needed to pass an issue (except for removing a medical staff officer or department chairperson).

i. Taking action during an MEC meeting

The MEC may take action during a meeting if there is a quorum. A quorum exists when at least a majority of voting MEC members is present at the meeting. For example, if there are 20 voting MEC members, at least 11 voting MEC members must be present at a meeting to have a quorum. All MEC members have the right to vote, *except* for the CCO, hospital president, chief nursing officer, pharmacy representative and the medical staff office manager. Voting by proxy is *not* allowed, but the MEC's executive committee may vote by proxy. Once there is a quorum,

A quorum for an MEC meeting is when a majority of voting MEC members are present at the meeting.

Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting. Voting by proxy is not allowed.

all actions taken are binding even though there may be less than a quorum later in the meeting.

ii. Taking action by ballot without an MEC meeting

The MEC may take action without meeting by electronic or written ballot. The issue or question to be decided must be emailed to voting MEC members, along with directions for returning ballots. Voting MEC members must have at least five days to return ballots, and a majority of ballots must be returned.

When voting by ballot, voting MEC members must have at least 5 days to return ballots and a majority of ballots must be returned.

4. Executive committee of the MEC

The MEC has an executive committee. The members of the executive committee are the chief of staff and vice-chief of staff. The CCO is a non-voting member of the MEC executive committee. The executive committee acts on matters that require attention between MEC meetings; its decisions have the full authority of the MEC and must be reported to it at its next meeting. If a particular clinical department or section is to be discussed, the chairperson for that clinical department or section may be invited to attend to the meeting. The executive committee may vote by proxy.

The members of the executive committee of the MEC are the chief of staff, the vice-chief of staff and the CCO. The CCO is a non-voting member.

B. Credentials committee

The medical staff has a standing credentials committee. The membership of the credentials committee is set out in the credentials committee's charter. The credentials committee reviews and evaluates the qualifications of applicants for initial appointment and/or clinical privileges and reappointment and/or clinical privileges. The committee may interview applicants and practitioners in order to resolve questions about appointment, reappointment or clinical privileges. The committee also monitors the initial focused professional practice evaluation and ongoing professional practice evaluation processes.

The credentials committee serves as the review and investigatory body as described in Article VI and, where appropriate, refers practitioners to programs and collaborates with these programs and the practitioners to determine appropriate privileges for each practitioner's individual circumstances.

1. Credentials committee meetings and taking action

The credentials committee meets and takes action as explained below. *See* Appendix 1 on page A-1 for how medical staff committees, clinical departments and the medical staff meet and take action.

Table 3. How the credentials committee meets and takes action

Meeting frequency	As often as needed to perform their functions, as determined by the chairperson
Meeting notice	May be given in any manner determined appropriate by the chairperson
Quorum	At least a majority of voting committee members present at a meeting
Who may vote	All voting committee members
Voting method	May vote during a meeting with a quorum *or* by ballot, as determined by the chairperson. If voting by ballot, members must have at least 5 days to return ballots and at least a majority of ballots must be returned.
Proxy voting	Proxy voting is allowed
Votes needed to pass an issue	At least a majority of those votes cast

a. Credentials committee meeting frequency and notice

The credentials committee meets as often as needed to perform its duties, and meeting notices may be given in any manner determined appropriate by the chairperson. The chairperson may allow, but is not required to allow, committee members to participate in a meeting by conference call or by other similar methods that allow everyone to communicate with one another. Participation in a meeting in this manner constitutes personal attendance at the meeting.

b. Taking action

The credentials committee may take action either during a credentials committee meeting at which a quorum is present *or* by ballot, as determined by the credentials committee chairperson. To be passed, the issue or question must receive a majority of those votes cast. All actions taken apply to all practitioners.

The credentials committee may take action either during a meeting when a quorum is present or by ballot. A majority of votes is needed to pass an issue.

i. Taking action during a credentials committee meeting

The credentials committee may take action during a meeting if there is a quorum. A quorum exists when at least a majority of voting members is present at the meeting. For example, if there are 20 voting members, at least 11 voting members must be present at a meeting to have a quorum. Voting by proxy is allowed. Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

A quorum for a credentials committee meeting is when a majority of voting members are present at the meeting.

Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting. Voting by proxy is allowed.

ii. Taking action by ballot without a credentials committee meeting

The credentials committee may take action without meeting by electronic or written ballot. The issue or question to be decided must be emailed to voting members, along with directions for returning ballots. Voting members must have at least five days to return ballots, and a majority of ballots must be returned.

When voting by ballot, voting credentials committee members must have at least 5 days to return ballots and a majority of ballots must be returned.

C. Other medical staff committees

This section applies to all medical staff committees except for the MEC and the credentials committee to the extent addressed in section 1-3, B, above. See section 1-3, A, on page 17 for information about the MEC.

Members of medical staff committees, except for the MEC, are appointed by the committee chairperson, in collaboration with the chief of staff and the CCO. The chief of staff, CCO and hospital president are non-voting members of all medical staff committees. Medical staff committees may include representatives from hospital administration, nursing and any other hospital department appropriate to the purpose of the committee.

1. Terms of medical staff committee members

Medical staff committee members serve for a period of two years or until a successor is appointed, unless they resign or are removed from the committee before the end of their term.

2. Filling vacancies on medical staff committees

Vacancies on medical staff committees are filled in the same manner in which the original appointment was made.

3. Removing medical staff committee members

Voting members of a medical staff committee may be removed by the chief of staff or the committee chairperson when good cause is demonstrated, such as excessive absence. Non-voting members of a medical staff committee may only be removed by the hospital president.

4. Medical staff committee meetings and taking action

See section 1-3, A, 3, on page 18 for how the MEC meets and takes action and section 1-3, B, 1, on page 21 for how the credentials committee meets and takes action.

Table 4. How medical staff committees meet and take action

Meeting frequency	As often as needed to perform their functions, as determined by the chairperson
Meeting notice	May be given in any manner determined appropriate by the chairperson
Quorum	That number of voting committee members who are present at a meeting, but *cannot* be less than 2 committee members.
Who may vote	Voting members (varies by committee)
Voting method	May vote during a meeting with a quorum *or* by ballot, as determined by the chairperson. If voting by ballot, members must have at least 5 days to return ballots and at least a majority of ballots must be returned.
Proxy voting	Not allowed
Votes needed to pass an issue	A majority of those votes cast

a. Medical staff committee meeting frequency and notice

Medical staff committees meet as often as needed to perform their duties, and meeting notices may be given in any manner determined appropriate by the chairperson. The chairperson may allow, but is not required to allow, committee members to participate in a meeting by conference call or by other similar methods that allow everyone to communicate with one another. Participation in a meeting in this manner constitutes personal attendance at the meeting.

b. Taking action

Medical staff committees may take action on an issue or question either during a meeting at which a quorum is present or by ballot, as determined by the chairperson. To be passed, the issue or question must receive at least a majority of those votes cast.

> *Medical staff committees may take action either during a meeting when a quorum is present or by ballot. A majority of votes is needed to pass an issue.*

i. Taking action during a medical staff committee meeting

Medical staff committees may take action during a meeting if there is a quorum. A quorum is that number of voting committee members who are present at the meeting, but it ***cannot*** be less than two committee members. Voting by proxy is ***not*** allowed. Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

A quorum for a medical staff committee meeting is that number of voting committee members who are present at a meeting, but it cannot be less than 2 committee members. Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

ii. Taking action by ballot without a medical staff committee meeting

Medical staff committees may take action without meeting by electronic or written ballot. The issue or question to be decided must be emailed to voting committee members, along with directions for returning ballots. Voting committee members must have at least five days to return ballots, and a majority of ballots must be returned.

When voting by ballot, voting committee members must have at least 5 days to return ballots and a majority of ballots must be returned.

Section 1-4. Medical Staff Meetings

Meetings of the medical staff are explained below.

- Table 5 below describes how the medical staff meets and takes action.
- Appendix 1 on page A-1 illustrates of how medical staff committees, clinical departments and the medical staff meet and take action.

Table 5. How the medical staff meets and takes action.

Meeting frequency	At least once each medical staff year. The medical staff year is from 5/1 to 4/30.
Meeting notice	By email at least 14 days before the meeting
Quorum	At least 10% of voting medical staff members (present at the meeting or represented by proxies)
Who may vote	▪ Active staff members; ▪ Current and former medical staff officers and department chairpersons; and ▪ Current medical staff members of the credentials committee, a peer review committee, a quality or clinical improvement committee, or a best practice committee
Voting method	May vote during a meeting with a quorum *or* by ballot, as determined by the chief of staff. If voting by ballot, voting medical staff members must have at least 5 days to return ballots and at least 10% of ballots must be returned.
Proxy voting	Is allowed – voting medical staff members may designate in writing another voting medical staff member to cast their proxy vote at a medical staff meeting
Votes needed to pass an issue	At least a majority of those votes cast (exception – bylaw amendments require at least 2/3 of votes cast and at least a 2/3 vote of all voting medical staff members is needed to remove a medical staff officer)

A. Medical staff meeting frequency and notice

The medical staff meets as often as needed but must have at least one meeting each medical staff year. The medical staff year is from May 1st to April 30th. The chief of staff, vice-chief of staff, the MEC or its chairperson, or the Board of Trustees or its chairperson may call a medical staff meeting.

The medical staff meets at least once a year. The date, time and place of the medical staff meeting are emailed to voting medical staff members at least 14 days before the meeting. Notices will include nominations for vice-chief of staff and department chairpersons, and proposed bylaw amendments, when applicable.

The medical staff office will notify all voting members of the medical staff of the date, time and place of the meeting by email at least 14 days before the meeting (*see*

section 1-4, B, on page 26 for who the voting members of the medical staff are). The notice must include nominations for medical staff officers and department chairpersons and summaries of any proposed bylaw amendments to be voted on, as applicable. The actual text of proposed bylaw amendments must be available at the meeting.

A member of the medical staff may request a medical staff meeting after discussing the matter with his/her clinical department chairperson and the chief of staff. If the issue is not resolved through this discussion, the member may request a medical staff meeting by submitting a petition signed by at least 50% of the voting members of the medical staff to the MEC. The MEC will meet with the petitioners to discuss the matter, and if the issue remains unresolved, the MEC chairperson will call a medical staff meeting to discuss the matter, as explained above.

B. Attendance and right to vote at medical staff meetings

All medical staff members are encouraged to attend medical staff meetings. The medical staff members who have the right to vote at a medical staff meeting are:

1. active medical staff members;
2. current and former medical staff officers and department chairpersons; and
3. current *medical staff members* of the credentials committee, a peer review committee, a quality or clinical improvement committee, or a best practice committee.

C. Taking action

Voting medical staff members may take action on a matter either during a medical staff meeting at which a quorum is present *or* by ballot, as determined by the MEC. To be passed, the matter must be approved by at least a majority of those votes cast, except for proposed bylaw amendments which must be approved by at least 2/3 of those votes cast and removal of a medical staff officer which requires a 2/3 vote of all voting medical staff members (*see* section 1-1, F, on page 8 for removal of a medical staff officer). All actions taken apply to all practitioners, including those who did not attend the meeting or vote.

The medical staff may take action either during a medical staff meeting when a quorum is present or by ballot. A majority of votes is needed to pass an issue (except for proposed bylaw amendments and removing a medical staff officer).

Voting by proxy is allowed for voting during a medical staff meeting.

1. Taking action during a medical staff meeting

Voting medical staff members may vote on matters during a meeting if a quorum is present (*see* section 1-4, B, on page 26 for the voting members of the medical staff). A quorum exists when at least 10% of the voting members of the medical staff are present

at the meeting or are represented by proxies. For example, if there are 100 voting medical staff members, at least 10 voting medical staff members must be present at a meeting or be represented by proxies to have a quorum. Voting medical staff members who cannot attend the meeting may designate, in writing, *another voting member of the medical staff* to cast their proxy vote during the meeting. Proxies *cannot* be given to a non-voting member of the medical staff. Once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

A quorum is 10% of the voting members of the medical staff (present at the meeting or represented by proxies). When voting during a medical staff meeting, once there is a quorum, all actions taken are binding even though there may be less than a quorum later in the meeting.

2. Taking action by ballot without a medical staff meeting

Voting medical staff members may vote on matters by written or electronic ballot. The medical staff office will email the matter to be decided to the voting medical staff members along with directions for returning ballots. Voting medical staff members must have at least five days to return ballots and at least 10% of ballots must be returned.

When voting by ballot, voting members of the medical staff must have at least 5 days to return ballots and at least 10% of ballots must be returned.

Section 1-5. Governing Documents

The medical staff adopts and enforces medical staff bylaws, rules & regulations and policies to carry out its functions and responsibilities. The medical staff's rules & regulations and policies cannot be inconsistent with these bylaws. The process for adopting and approving changes to the governing documents is set out below.

Table 6. How the medical staff's governing documents are adopted and approved

Bylaws	**Step 1. At least a majority of voting MEC members must vote to recommend that the medical staff adopt the bylaws**. Voting MEC members may vote: ▪ **At an MEC meeting** with a quorum (at least a majority of voting MEC members must be present); or ▪ **By ballot**. Instructions for returning ballots are emailed to MEC members (must have at least 5 days to return ballots and at least a majority of ballots must be returned). **Step 2. At least 2/3 of the votes cast by the voting members of the medical staff must vote to adopt the bylaws** (the MEC decides the method of voting). Voting medical staff members may vote: ▪ **At a medical staff meeting** with a quorum (at least 10% of voting medical staff members must be present or represented by proxies). A meeting notice and a summary of the proposed amendments are emailed to voting medical staff members at least 14 days before the meeting. The actual text of the proposed amendments must be available at the meeting; or ▪ **By ballot**. A summary of proposed amendments and instructions for returning ballots are emailed to voting medical staff members (must have at least 5 days to return ballots and at least 10% of ballots must be returned) **Step 3. Amendments are effective when approved by the Board of Trustees.**
Rules & Regulations	**Step 1. The MEC communicates proposed amendments to rules & regulations to the medical staff *before* adopting them.** **Step 2. *After* communicating the proposed amendments to rules & regulations to the medical staff, at least a majority of voting MEC members must vote to adopt them.** Voting MEC members may vote: ▪ **At an MEC meeting** with a quorum (at least a majority of voting MEC members must be present); or ▪ **By ballot**. Instructions for returning ballots are emailed to MEC members (must have at least 5 days to return ballots and at least a majority of ballots must be returned). **Step 3**. **Amendments are effective when approved by the Board of Trustees.**
Policies	**Step 1. At least a majority of voting MEC members must vote to approve proposed medical staff policies**. Voting MEC members may vote: ▪ **At an MEC meeting** with a quorum (at least a majority of voting MEC members must be present); or ▪ **By ballot**. Instructions for returning ballots are emailed to MEC members (must have at least 5 days to return ballots and at least a majority of ballots must be returned). Amendments are effective when approved by the MEC. **Step 2. Medical staff policies approved by the MEC are communicated promptly to the medical staff.**

A. Medical staff bylaws

The bylaws cannot be amended unilaterally by the medical staff or the Board of Trustees. The process for adopting and approving the medical staff's bylaws is described below.

1. Bylaw amendments proposed by the MEC

The MEC may propose bylaw amendments it has adopted to the voting members of the medical staff at any time (*see* section 1-3, A, 3, on page 18 for how the MEC meets and takes action, and section 1-4, B, on page 26 for the voting members of the medical staff). Voting medical staff members may vote on proposed amendments either at a medical staff meeting or by ballot as explained in section 1-4, C, on page 26. Amendments that are adopted by the voting members of the medical staff are then submitted to the Board of Trustees for final action. Bylaw amendments are not effective until they are approved by the Board of Trustees.

Bylaw amendments are first adopted by the MEC and then by the voting members of the medical staff.

Bylaw amendments that have been adopted by both the MEC and the voting members of the medical staff are then submitted to the Board of Trustees for final action. The amendments are <u>not</u> effective until the Board of Trustees approves them.

The MEC, on its own, may adopt and approve technical corrections to the bylaws (*e.g.,* the MEC may correct errors in punctuation, spelling, or grammar and correct inaccurate cross-references, labeling or numbering); the MEC ***<u>cannot</u>*** on its own adopt and approve substantive amendments. Technical corrections are effective immediately and will be permanent unless disapproved by the medical staff or the Board of Trustees within 60 days.

2. Bylaw amendments proposed by the medical staff

The medical staff may propose bylaw amendments to the Board of Trustees. Before it does so, however, the exact language of the proposed amendments must be included in a written petition that is signed by at least 50% of the voting members of the medical staff, and the proposed changes must be submitted to voting medical staff members and adopted by them at a medical staff meeting as explained in section 1-4, C, on page 26 (*see* section 1-4, B, on page 26 for the voting members of the medical staff). Amendments that have been adopted by the voting members of the medical staff are then submitted ***<u>simultaneously</u>*** to the Board of Trustees and to the MEC. The MEC may submit its opinion on the amendments to the Board of Trustees. Bylaw amendments are not effective until they are approved by the Board of Trustees.

Bylaw amendments proposed by the medical staff that have been adopted by the voting members of the medical staff must be submitted simultaneously to the Board of Trustees and the MEC.

B. Medical staff rules & regulations

The medical staff has delegated to the MEC the authority to adopt, amend and repeal rules & regulations as necessary to implement the general principles in these bylaws. Rules & regulations cannot be inconsistent with these bylaws.

1. Rules & regulations amendments proposed by the MEC

Except when urgent action is needed as described below, ***before*** the MEC adopts proposed amendments to the rules & regulations, it must communicate the proposed amendments to the medical staff. The MEC may take action on the proposed amendments to the rules & regulations only after they have been communicated to the medical staff (*see* section 1-3, A, 3, on page 18 for how the MEC takes action). If the amendments are adopted by the MEC, they are then submitted to the Board of Trustees for final action. Amendments to rules & regulations are not effective until they are approved by the Board of Trustees.

The MEC must communicate proposed amendments to the rules & regulations, to the medical staff before it may adopt them (unless urgent action is needed as described in section 1-5, B, 1).

After the proposed amendments have been communicated to the medical staff and adopted by the MEC, they may be submitted to the Board of Trustees for final action. The amendments are not effective until the Board of Trustees approves them.

If an *urgent amendment* to the rules & regulations is needed in order to comply with a law or regulation, the medical staff has authorized the MEC to adopt provisionally, and the Board of Trustees may approve provisionally, the amendment without prior notification to the medical staff. Immediately after the provisional adoption, the MEC will notify the medical staff and provide it an opportunity to review and comment on the provisionally adopted amendment. If there is no conflict between the medical staff and the MEC, the provisional amendment will stand. If there is a conflict, the process for resolving conflict will be used, and if necessary, a revised amendment will be submitted to the Board of Trustees for final action.

2. Rules & regulations amendments proposed by the medical staff

The medical staff may propose amendments to the rules & regulations to the Board of Trustees. To do this, the medical staff must submit a written petition to the MEC that has been signed by at least 50% of the voting members of the medical staff and includes the exact language of the proposed amendments. If the petition meets these requirements, the MEC will call a medical staff meeting to vote on the proposed amendments per section 1-4, A and C, on pages 25 and 26. Proposed amendments adopted by the voting members of the medical staff are submitted to the Board of Trustees for final action. The

MEC may submit its opinion on the amendments to the Board of Trustees. Amendments only become effective if approved by the Board of Trustees.

3. Rules & regulations amendments proposed by the Board of Trustees

The Board of Trustees may, on its own, adopt, amend or repeal rules & regulations when needed urgently to comply with the law, an accrediting body or to protect the safety or orderly operations of the hospital. The Board of Trustees will notify the MEC 30 days before it takes final action and will consider the MEC's recommendations during its deliberations and actions.

C. Medical staff policies

1. Medical staff policies proposed by the MEC

The medical staff has delegated to the MEC the authority to adopt, amend and repeal medical staff policies as necessary to implement the general principles in these bylaws (*see* section 1-3, A, 3, on page 18 for how the MEC takes action). The policy is effective once it has been approved by the MEC, and it must then be communicated promptly to the medical staff.

Medical staff policies are effective when they are approved by the MEC. The policy is then communicated to the medical staff.

2. Medical staff policies proposed by the medical staff

The medical staff may propose policies to the Board of Trustees. To do so, it must submit a written petition that has been signed by at least 50% of the voting members of the medical staff and includes the exact language of the proposed policy to the MEC. If the petition meets these requirements, the MEC will call a medical staff meeting to vote on the proposed policy per section 1-4, on page 25. Proposed policies adopted by the voting members of the medical staff are submitted to the Board of Trustees for final action. The MEC may submit its opinion on the proposed policy to the Board of Trustees. These policies only become effective if approved by the Board of Trustees.

ARTICLE II – MEMBERSHIP & CATEGORIES OF THE MEDICAL STAFF

Article II explains the principles associated with medical staff membership. It addresses which practitioners are eligible to become members of the medical staff; the basic qualification they must meet and continue to meet to remain on the medical staff; and the qualifications, rights and responsibilities associated with each medical staff category. The leave of absence process, how practitioners may resign their medical staff membership and/or clinical privileges in good standing, and the criteria that trigger automatic termination of a practitioner's membership and/or clinical privileges are also explained in this Article.

ARTICLE II – MEMBERSHIP & CATEGORIES OF THE MEDICAL STAFF
Table of Contents

ARTICLE II – MEMBERSHIP & CATEGORIES OF THE MEDICAL STAFF

Section 2-1. Basic Qualifications for Membership

Membership on the medical staff is a privilege. Only physicians, oral surgeons, podiatrists and dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws and in policies adopted by the Board of Trustees are eligible to be members of the medical staff. The basic qualifications for medical staff membership that applicants must meet are described below, and medical staff members must continuously meet these qualifications in order to maintain their membership and clinical privileges.

Only individuals from the following disciplines who meet the qualifications are eligible to be members of the medical staff:

- *physicians*
- *oral surgeons*
- *podiatrists*
- *dentists.*

Others, such as CRNAs, certified nurse midwives, NPs and PAs, may hold clinical privileges, but they are not eligible to be members of the medical staff.

Applicants may have an application *in process* for a license, professional liability insurance or DEA registration when applying for membership or clinical privileges (*see* sections 2-1, A, F and H, below), but membership or clinical privileges will not be granted until the license, insurance coverage or DEA registration has been issued.

A. Licensure

Applicants for medical staff membership must have a current, active and unrestricted license to practice medicine, oral surgery, podiatry or general dentistry in North Carolina.

B. Board eligibility and board certification

Applicants for medical staff membership must be board eligible or board certified. Board eligibility is defined as the period of time between completion of an accredited residency program or fellowship and achievement of initial certification in a specialty. Applicants whose board certification is lapsed are not considered board eligible for initial medical staff membership purposes. Board certification must be achieved within the timeframe set by the

Board certification must be achieved within the timeframe set by the specialty board or within five years of completing residency or fellowship training, whichever is earlier. When recertification is required, recertification must be obtained within two years.

specialty board or within five years of completing residency or fellowship training, *whichever is earlier*. When a medical staff member has a board certificate that contains an expiration date, recertification must be achieved no later than two years after the expiration date.

- ❖ Members who were appointed to the medical staff *before* February, 1989 are ***exempt*** from the board eligibility and board certification requirement.

1. Physicians

   MD applicants must be board certified or board eligible in their primary specialty or subspecialty by an American Board of Medical Specialties (ABMS) member board. DO applicants must be board certified or board eligible in their primary specialty or subspecialty by the American Osteopathic Association (AOA) or an ABMS member board.

   MDs must be board certified or board eligible in their primary specialty or subspecialty by an ABMS member board.

2. Oral surgeons who are not physicians

   DDS and DMD applicants who are oral surgeons but *not* physicians must be board certified or board eligible by the American Board of Oral and Maxillofacial Surgery (ABOMS).

3. Podiatrists

   DPM applicants must be board certified or board eligible by the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

C. Current competence, experience, ethics and character

Applicants for medical staff membership must provide sufficient documentation of their background, experience, training and current clinical competence; adherence to the ethics of their profession; good reputation and character, including physical health and mental and emotional stability; and their ability to work harmoniously with others to convince the medical staff that all hospital patients treated by them will receive quality care and that the medical staff and hospital will be able to operate in an orderly manner.

D. Health status and ability to perform clinical privileges

Applicants for medical staff membership must be able to perform the clinical privileges requested.

E. Geographic service area of the hospital

Applicants for medical staff membership must be located (office and residence) within the geographic service area of the hospital, as defined by the hospital, close enough to provide timely care for their patients.

- ❖ Applicants requesting membership on the **telemedicine** or **affiliate** staff categories are ***exempt*** from this requirement.

F. Professional liability insurance

Applicants for medical staff membership must have current and valid professional liability insurance coverage with limits of at least one million dollars for each claim and three million dollars in the aggregate for the clinical privileges requested from an insurance company that is licensed or approved to do business in North Carolina.

G. Federally funded healthcare programs

Applicants for medical staff membership must be eligible to participate in Medicare, Medicaid and other federally funded healthcare programs and cannot be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally funded healthcare program.

H. Controlled substance registration

Applicants for medical staff membership, where applicable to their practice, must have a current, valid and unrestricted Federal Drug Enforcement Administration (DEA) registration.

I. Membership and privileges at other healthcare facilities

Applicants for medical staff membership must not have had medical staff membership or clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities.

Section 2-2. Categories of the Medical Staff

The categories of the medical staff are: ***active, courtesy, consulting, telemedicine*** and ***affiliate***.

- Table 7 below summarizes the qualifications for each medical staff category.
- Appendix 4 on page A-4 summarizes the categories of the medical staff and their respective rights and responsibilities.

The Board of Trustees, based on the MEC's recommendation, assigns each medical staff member to a medical staff category at initial appointment and at reappointment. The rights associated with any category may be limited by special conditions attached to a member's membership or clinical privileges by these bylaws, the medical staff's rules & regulations or policies or by hospital policy.

A patient encounter is:

- *admitting or attending a patient,*
- *consulting on an inpatient, or*
- *performing an inpatient or an outpatient procedure (including procedures in the emergency department).*

Patients seen in the emergency department who are not admitted are not counted as a patient encounter.

The qualifications for the ***active***, ***courtesy*** and ***consulting*** staff categories include ***patient encounter volumes***. A patient encounter is defined as admitting or attending a patient, consulting on an inpatient, or performing an inpatient or outpatient procedure. Emergency department patients who are seen, but not admitted, are *not* counted. Patient encounters are monitored periodically, and members are reassigned to an appropriate category as needed (*see* section 2-2, F, on page 43 for how requests to transfer to another medical staff category are handled).

Assignments and reassignments to a medical staff category are final and do not entitle a member to exercise the hearing and appeal provisions of these bylaws.

Table 7. Summary of qualifications for medical staff categories

Active	- Per request or when have ≥25 patient encounters/ year - May admit, attend and discharge patients per the delineation of privileges form
Courtesy	- ≤24 patient encounters/ year - May admit, attend and discharge patients per the delineation of privileges form
Consulting	- ≤24 patient encounters/ year - Cannot admit, attend or discharge patients
Telemedicine	- Provides telemedicine services - Cannot attend, admit or discharge patients
Affiliate	- May only order outpatient services and/or treat outpatients in hospital-based physician practices - Cannot admit, attend or discharge inpatients
Locum Tenens	- When providing locum tenens services to a current member of the medical staff - May admit, attend and discharge patients per the delineation of privileges form

A. Active staff

Members are assigned to the active staff per their request *or* when they have 25 or more (≥25) patient encounters per year and will admit, attend and discharge patients as allowed by their delineated clinical privileges. The prerogatives and responsibilities of the active staff are listed below.

Members are assigned to the active staff per their request or when they have ≥25 patient encounters per year. Active staff may admit, attend and discharge patients per their DOP.

Active staff:

1. May admit, attend and discharge patients as allowed by their delineated clinical privileges and may otherwise exercise the clinical privileges granted by the Board of Trustees
   - *Exception*: Podiatrists and dentists are not eligible to admit, attend or discharge patients;
2. Have the right to attend and vote at meetings of the medical staff;
3. Are eligible to serve as a medical staff officer, if the member meets the qualifications for the office and is nominated and elected as provided in these bylaws;
4. Have the right to attend and vote at meetings of the clinical department or specialty section to which they have been assigned;

5. Are eligible to serve as the chairperson of a clinical department, if the member meets the qualifications for the position and is nominated and elected as provided in these bylaws;
6. May serve and vote on those medical staff committees to which they have been appointed; and
7. Are required to take call for unassigned patients and have the right to request to be exempt from unassigned patient call per the medical staff's rules & regulations.

B. Courtesy staff

Members are assigned to the courtesy staff when they have 24 or less (≤24) patient encounters per year and will admit, attend and discharge patients as allowed by their delineated clinical privileges. The prerogatives and responsibilities of the courtesy staff are listed below.

Members are assigned to the courtesy staff when they have ≤24 patient encounters per year. Courtesy staff may admit, attend and discharge patients per their DOP.

Courtesy staff:

1. May admit, attend and discharge patients as allowed by their delineated clinical privileges and otherwise exercise the clinical privileges granted by the Board of Trustees
   - *Exception*: Podiatrists and dentists are not eligible to admit, attend or discharge patients;
2. May attend meetings of the medical staff, but they do not have the right to vote unless they are a former medical staff officer or department chairperson, or are a current member of the credentials committee, a peer review committee, a quality or clinical improvement committee or a best practice committee;
3. May attend meetings of the clinical department or specialty section to which they have been assigned, but courtesy staff do not have the right to vote (but see the exception in subsection 4 below);
4. Are not eligible to serve as the chairperson of a clinical department or specialty section but may serve if the Board of Trustees determines it is in the best interest of patients. While serving as a chairperson, the courtesy staff member has the right to vote at meetings of that clinical department or specialty section;
5. May serve and vote on those medical staff committees to which they have been appointed; and
6. May request to be included on the call list for unassigned patients, but courtesy staff are not required to take call for unassigned patients unless mandated by their clinical department or specialty section chairperson. Courtesy staff required to take call for

unassigned patients have the right to request to be exempt from unassigned patient call per the medical staff's rules & regulations.

C. Consulting staff

Members are assigned to the consulting staff when they have 24 or less (≤24) patient encounters per year, provide consultations for patients at the request of other practitioners, and will not admit, attend or discharge patients. The prerogatives and responsibilities of the consulting staff are listed below.

Members are assigned to the consulting staff when they have ≤24 patient encounters per year. Consulting staff may not admit, attend or discharge patients.

Consulting staff:

1. May exercise the clinical privileges granted by the Board of Trustees, but consulting staff may *not* admit, attend or discharge patients;
2. May attend meetings of the medical staff, but they do not have the right to vote unless they are a former medical staff officer or department chairperson, or are a current member of the credentials committee, a peer review committee, a quality or clinical improvement committee or a best practice committee;
3. May attend meetings of the clinical department or specialty section to which they have been assigned, but consulting staff do not have the right to vote (but see the exception in subsection 4 below);
4. Are not eligible to serve as the chairperson of a clinical department or specialty section but may serve if the Board of Trustees determines it is in the best interest of patients. While serving as a chairperson, the consulting staff member has the right to vote at meetings of that clinical department or specialty section;
5. May serve and vote on those medical staff committees to which they have been appointed; and
6. May request to be included on the call list unassigned patients, but consulting staff are not required to take call for unassigned patients unless mandated by their clinical department or specialty section chairperson. Consulting staff required to take call for unassigned patients have the right to request to be exempt from unassigned patient call per the medical staff's rules & regulations.

D. Telemedicine staff

Members are assigned to the telemedicine staff when they will provide telemedicine services for patients. Telemedicine staff members do not have to meet the geographic location requirements described in section 2-1, E, on page 36. The prerogatives and responsibilities of the telemedicine staff are set out below.

Members are assigned to the telemedicine staff when they will provide telemedicine services for patients. Telemedicine staff are exempt from the geographic service location requirement and may not admit, attend or discharge patients.

Telemedicine staff:

1. May exercise the clinical privileges granted by the Board of Trustees;
2. Are exempt from the geographic location requirement described in section 2-1, E, on page 36;
3. May attend meetings of the medical staff, but they do not have the right to vote unless they are a former medical staff officer or department chairperson, or are a current member of the credentials committee, a peer review committee, a quality or clinical improvement committee or a best practice committee;
4. May attend meetings of the clinical department or specialty section to which they have been assigned, but telemedicine staff do not have the right to vote; and
5. May serve and vote on those medical staff committees to which they have been appointed.

E. Affiliate staff

Members are assigned to the affiliate staff when the only clinical privileges they need are ordering outpatient services and/or treating outpatients in the hospital's hospital-based physician practices. Affiliate staff members cannot admit, attend or discharge inpatients. Affiliate staff members do not have to meet the geographic location requirement described in section 2-1, E, on page 36. The prerogatives and responsibilities of the affiliate staff are listed below.

Members of the affiliate staff may only order outpatient services and/or treat outpatients in the hospital's hospital-based physician practices. Affiliate staff are exempt from the geographic service location requirement and may not admit, attend or discharge inpatients.

Affiliate staff:

1. May exercise the clinical privileges granted by the Board of Trustees, which are limited to ordering outpatient services and/or treating outpatients in the hospital's hospital-based physician practices. Affiliate staff members cannot admit, attend or discharge inpatients;

2. Are exempt from the geographic location requirement described in section 2-1, E, on page 36;
3. May attend meetings of the medical staff, but they do not have the right to vote unless they are a former medical staff officer or department chairperson, or are a current member of the credentials committee, a peer review committee, a quality or clinical improvement committee or a best practice committee;
4. May attend meetings of the clinical department or specialty section to which they have been assigned, but affiliate staff do not have the right to vote unless the department does not have active staff members assigned to it as described in section 1-2, B, 2, on page 15 (*see also* the exception in subsection 5 below);
5. Are not eligible to serve as the chairperson of a clinical department or specialty section, but may serve if the Board of Trustees determines it is in the best interest of patients. While serving as a chairperson, the affiliate staff member has the right to vote at meetings of that clinical department or specialty section; and
6. May serve and vote on those medical staff committees to which they have been appointed.

F. Locum Tenens staff

Members are assigned to the locum tenens staff when they have been engaged to provide locum tenens services for a current member of the medical staff and will admit, attend and discharge patients as allowed by their delineated clinical privileges. The prerogatives and responsibilities of the locum tenens staff are listed below.

Locum tenens staff:

1. May admit, attend and discharge patients as allowed by their delineated clinical privileges and may otherwise exercise the clinical privileges granted by the Board of Trustees
2. May not attend meetings of the medical staff and do not have the right to vote;
3. May attend meetings of the clinical department or specialty section to which they have been assigned, but locum tenens staff do not have the right to vote;
4. Are not eligible to serve as the chairperson of a clinical department or specialty section;
5. May not serve or vote on medical staff committees; and
6. May request to be included on the call list for unassigned patients, but are not required to take call for unassigned patients unless mandated by their clinical department or specialty section chairperson.

G. Requests to transfer to another medical staff category

Requests to transfer to another medical staff category must be emailed to the CCO (*see* section 2-2, on page 38 for the categories of the medical staff). The credentials committee and the MEC consider the request and make a recommendation on the request to the Board of Trustees, which takes final action.

If the request is to transfer from a medical staff category where members are required to take unassigned patient call, the member is still responsible for the next *90 days* of unassigned patient call, regardless of whether the call schedule has been published or not. The member may make arrangements with another member in the same specialty to take his/her call. The member's patient encounters will be monitored for 60 days to ensure that clinical activity levels are appropriate for the new staff category (*see* section 2-2, on page 38 for the definition of a patient encounter). Patient encounters resulting from covering unassigned patient call during the monitoring period will ***not*** be counted. The member will be reassigned to a more appropriate medical staff category, as needed.

Unassigned patient call is the call schedule of patients who do not have a physician on the medical staff with appropriate clinical privileges to manage the patient's condition.

Members required to take unassigned patient call who request a transfer to another staff category are still responsible for the next 90 days of call, even if the call schedule has not been published or distributed.

Decisions on requests for transfers are final and do not entitle a member to exercise the hearing and appeals provisions of these bylaws.

Section 2-3. Rights of the Medical Staff

The rights of the medical staff are listed below. *See* section 3-1, D, on page 61 for the rights of advanced practice practitioners (APPs). Members of the medical staff have the right to:

A. The credentialing and hearing and appeal procedures described in Article IV, V and VI of these bylaws;

B. Propose bylaw amendments directly to the Board of Trustees and to propose rules & regulations and policy amendments, as described in section 1-5 on page 28;

C. Call a medical staff meeting, as described in section 1-4, on page 25;

D. Nominate candidates for medical staff office, as described in section 1-1, C, 2, a, ii, on page 6;

E. Initiate a recall election of a medical staff officer or a department chairperson, as described respectively in section 1-1, F, on page 8 and section 1-2, A, 7, b, ii, on page 14;

F. Meet with his/her department chairperson. If the issue is not resolved by working with the department chairperson, the member has the right to an audience with the chief of staff and/or the credentials committee chairperson. If the issue is not resolved through that meeting, the member may, upon presentation of a written notice, meet with the MEC to discuss the issue;

G. Challenge any rule & regulation or policy the MEC has established by submitting a petition signed by at least 50% of the voting members of the medical staff to the MEC (*see* section 1-4, B, on page 26 for who the voting members of the medical staff are). When the MEC receives such a petition, it will provide the petitioners with information clarifying the intent of the rule & regulation or policy and/or schedule a meeting with the petitioners to discuss the issue; and

H. Request a department meeting when a majority of the medical staff members assigned to the department believe a meeting is needed.

Section 2-4. Basic Obligations of Practitioners

When an applicant applies for membership and/or clinical privileges, and for as long as a practitioner is a medical staff member and/or holds clinical privileges, the applicant or practitioner automatically agrees to fulfill the following obligations:

A. Treat all patients, visitors and members of the healthcare team with respect, courtesy, and dignity;

B. Provide continuous care and supervision to his/her patients, seek consultation whenever necessary and per the medical staff's rules & regulations on consultations, and only delegate to those practitioners qualified to care for patients;

C. Abide by these bylaws, rules & regulations, and the policies and procedures of the medical staff and hospital, as well as the generally recognized ethics of his/her profession;

D. Successfully complete:

   1. patient safety education materials approved by the MEC;
   2. orientation; and
   3. any electronic health record training and associated competency validation, and use the electronic health record for all patient care documentation and order entry;

E. Satisfy all medical record documentation requirements and unassigned patient call responsibilities;

F. Appear for any requested interview about an application, clinical performance or professional behavior and permit the medical staff and hospital to obtain evaluations about clinical performance or behavior by a consultant;

G. Participate in on-going professional practice evaluations (OPPE), focused professional practice evaluations (FPPE) and peer review, as well as clinical improvement , risk management, case/resource management and other improvement activities as requested;

H. Cooperate with the hospital in matters involving accreditation, licensure surveys and the hospital's fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payers;

I. Participate in an organized health care arrangement (OCHA) with the hospital and follow Novant Health's Joint Notice of Privacy Practices and HIPAA policies while practicing in a Novant Health facility; and

J. Notify the medical staff office immediately in writing if he/she:

   1. is the subject of a complaint to, or under investigation by, his/her licensing board and of any actual or proposed disciplinary actions;

2. is charged with any felony or misdemeanor, including DWI (but excluding minor traffic citations such as parking or speeding tickets);
3. has a significant medical condition that could adversely affect his/her ability to care for patients safely and competently;
4. is notified by his/her professional liability insurance carrier that it intends to cancel, not renew or impose any conditions on professional liability insurance coverage;
5. loses DEA registration;
6. is under investigation by Medicare or Medicaid or is excluded, voluntarily or involuntarily, from participating in Medicare, Medicaid or any other federally funded healthcare program;
7. is under investigation by another hospital or health care facility; or
8. is referred to, contacts or enters into a contract or agreement with any individual, group, program or impaired physician committee because of substance abuse or other disease.

Section 2-5. Responsibilities of the Medical Staff

The medical staff performs the following responsibilities through its officers, medical staff committees, clinical departments and sections:

A. Establish a framework for self-governance of the medical staff, and develop, follow and enforce medical staff bylaws, rules & regulations and policies;

B. Provide a means for communication and conflict management between the medical staff, hospital and Board of Trustees;

C. Maintain medical staff compliance with accreditation standards and applicable federal and state law;

D. Establish professional criteria and a process for appointment and reappointment to the medical staff and for granting delineated clinical privileges;

E. Evaluate and make recommendations to the Board of Trustees regarding the qualifications of an individual for appointment, reappointment and/or clinical privileges;

F. Provide patients with quality of care that meets acceptable standards and available community resources;

G. Initiate and pursue collegial and remedial action when needed and establish a mechanism for fair hearing and appellate review;

H. Collaborate with the hospital in providing uniform patient care processes throughout the hospital and coordinate care with nursing and other patient care departments;

I. Be accountable to the Board of Trustees for the quality and efficiency of patient care provided by those authorized to practice in the hospital and provide the Board of Trustees with regular reports and recommendations on quality improvement and outcome management processes;

J. Provide oversight for managing patient specific information, including but not limited to, review for completeness, timeliness and clinical pertinence of patient medical data and related records;

K. Establish an organizational structure and mechanisms that allow on-going monitoring, evaluation and improvement in patient care practices;

L. Provide leadership and participate in First Do No Harm and other hospital initiatives to measure and improve performance such as quality assessment, performance improvement, risk management, case management, utilization review and resource management;

M. Be actively involved in the measurement, assessment and improvement of medical assessment and treatment of patients; medication usage, the formulary and adverse drug reactions; blood and blood components; surgical and invasive procedures; clinical practice patterns; autopsies and hospital-acquired infections; and

N. Provide continuing education fashioned at least in part on the needs demonstrated through the quality improvement process, new state-of-the-art developments and other perceived needs, to assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill.

Section 2-6. Leaves of Absence

The term "leave of absence" or "LOA" automatically includes "administrative leave" or "ALOA," which is a category of LOA, unless the context clearly requires otherwise.

Practitioners must request an LOA, or will be placed on LOA, if they:

- are away from patient care responsibilities for more than 60 days (> 60);
- develop a physical or mental health condition (*e.g.,* seizure, MI, TIA/stroke, addiction or substance abuse) that may affect their ability to care for patients safely and competently; or
- otherwise meet one of the LOA criteria described in section 2-6, B, below.

LOAs are matters of courtesy, not of right. Determinations that a practitioner has not demonstrated good cause for an LOA or not to grant an extension are final and do not entitle the practitioner to exercise the hearing and appeals provisions of these bylaws.

A. Requesting an LOA

Requests for an LOA must be submitted in writing to the medical staff office and include the reason for the requested LOA and the proposed duration of LOA. LOA requests may ***not*** be for more than one year. The credentials committee forwards its recommendation on the LOA request to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges and are excused from membership responsibilities (*e.g.,* committee service, etc) during LOA, but practitioners whose reappointment or renewal of clinical privileges period occurs during a LOA *must* complete the reappointment and clinical privileges renewal requirements if they wish to remain on the medical staff and/or hold clinical privileges.

Practitioners cannot exercise clinical privileges while on LOA.

If a practitioner's reappointment or renewal of clinical privileges occurs while on LOA, he/she must complete that process, even though he/she is on LOA.

B. LOA categories

The LOA categories are described below.

1. Administrative LOA

Practitioners placed on ALOA for failure to comply with the medical staff's policy on influenza vaccinations may remain on ALOA for more than 90 days and will be removed from ALOA per that policy.

Practitioners are placed automatically on ALOA for ***up to 90 days*** when they do not meet an administrative requirement of membership or holding clinical privileges (*e.g.,* loss of back-up provider for a solo practitioner). ***The ALOA period cannot be renewed or extended.*** ALOAs automatically end when the practitioner resolves the technical issue or

at the end of the 90 day period, *whichever occurs first*. If the practitioner has not resolved the administrative issue by the end of the 90 days, he/she must request to move to another LOA category or he/she will be deemed to have automatically and voluntarily relinquished membership and/or clinical privileges and is not entitled to exercise the hearing and appeal provisions of these bylaws. A request for membership or clinical privileges subsequently received from the practitioner is processed as an initial application.

Unlike other LOA categories and except as specified in the medical staff's policy on influenza vaccinations, ALOAs are limited to 90 days; ALOAs cannot be renewed or extended.

Practitioners who have not resolved the issue resulting in the ALOA by the end of the 90 days must request to move to another LOA category or will be deemed to have automatically voluntarily relinquished membership and/or clinical privileges. They may reapply but must do so as a new applicant.

Category 2 APPs are placed on ALOA for up to 90 days when their primary supervising physician goes on LOA or ALOA, they lose their primary supervising physician; or their primary supervising physician resigns medical staff membership or clinical privileges or has his/ her medical staff membership or clinical privileges terminated. If the Category 2 APP has not secured a new primary supervising physician who is a current member of the medical staff by the end of the 90 day period, he/she must request to move to another LOA category or will be deemed to have automatically and voluntarily relinquished clinical privileges and is not entitled to the hearing and appeals provisions of these bylaws.

2. Military LOA

A practitioner may request, and be granted, an LOA to fulfill military service obligations. In addition to the written request for leave explained above in section 2-6, A, above, a military reservist must submit a copy of his/her deployment orders. If the practitioner is on active military duty for more than one year, the LOA will be extended *automatically* until the practitioner's active duty is completed.

3. Personal or professional LOA

A practitioner may request an LOA for a variety of personal and professional reasons (*e.g.,* for medical reasons, to pursue additional education, or to serve as a volunteer with Doctors without Borders, etc.). If a practitioner is not able to request LOA because of a physical or psychological condition or health issue, the chief of staff, in consultation with the CCO, may place the practitioner on LOA and inform the practitioner of this action.

C. Reappointment during LOA

If a practitioner's reappointment or renewal of clinical privileges period occurs during an ALOA or LOA, he/she still must complete the reappointment and/or renewal of clinical privileges application and otherwise comply with all the requirements in these bylaws.

D. Requests for reinstatement

This subsection does not apply to ALOAs; ALOAs automatically end when the practitioner resolves the technical issue or at the end of the 90 day period, whichever occurs first (except for practitioners who are placed on ALOA for failure to comply with the medical staff's policy on influenza vaccinations; those practitioners may remain on ALOA for more than 90 days and will be removed from ALOA per that policy).

Requests for reinstatement must be submitted in writing to the medical staff office before the end of the LOA and include a summary of the practitioner's relevant clinical activities, if any, during the LOA. The practitioner must provide any other information requested by the hospital. If the reason for the LOA was related to the practitioner's physical or mental health (including impairment due to addiction) or the ability to care for patients safely and competently, the practitioner must submit an appropriate report from his/her healthcare provider indicating that he/she is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

The department chairperson forwards his/her reinstatement recommendation to the credentials committee, which forwards its recommendation to the MEC and the Board of Trustees for final action. Reinstatement may be to the same, or different, medical staff category and clinical privileges may be limited, modified or be subject to monitoring or proctoring conditions.

E. Requests for an extension

This subsection does not apply to those on military LOA or ALOA.

Except for military leave and ALOA, requests for an LOA extension must be submitted in writing to the medical staff office and include the reason for, and the dates of, the requested extension. Extension requests may not be for more than one year. The credentials committee forwards it recommendation on the LOA extension to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges during the extension and must complete the reappointment and clinical privileges renewal requirements if they wish to remain on the medical staff and/or hold clinical privileges.

F. Failure to request an extension or reinstatement

Practitioners who, without good cause, do not request an extension or reinstatement are deemed to have automatically and voluntary relinquished their membership and/or clinical privileges and do not have the right to the hearing and appeal provisions in these bylaws. A request for membership or clinical privileges subsequently received from the practitioner is processed as an initial application.

Section 2-7. Exclusive Contracts

The hospital may enter into a contract with a practitioner or a group of practitioners for clinical or administrative services. To the extent a contract confers the exclusive right to perform clinical services at the hospital on a practitioner or a group of practitioners, no other practitioners may apply for, hold or exercise clinical privileges to perform those specified clinical services while the contract is in effect, other than as defined by the terms of the contract or the Board of Trustees, and the terms of the contract take precedence over these bylaws.

Section 2-8. Resigning Membership & Clinical Privileges

In order to resign membership and/or clinical privileges ***in good standing***, a practitioner must:

1. submit a written or emailed letter of resignation to the medical staff office;
2. complete all clinical, billing and record-keeping responsibilities;
3. allow for the orderly transfer of his/her clinical responsibilities, including satisfying any unassigned patient call responsibilities;
4. not be under an investigation as described in Article VI or have a significant case under peer review; and
5. not have refused to participate in collegial efforts recommended by the credentials committee.

Practitioners who do not meet these criteria and resign their membership or clinical privileges are deemed to have resigned ***not in good standing***. The credentials committee and the MEC will forward their recommendations on the practitioner's resignation status to the Board of Trustees for final approval.

Section 2-9. Automatic Relinquishment

A practitioner's membership and/or clinical privileges are automatically and voluntarily relinquished if the practitioner:

1. loses his/her license to practice;
2. is excluded or terminated from participating in Medicare, Medicaid or any other federally funded healthcare program;
3. is on LOA and does not request an extension or reinstatement by the end of the LOA period (*see* section 2-6, D and E, on page 52 for requesting an LOA extension and reinstatement);
4. is on ALOA and has not resolved the issue or requested a transfer to another LOA category at the end of the 90 day ALOA period (*see* section 2-6, B, 1, on page 50);
5. fails to complete the reappointment and/or renewal of clinical privileges process per section 4-3 on page 74; or
6. does not undergo a physical or mental examination within a reasonable time as requested by an investigating committee or the credentials committee and make the examination results available to the committee (*see* section 4-2, B, on page 71 and section 5-2, C, 2, on page 88).

The practitioner will be notified in writing that his/her membership and/or clinical privileges have been deemed automatically relinquished, and the practitioner's resignation status (*in good standing* or *not in good standing*) will be considered as explained in section 2-8 on page 55. Practitioners whose membership and/or clinical privileges are automatically and voluntarily relinquished under this section are not entitled to exercise the hearing and appeals procedures in these bylaws.

ARTICLE III – ADVANCED PRACTICE PROVIDERS & HOUSE STAFF

Article III addresses APPs and house staff. APPs and house staff are not members of the medical staff. APPs have clinical privileges and are privileged through the medical staff privileging process. House staff are not granted clinical privileges though the medical staff privileging process; they are supervised, monitored and evaluated through their residency programs.

ARTICLE III –ADVANCED PRACTICE PROVIDERS & HOUSE STAFF

Table of Contents

ARTICLE III – ADVANCED PRACTICE PROVIDERS & HOUSE STAFF

Section 3-1. Advanced Practice Providers

There are two categories of APPs:

- ***Category 1 APPs*** have *independent scopes of practice* and include psychologists (PsychD or PhD only), chiropractors and optometrists; and
- ***Category 2 APPs*** perform delegated medical acts *under the supervision of a physician* and include CNMs, CRNAs, CPPs, NPs, and PAs.

APPs may hold and exercise clinical privileges, but they are *not* members of the medical staff. The basic qualifications APPs must meet are set out below, and APPs must continuously meet these qualifications in order to maintain their clinical privileges. APP applicants may have an application *in process* for a license, professional liability insurance or DEA registration when applying for clinical privileges (*see* sections 3-1, A, 1, 6 and 8, below), but clinical privileges will not be granted until the license, insurance coverage or DEA registration has been issued.

APPs may hold clinical privileges, but they are not members of the medical staff.

A. Basic qualifications for APPs

1. Licensure

a. *Category 1 APP applicants* for clinical privileges must have a current, active and unrestricted license to practice psychology (PsychD or PhD only), chiropractic or optometry in North Carolina.

b. *Category 2 APP applicants* for clinical privileges must have a current, active and unrestricted license/ registration to practice as a CNM, CRNA, CPP, NP, or PA in North Carolina.

2. Certifications

APP applicants for clinical privileges must be certified by the appropriate board, and meet any recertification requirements, as follows:

a. ***Certified nurse midwives*** must be certified by the American Midwifery Certification Board;

b. ***Certified registered nurse anesthetists*** must be certified by the National Board of Certification and Recertification for Nurse Anesthetists;

c. ***Chiropractors*** must be certified by the National Board of Chiropractic Examination;

d. ***Nurse practitioners*** must be certified by the American Nurses' Credentialing Center, American Academy of Nurse Practitioners, American Association of Critical Care Nurses, National Certification Corporation or the Pediatric Nursing Certification Board;

e. ***Optometrists*** must be certified by the National Board of Examiners in Optometry; and

f. ***Physician assistants*** must be certified by the National Commission on Certification of Physician Assistants.

3. Current competence, experience, ethics and character

APP applicants for clinical privileges must provide sufficient documentation of their background, experience, training and current clinical competence; adherence to the ethics of their profession; good reputation and character, including physical health and mental and emotional stability; and their ability to work harmoniously with others to convince the hospital that all hospital patients treated by them will receive quality care and that the hospital and medical staff will be able to operate in an orderly manner.

4. Health status and ability to perform privileges

APP applicants for clinical privileges must be able to perform the clinical privileges requested.

5. Geographic service area of the hospital

APP applicants for clinical privileges must be located (office and residence) within the geographic service area of the hospital, as defined by the hospital, close enough to provide timely care for their patients.

6. Professional liability insurance

APP applicants for clinical privileges must have current and valid professional liability insurance coverage with limits of at least one million dollars for each claim and three million dollars in the aggregate for the clinical privileges requested from an insurance company that is licensed or approved to do business in North Carolina.

7. Federally funded healthcare programs

APP applicants for clinical privileges must be eligible to participate in Medicare, Medicaid and other federally funded healthcare programs and cannot be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally funded healthcare program.

8. Controlled substance registration

APP applicants for clinical privileges, where applicable to their practice, must have a current, valid and unrestricted DEA registration.

9. Clinical privileges at other healthcare facilities

   APP applicants for clinical privileges must not have had clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities.

10. Primary supervising physician for APP 2

    Category 2 APP applicants for clinical privileges must have a primary supervising physician who is a current member of the medical staff in good standing and must submit a copy of their current collaborative practice agreement that has been signed by the primary supervising physician and any back-up supervising physicians to the CVO.

B. Applications for clinical privileges

Applications for clinical privileges are addressed in section 4-4 on page 76. The primary supervising physician for a Category 2 APP applicant must sign the APP's application for clinical privileges. Applications for initial clinical privileges are processed per the procedures in section 4-2 on page 71.

C. Renewal of clinical privileges

APPs must apply to renew their clinical privileges at least every two years. The primary supervising physician for a Category 2 APP applicant must sign the application for renewal of clinical privileges. Applications for renewal of clinical privileges are processed per section 4-3 on page 74.

D. Rights of APPs

APPs have the right to:

1. The credentialing, hearing and appeal procedures described in Articles IV, V and VI of these bylaws;
2. Attend medical staff meetings, but APPs do ***not*** have the right to vote;
3. Attend meetings of the clinical department or section to which they have been assigned, but APPs do ***not*** have the right to vote;
4. Serve and vote on those medical staff committees to which they have been assigned; and
5. Meet with his/her department chairperson. If the issue is not resolved by working with the department chairperson, the APP then has the right to meet with the chief of staff or the credentials committee chairperson.

E. Conditions of practice for APPs

The following conditions of practice are applicable to APPs:

1. APPs may *only* act within the delineated clinical privileges specifically granted to them by the Board of Trustees.
2. APPs must satisfy the basic obligations set out in section 2-4 on page 46**.**
3. A Category 2 APP:
   a. may not be granted clinical privileges that are broader than the privileges granted to their primary supervising physician and cannot practice outside the scope of these clinical privileges;
   b. must submit to the central verification office (CVO) a current copy of their collaborative practice agreement that has been signed by their primary supervising physician and any back-up supervising physicians;
   c. must report any changes in primary supervising physician sponsorship to the medical staff office within 24 hours;
   d. automatically is placed on ALOA for a period of up to 90 days per section 2-6, B, 1, on page 50 if:
      i. his/her primary supervising physician goes on LOA;
      ii. he/she loses their primary supervising physician; or
      iii. his/her primary supervising physician resigns membership or clinical privileges or has clinical privileges or membership terminated.
   e. automatically has his/her clinical privileges reduced or decreased and voluntarily relinquished to the same extent as any reduction or decrease in his/her primary supervising physician's clinical privileges and cannot exercise the hearing and appeal rights in these bylaws.

Section 3-2. House Staff

House staff are residents who are training either in a Novant Health sponsored graduate medical education program or another program. They are *not* members of the medical staff and are *not* granted delineated clinical privileges through the processes in these bylaws. House staff may, however, practice within the hospital under the supervision of their program directors and faculty consistent with the supervision requirements of the Accreditation Council for Graduate Medical Education (ACGME). Their clinical performance is monitored and evaluated by their program directors.

House staff do not hold clinical privileges and are not members of the medical staff. They practice under the supervision of their residency program directors.

ARTICLE IV – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Article IV describes the process for appointment and reappointment to the medical staff and how practitioners are granted clinical privileges.

ARTICLE IV – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Table of Contents

ARTICLE IV – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Being granted membership on the medical staff means the same thing as being appointed or reappointed to the medical staff. Individuals who are granted membership on the medical staff are not automatically granted clinical privileges, and individuals who are granted clinical privileges are not automatically granted membership on the medical staff. Some individuals, such as CRNAs, CNMs, CPPs, NPs, and PAs hold and exercise clinical privileges but are *not* members of the medical staff.

Individuals will not be denied membership or clinical privileges on the basis of race, creed, religion, gender, national origin, veteran's status or any other status protected by law. Individuals also are not entitled to receive an application, to be appointed or reappointed to the medical staff or to be granted any particular clinical privileges because he/she is licensed to practice in this, or any other, commonwealth or state; is a member of any particular professional organization; has had, or currently has, medical staff appointment or privileges at any hospital or health care facility; resides in the geographic service area of the hospital; or is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO or other entity.

Section 4-1. Applications for Membership & Clinical Privileges

A. Eligibility for an application for membership and clinical privileges

In order to be eligible to receive an application for membership and/or clinical privileges, a prospective applicant must meet the criteria set out below; applications will not be provided, accepted or processed from anyone who does not meet the criteria. Prospective applicants are not entitled to the hearing and appeal provisions in these bylaws because of a refusal to provide, accept or process an application for membership and/or privileges for failure to meet the criteria.

Prospective applicants who have applications *in process* for a license, professional liability insurance or a DEA registration (*see* sections 4-1, A, 1, 3 and 5 below) may receive an application for membership and/or clinical privileges if they otherwise meet the criteria listed below, but membership and/or clinical privileges will not be granted until the license, insurance coverage and/or DEA registration has been issued.

Prospective applicants for membership and/or clinical privileges must:

1. have a current and unrestricted license to practice in North Carolina (or an application for a license in process) in a discipline eligible for membership per section 2-1, A, on page 35 or clinical privileges per section 3-1, A, on page 59;
2. be board eligible or board certified per section 2-1, B, on page 35 if the prospective applicant wishes to apply for membership on the medical staff;
3. be certified per section 3-1, A, 2, on page 59 if the prospective applicant wishes to apply for clinical privileges as a category 1 or category 2 APP;
4. have current and valid professional liability insurance coverage (or an application for coverage in process) with limits of at least one million dollars for each claim and three million dollars in the aggregate from an insurance company that is licensed or approved to do business in North Carolina;
5. be eligible to participate in Medicare, Medicaid and other federally funded healthcare programs and not be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally funded healthcare program;
6. have a current, valid and unrestricted DEA registration (or an application for a DEA registration in process), where applicable to their practice;
7. have not had clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities; and
8. have a primary supervising physician who is currently on staff in good standing or is simultaneously applying for membership and clinical privileges if the prospective applicant is applying for clinical privileges as a category 2 APP.

B. Application form and content

Applications for membership and/or clinical privileges must be signed by the applicant and be submitted to the central verification office (CVO) on approved forms. Applications must include a request for the specific clinical privileges sought and require detailed information about the applicant's professional qualifications, which will include, but not be limited to:

1. ***Peer references*** from practitioners who can provide adequate information about the applicant's current professional competence and character.
   a. at least one peer reference must be in the same specialty area as the applicant, and
   b. peer references cannot be from anyone who is:
      - personally related to the applicant or
      - professionally associated with the applicant (or is about to be professionally associated with the applicant.
2. Information about the applicant's:

a. medical staff ***membership and/or clinical privileges at other hospitals or health care facilities***, including any denial, voluntary or involuntary relinquishment, termination, suspension, limitation or reduction of medical staff membership or clinical privileges and whether the applicant has ever withdrawn an application for membership or privileges or resigned before a final decision was made by the Board of Trustees;

b. ***licenses*** to practice any profession in any state, commonwealth or territory;

c. ***DEA registration***, where applicable to the applicant's practice;

d. ***professional liability insurance*** coverage, professional liability litigation and settlement experience, and whether professional liability insurance coverage has ever been denied, refused or not renewed;

e. membership in ***professional societies***;

f. ***ability to participate in Medicare, Medicaid*** or any other government sponsored program or any private or public medical insurance program;

g. ***physical and mental health*** ability to perform the clinical privileges requested within applicable standards of care;

h. ***criminal background history***;

i. ***citizenship*** and/or visa status information and information to confirm the applicant's identity;

j. plan for qualified physicians or other appropriate practitioners to provide ***back-up medical coverage*** for the applicant;

3. Documentation of:

a. negative PPD skin testing within the past year, or, if the applicant has a history of a positive PPD skin test, documentation of a subsequent chest radiograph with no radiographic evidence of active tuberculosis or a completed course of anti-tuberculous therapy;

b. receipt of a Hepatitis B vaccine, a positive Hepatitis B antibody titer within the past 10 years or a completed *Hepatitis B Declination* form;

c. an influenza vaccination per the medical staff's policy on influenza vaccinations; and

4. Any other information the Board of Trustees may require.

C. Applicants already on staff at another Novant Health hospital

If a prospective applicant for membership and/or clinical privileges is already a member or holds clinical privileges at another Novant Health hospital, a streamlined application and verification process may be used. This includes a pre-populated short form application; a new privilege form with evidence satisfying the privilege criteria for the privileges being requested, review of primary source verifications of education and training completed

previously to ensure current requirements are satisfied; a completed competency evaluation form from a department chairperson, chief of staff, or CCO; verification of current licensure and board certification; a National Practitioner Data Bank query; and completion of patient safety education materials as approved by the MEC. Otherwise, the application will follow the processing, review and approval processes set out in these bylaws.

D. Burden to provide required information

The burden is on the ***applicant*** to produce all information deemed adequate by the medical staff to properly evaluate the applicant's qualifications for membership and/or clinical privileges, to resolve any doubts about the application and to establish that he/she is competent to exercise the clinical privileges requested. The applicant is responsible for answering all questions on the application; providing accurate, up-to-date information and for ensuring that all supporting information and verifications, including information from training programs, peer references and other health care facilities, are submitted as requested. Any misrepresentation or misstatement in, or omission from, the application (whether intentional or not) is grounds for the automatic rejection of the application, resulting in denial of membership and/or clinical privileges. If membership or clinical privileges was granted before discovering a misrepresentation, misstatement or omission, the practitioner's membership or clinical privileges may be summarily dismissed.

The burden is on the applicant to provide all required information and resolve any doubts about his/her ability to exercise clinical privileges competently.

Once notified additional information is required, applicants have 90 days to provide the required information. If the information is not provided, the application is deemed voluntarily withdrawn. The applicant may reapply, but if the application is deemed voluntarily withdrawn again, the applicant cannot apply again for one year.

The medical staff, hospital and any of their committees or representatives may request additional information from the applicant at any time, and the application will not be processed further or considered until the information needed to resolve the doubt or concern is received; neither the medical staff nor the Board of Trustees is obligated to review or consider such an application. Applications are deemed voluntarily withdrawn if the applicant has not provided the requested information or otherwise resolved the doubt or concern ***90 days*** after being notified in writing of the need for further information, and the applicant is not entitled to exercise the hearing and appeal rights in these bylaws. The applicant may reapply for membership and clinical privileges, but if the application is deemed voluntarily withdrawn again under this subsection, the applicant cannot apply again for a period of one year.

Section 4-2. Initial Appointment and Privileging Process

This section explains the basic steps in the initial appointment and clinical privileging process.

An individual term of appointment and/or granting of clinical privileges cannot be for more than two years but may be for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to appoint or grant clinical privileges for less than two years.

A term of appointment or clinical privileges cannot be for more than two years but may be for two years or less.

A. Department chairperson recommendation

Applications are submitted to the chairperson of each department in which the applicant requests privileges. Each chairperson (or a former chairperson if the current chairperson is not available) reviews the application and supporting documentation and makes a recommendation on the applicant's request for appointment and/or clinical privileges, including any limitations to privileges or conditions on appointment. A former chairperson may perform these duties if the current chairperson is unavailable. The department chairperson has the right to meet with the applicant to discuss any aspect of the application.

B. Credentials committee recommendation

The credentials committee reviews the applicant's application and supporting documentation and the recommendation from each department chairperson to determine whether the applicant has established and satisfied all the necessary qualifications for appointment and/or clinical privileges.

1. As part of its evaluation, the credentials committee may:
    a. use the expertise of the department chairperson, any other department member or an outside consultant;
    b. require the applicant to meet with the credentials committee to discuss any aspect of the application; and/or
    c. require the applicant to undergo physical or mental examination by a physician or other provider acceptable to the credentials committee in order to determine the applicant's ability to perform the privileges requested. The applicant must make the examination results available to the credentials committee for its consideration. If an applicant does not have the examination or provide the results to the credentials committee within a reasonable time, the application is deemed voluntarily withdrawn. Applicants who are deemed to have voluntarily withdrawn an application do not have the right to exercise the hearing and appeal provisions in these bylaws.

2. No more than 90 days after the applicant has provided all required information, the credentials committee will make a written recommendation to the MEC either to:
   a. ***appoint the applicant to the medical staff and/or grant clinical privileges***. A recommendation to appoint an applicant to the medical staff must include the medical staff category and clinical department to which the applicant should be assigned, and a recommendation to grant clinical privileges must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment
   b. ***defer*** the application for further consideration; or
   c. ***deny*** appointment and/or clinical privileges. The hearing and appeals procedures in these bylaws are *not* triggered by a recommendation from the *credentials committee* to deny appointment and/or clinical privileges.

C. MEC recommendation

At its next meeting after all required information has been received, the MEC or its executive committee reviews the applicant's application and supporting documentation, the recommendations from the credentials committee and the department chairperson and decides whether to defer the application for further consideration or whether to make a recommendation that the Board of Trustees grant or deny membership and/or clinical privileges.

1. Deferring an application

If the MEC defers the application for further consideration, it must make a written recommendation to the Board of Trustees to grant or deny membership and/or clinical privileges within the next 60 days.

2. Recommendations that are different from the credentials committee

When the MEC's recommendation is different from the credentials committee's recommendation, the MEC will either:

a. send the application back to the credentials committee for further investigation and responses to the MEC's specific questions; or
b. provide clear and convincing reasons, along with supporting information, for its disagreement with the credentials committee's recommendation and forward its recommendation along with the credentials committee's findings and recommendation to the Board of Trustees.

3. MEC recommendations that entitle an applicant to request a hearing

MEC recommendations that are ***adverse*** to the applicant entitle the applicant to request a hearing per Article VI (*see* section 6-1, A, on page 94 for recommendations that are

adverse). The MEC forwards the adverse recommendation to the hospital president rather than the Board of Trustees, and the hospital president sends written notice of the adverse recommendation to the applicant per section 6-2, B, on page 94. The MEC's recommendation will be held and will not be sent to the Board of Trustees for final action until the hearing and appeals process in Article VI is complete *or* the practitioner has waived his/her right to a hearing and appeal.

4. MEC recommendations that do not entitle an applicant to request a hearing

   MEC recommendations that are ***not adverse*** are forwarded to the Board of Trustees for final action, and the applicant is not entitled to request a hearing. A recommendation to appoint an applicant to the medical staff must include the medical staff category and clinical department to which the applicant should be assigned, and a recommendation to grant clinical privileges must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment.

D. Board of trustees' final action

The Board of Trustees will take action on the application at its next regular meeting following receipt of the MEC's recommendation. The Board of Trustees may either:

1. adopt the MEC's recommendation;
2. refer the matter back to the MEC with instructions for further review and a time frame for responding to the Board of Trustees; or
3. take unilateral action.

Decisions to appoint an applicant to the medical staff must include the medical staff category and clinical department to which the applicant should be assigned, and decisions to grant clinical privileges must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment. Applicants will be notified in writing of the Board of Trustees' final decision within 30 days.

When the MEC's recommendation to the Board of Trustees is ***not adverse***, but the Board of Trustees considers modifying it such that it ***is adverse*** per section 6-1, A, on page 94, the practitioner is entitled to a hearing, and the hospital president will send the practitioner written notice of the adverse recommendation as explained in section 6-1, B, on page 94 and the Board of Trustees will not take final action until the hearing and appeals process in Article VI is complete *or* the practitioner has waived his/her right to a hearing and appeal.

Section 4-3. Reappointment and Renewal of Clinical Privileges

This section explains the basic steps in the reappointment and renewal of clinical privileges process.

Members of the medical staff are reappointed and practitioners with clinical privileges must renew clinical privileges *at least every two years*. Applications for reappointment and/or renewal of privileges must be processed and approved before the current appointment and/or privileges term expires. ***Membership and clinical privileges cannot be granted for more than two years***, but they may be granted for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to grant membership or clinical privileges for less than two years.

> *Reappointment and renewal of clinical privileges must occur at least every two years. Applications for reappointment and/or renewal of privileges must be processed and approved before the current appointment and/or privileges term expires.*

A. Applications for reappointment and renewal of clinical privileges

The central verification office (CVO) will provide practitioners who meet the eligibility requirements in section 4-1, A on page 67 with electronic access to an application for reappointment and/or renewal of clinical privileges before the practitioner's current appointment or privileges term expires. Applications must include a request for the specific clinical privileges sought and require detailed information concerning the practitioner's professional qualifications, which will include, but not be limited to, those items listed in section 4-1, B, on page 68.

Applications for reappointment and/or renewal of clinical privileges are processed in the same manner as applications for initial appointment and clinical privileges (*see* section 4-2, on page 71). Recommendations for reappointment are based on the member's:

1. ethical behavior, current clinical competence, and clinical judgment in the treatment of patients, including any professional performance evaluations;
2. participation in staff duties, as required by the bylaws;
3. compliance with the medical staff's bylaws, rules & regulations and policies; and the hospital's policies;
4. professional behavior;
5. physical, mental, and emotional health;
6. capacity to satisfactorily treat patients as indicated by the results of the hospital's quality assessment activities or other reasonable indicators of continuing qualifications;

7. satisfactory completion of continuing education requirements that directly relate to the practitioner's area of practice per the appropriate licensure board;
8. current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;
9. current licensures and registrations, including pending challenges to any license or registration or any voluntary or involuntary relinquishment of any license or registration;
10. voluntary or involuntary termination of appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility;
11. criminal background history; and
12. other reasonable indicators of continuing qualifications and relevant findings from the hospital's quality assessment activities.

B. Burden to provide required information

Practitioners are responsible for submitting an application and all required information per section 4-1, D, on page 70 to the CVO by the due date. Practitioners who do not submit all required materials by the due date may obtain an extension of time by paying a processing fee; if the processing fee is not paid, membership and/or clinical privileges will be deemed voluntarily relinquished. Applications from practitioners who pay the processing fee but fail to submit the required information by the end of the extension period will ***not*** be processed, and membership and/or clinical privileges will be deemed voluntarily relinquished.

Practitioners whose membership or privileges have been deemed voluntarily relinquished may reapply but must do so as new applicants. Those who reapply as new applicants within the year following the voluntary relinquishment of their membership or privileges must pay an additional processing fee.

Practitioners whose membership and/or clinical privileges are deemed voluntarily relinquished under this subsection are not entitled to the hearing and appeals procedures in these bylaws. These practitioners may reapply but must do so as new applicants. Practitioners who reapply as new applicants within the year following the voluntary relinquishment of their membership and/or clinical privileges must pay an additional processing fee.

Section 4-4. Clinical Privileges

Being appointed or reappointed to the medical staff does not grant automatically clinical privileges. Clinical privileges are delineated on an individual basis and will include any limitations or restrictions, where necessary. Practitioners are only able to exercise those clinical privileges that have been specifically granted to them by the Board of Trustees, except in an emergency per section 4-4, F, 3, on page 80. Practitioners who exercise clinical privileges within a department are subject to the rules and regulations of that department and to the authority of the department chairperson. Clinical privileges cannot be granted for more than two years, but they may be granted for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to grant clinical privileges for less than two years.

Practitioners may only exercise those clinical privileges that have been specifically granted to them by the Board of Trustees.

Applicants for clinical privileges and practitioners who hold clinical privileges agree to fulfill the basic obligations contained in section 2-4 on page 46.

A. Eligibility for an application for clinical privileges

Prospective applicants for initial clinical privileges and practitioners renewing clinical privileges must meet the eligibility requirements in section 4-1, A, on page 67.

B. Applications for clinical privileges content and processing

The requirements on application forms, content and the burden to provide required information in section 4-1, B and D, on pages 68 and 70 apply to applicants for initial clinical privileges and practitioners renewing clinical privileges.

Applications for initial clinical privileges are processed in the same manner as applications for initial appointment per section 4-2 on page 71, and applications for renewal of clinical privileges are processed in the same manner as applications for reappointment per section 4-3, on page 74.

C. Clinical privileges recommendations

Clinical privileges recommended to the Board of Trustees are based on the following:

1. the applicant's education, training, experience, demonstrated current competence, judgment, references, utilization patterns, and health status;
2. the availability of qualified physicians or other appropriate practitioners to provide back-up medical coverage for the applicant;
3. adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

4. the hospital's available resources and personnel;
5. any successful or pending challenges to licensure or registration, or the voluntary or involuntary relinquishment of licensure or registration;
6. any information concerning the voluntary or involuntary termination, lapse or relinquishment of medical staff membership or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility; and
7. other relevant information, including the written report and findings by the chairperson of each of the clinical departments in which privileges are sought.

D. Requests for additional clinical privileges

Practitioners may request additional clinical privileges at any time, but the request must be in writing on approved forms, detail the specific additional clinical privileges desired, and be supported by documentation of training and experience that justify the additional privileges. Requests for additional privileges made during a current appointment or privileges term are processed in the same manner as an application for initial clinical privileges (*see* section 4-2 on page 71).

Recommendations for additional clinical privileges are based on the practitioner's relevant recent training; OPPE; observation of patient care provided; reviews of the records of patients treated in this or other hospitals, if available; results of the hospital's quality assessment activities; and other reasonable indicators of the practitioner's continuing qualifications for the privileges requested, including any professional performance evaluations. Recommendation for additional clinical privileges may include requirements for supervision, consultation or other conditions for such periods of time as are thought necessary.

E. Clinical privileges for new procedures and techniques

Requests for clinical privileges to perform a significant procedure not currently being performed at the hospital or a significant new technique for performing an existing procedure will ***not*** be processed until the medical staff, in conjunction with hospital administration and relevant hospital departments such as nursing, pharmacy, etc, determines that the procedure will be offered, and the medical staff has established eligibility criteria for requesting those clinical privileges.

The credentials committee will work in conjunction with the department chairperson and the practitioner requesting permission to perform the new procedure or technique to make a preliminary recommendation to the MEC about whether the new procedure or technique should be offered to the community. Factors to be considered will include, but are not limited to whether:

1. there is empirical evidence of improved patient outcomes or other clinical benefits to patients;
2. the new procedure or technique is being performed at other similar hospitals and the experiences of those hospitals; and
3. the hospital has the resources, including space, equipment, personnel and other support services, to safely and effectively perform the new procedure or technique.

If the recommendation is to offer the new procedure or technique, the credentials committee will partner with the department chairperson to develop recommendations regarding the minimum education, training, and experience necessary to perform the new procedure or technique, as well as the extent of monitoring and supervision that should occur if the privileges are granted. The credentials committee may also develop criteria and/or indications for when the new procedure or technique is appropriate.

The credentials committee forwards its recommendations to the MEC, which will review the matter and forward its recommendation to the Board of Trustees for final action.

F. Temporary clinical privileges

The hospital president may grant temporary privileges in the situations set out below. Temporary privileges must be specifically delineated and may include the privilege to admit patients; special requirements for supervision and reporting may be imposed by the department chairperson. Temporary privileges *automatically terminate* at the end of the specific period for which they were granted.

Temporary privileges automatically terminate at the end of the specific period for which they were granted.

Granting temporary privileges is a courtesy and not a right. For good cause shown, the hospital president, after consultation with the department chairperson, the credentials committee chairperson and/or the chief of staff, may terminate an individual's temporary privileges. If the individual has patients admitted to the hospital, the chief of staff or the department chairperson will reassign the patients to members of the medical staff with appropriate privileges. The patient's wishes will be considered. This assignment will be effective until the patients are discharged. Individuals do *not* have the right to the hearing and appeal provisions in these bylaws because of their inability to obtain temporary privileges or because temporary privileges are terminated.

1. To an applicant when the application raises no concerns

When an applicant has applied for clinical privileges, the hospital president may grant temporary clinical privileges for ***no more than 120 days*** on the recommendation of the chief of staff if:

a. all required information has been received and raises no concerns;
b. information about the applicant's current licensure; training or experience; current competence and ability to perform the privileges requested; character and ethical standing; DEA registration (where applicable to the applicant's practice); and professional liability insurance have been received and reviewed;
c. the applicant meets all qualifications and conditions of appointment set out in these bylaws;
d. a query from the National Practitioner Data Bank has been obtained and evaluated;
e. information verifies that there are no current or previously successful challenges to licensure or registration; medical staff membership at another organization has not been involuntarily terminated; and clinical privileges have not been involuntarily limited, reduced, denied or lost; and
f. the department chairperson and the credentials committee have recommended that clinical privileges be granted.

2. To an individual to care for a specific patient

The hospital president, on the recommendation of the department chairperson, credentials committee chairperson or the chief of staff, may grant temporary privileges to a provider who does not have clinical privileges at the hospital and has not applied for clinical privileges under the following circumstances:

a. there is an important need to care for a specific patient or patients;
b. no existing practitioner has the clinical privileges necessary to meet the patient care need;
c. the individual's current licensure and current competence are verified; and
d. a query from the National Practitioner Data Bank has been obtained and evaluated.

The individual must sign a statement acknowledging that he/she agrees to be bound by these medial staff bylaws and by the medical staff's rules & regulations. Temporary privileges granted under this subsection may only be ***for the length of stay of the specific patient(s) or 30 days, <u>whichever is less</u>***. The provider must apply for membership and/or clinical privileges in order to attend patients beyond the 30 day period. Temporary privileges under this subsection do not grant or imply membership on the medical staff, do not entitle the provider to the hearing and appeal provisions set forth in these bylaws, and do not afford them any of the rights outlined in these bylaws.

3. To an individual in an emergency

   For the purposes of this subsection, an emergency is a condition that could result in serious or permanent harm to a patient and any delay in administering treatment would add to that harm or danger.

   In an emergency, any provider, regardless of membership status, medical staff category or clinical privileges, is permitted to do everything possible within the scope of his/her license to save the life of a patient or prevent serious harm. When the emergency situation no longer exists, the patient's care will be assigned to a medical staff member with appropriate privileges. If the provider who provided the emergency care to the patient wants to continue to care for the patient, he/she must apply for membership and/or privileges per these bylaws. Emergency temporary privileges do not grant or imply membership on the medical staff, do not entitle the provider to the hearing and appeal provisions set forth in these bylaws, and do not afford them any of the rights outlined in these bylaws.

4. To a volunteer licensed independent practitioner during a disaster

   When the hospital activates its disaster plan and the immediate needs of its patients cannot be met, the CCO (or designee) may grant disaster privileges to eligible volunteer licensed independent practitioners per the *Practitioner Credentialing for Disasters* policy. The medical staff will oversee the care provided by the volunteer licensed independent practitioners. Disaster privileges will only be for the time period needed during the disaster and automatically terminate at the end of the needed services. Disaster privileges do not grant or imply membership on the medical staff, do not entitle the volunteer licensed independent practitioners to the hearing and appeal provisions set forth in these bylaws, and do not afford them any of the rights outlined in these bylaws.

Section 4-5. Authorization to Obtain and Release Information

When applicants apply for appointment, reappointment or clinical privileges, they authorize the medical staff and hospital to obtain and release information during the processing and consideration of the application, whether or not appointment, reappointment or clinical privileges are granted. This authorization also applies throughout any term of appointment, reappointment or clinical privileges.

A. Authorization to obtain and release information

Applicants and practitioners specifically authorize the hospital and its authorized representatives to:

1. consult with any third party who may have information bearing on the applicant's or practitioner's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on his/her qualifications for appointment, reappointment or clinical privileges;
2. inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures from third parties that may be relevant to such questions, and applicants and practitioners specifically authorize third parties to release this information to the hospital and its authorized representatives upon request; and
3. release such information to other hospitals, health care facilities, managed care organizations and their agents who solicit such information for the purpose of evaluating the applicant's or practitioner's professional qualifications pursuant to a request for appointment, reappointment or clinical privileges.

B. Immunity

To the fullest extent permitted by law, applicants and practitioners release from any and all liability, agree not to sue and extend immunity to the hospital, its authorized representatives, and any third parties with respect to any acts, communications, documents, recommendations or disclosures involving the applicant or practitioner as set forth below:

1. applications for appointment or clinical privileges, including temporary privileges;
2. evaluations concerning reappointment or changes in clinical privileges;
3. proceedings for suspension or reduction of clinical privileges, termination of medical staff membership or clinical privileges, or any other disciplinary action;
4. precautionary suspension;
5. hearing and appellate reviews;

6. medical care evaluations and other activities relating to the quality of patient care or professional conduct;
7. matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or
8. any other matter that might directly or indirectly relate to clinical competence, patient care, or to the orderly operation of this or any other hospital or health care facility.

C. Definitions

As used in this section, the terms:

1. "hospital and its authorized representatives" means Novant Health, Inc., the hospital and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's or practitioner's credentials or for acting upon an application or conduct at the hospital: the members of the Board of Trustees and their appointed representatives; the hospital president and his/her designees; the CCO and chief medical officer; hospital employees and consultants; hospital attorneys and their partners, associates or designees; members of the medical staff and APPs; and
2. "third parties" means all individuals, including but not limited to: members of the medical staff and APPs; members of other medical staffs; other physicians and advanced practice clinicians; nurses and other members of the healthcare team; and other organizations, associations, partnerships, corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

Section 4-6. State and Federal Protections

All minutes, documents, reports, communications, recommendations and actions made or taken pursuant to Articles IV, V and VI of these bylaws are deemed to be covered by the provisions of NCGS §131E-95, §131E-97.2 and/or the corresponding provisions of any other federal or state statute providing protection to peer review, credentialing or related activities. Furthermore, the committees, individuals and/or panels charged with making reports, findings, recommendations or investigations pursuant to Articles IV, V and VI are acting on behalf of the hospital and its Board of Trustees when engaged in such professional review activities and are deemed to be "professional review bodies" and/or “medical review committees” as those terms are defined in the Health Care Quality Improvement Act of 1986 and/or North Carolina state statutes.

ARTICLE V – REVIEW & INVESTIGATIONS

Article V describes how medical staff leadership works collegially with practitioners to review and improve clinical performance or behavior. It also addresses the investigatory process used when medical staff leadership do not believe collegial action is appropriate or when the practitioner does not wish to proceed collegially.

ARTICLE V – REVIEWS & INVESTIGATIONS
Table of Contents

ARTICLE V – REVIEWS & INVESTIGATIONS

Section 5-1. Reviews

Concerns related to clinical competence or professional behavior may be reviewed and addressed collegially with the practitioner without conducting an investigation or recommending adverse actions (*see* section 5-2 on page 87 for information on investigations and section 6-1, A, on page 94 for adverse recommendations). The goal of these efforts is to promote a collegial and educational approach to resolve the concerns through voluntary action by the practitioner. Examples of collegial efforts include, but are not limited to:

1. letters of education, warning or reprimand;
2. requirements for additional education or training;
3. retrospective reviews and prospective monitoring;
4. proctoring or consultation with another provider when the consultant's approval is *not* needed to proceed with clinical care; and
5. requirements for outside assessment, examination or screening.

While collegial efforts are encouraged, they are not mandatory and an investigation may be requested per section 5-1, A, on page 87 if a practitioner does not wish to participate in the collegial process or in the discretion of the appropriate medical staff leader or committee. Collegial efforts are part of the hospital's professional review activities, but they are ***not adverse*** actions or recommendations and do not entitle the practitioner to the hearing and appeal provisions in these bylaws.

Section 5-2. Investigations

A. Grounds for requesting an investigation

The chief of staff, a department chairperson, a medical staff committee chairperson, a majority of the members of a medical staff committee, the hospital president or the Board of Trustees chairperson may request an investigation when, on information and belief, there is cause to question a practitioner's:

1. clinical competence;
2. care and treatment of patients or management of a case;
3. known or suspected violation of applicable ethical standards;
4. known of suspected violation of medical staff, hospital or Board of Trustees bylaws, rules & regulations or policies (including, but not limited to, the hospital's quality assessment, risk management and utilization review programs); and/or
5. behavior or conduct that is considered lower than the standards of the hospital or disruptive to the orderly operations of the medical staff or the hospital, including the inability of the practitioner to work harmoniously with others.

The request for the investigation must be in writing, submitted to the credentials committee and specifically reference to the activity or conduct for the request. The credentials committee also may initiate an investigation on its own motion.

B. Initial review by credentials committee

The credentials committee will meet as soon as possible after receiving a request for an investigation to discuss it. In its discretion, the credentials committee may, among other actions:

1. determine the matter is unfounded and take no further action;
2. address the matter through collegial efforts;
3. proceed under an applicable medical staff policy;
4. refer the matter to an appropriate medical staff committee; and/or
5. conduct a formal investigation.

In making its determination, the credentials committee may discuss the matter with the practitioner but is ***not*** required to do so. If the credentials committee decides to conduct a formal investigation, the meeting minutes will specifically recite that an investigation is being conducted, the credentials committee will appoint an investigating committee per section 5-2, C, 2, on page 88, and the investigation procedures set out below will be followed.

C. Investigation procedures

1. Notice of the investigation

When the credentials committee decide to investigate a matter, the credentials committee chairperson or the CCO will send the practitioner written notice that the credentials committee has opened an investigation and advise the practitioner that he/she will have an opportunity to meet with the investigating committee before it makes a final recommendation (*see* section 5-2, C, 2, b, below).

The decision to conduct an investigation should be reflected in the credentials committee's meeting minutes. Practitioners under investigation are notified in writing of the investigation.

Investigations are conducted by the full credentials committee, a subcommittee of the credentials committee, or an ad hoc committee of no more than three members who may be, but are not required to be, members of the medical staff.

2. Investigating committee

The credentials committee may decide to:

- conduct the investigation by the full credentials committee;
- appoint a subcommittee of the credentials committee to conduct the investigation; or
- appoint an ad hoc committee to conduct the investigation. If an ad hoc committee is used, it *cannot* have more than three members. Ad hoc committee members may, but do not have to be, members of the medical staff, and they *cannot* be partners, associates or relatives of the practitioner being investigated.

a. Authority of the investigating committee

The investigating committee may use the full resources of the medical staff and hospital to conduct the investigation. This includes, but is not limited to, reviewing relevant documents, interviewing individuals, using outside consultants, and/or requiring the practitioner to undergo a physical and/or mental examination by a health care professional satisfactory to the investigating committee. The practitioner must make the examination results available to the investigating committee for its consideration. If a practitioner does not undergo the examination within a reasonable time, his/her membership and/or clinical privileges will be deemed to have been voluntarily relinquished, and the practitioner does not have the right to exercise the fair hearing and appeal provisions in these bylaws.

b. Practitioner's opportunity to respond

The practitioner being investigated *must* be given an opportunity to meet with the investigating committee *before* it makes a recommendation to the credentials

committee. At this meeting (but not as a matter of right before it), the practitioner will be informed of the general nature of the evidence supporting the matter being investigated and be invited to discuss, explain or refute it. This meeting is *not* a hearing, and none of the procedural rules for hearings apply to this meeting (*see* section 6-1 on page 94 for hearings). The practitioner does *not* have the right to represented by legal counsel at this meeting. A summary of the meeting will be included in the investigating committee's report to the credentials committee.

Practitioners under investigation must be given an opportunity to meet with the investigating committee before it makes a recommendation on the matter to the credentials committee. This meeting is not a hearing and none of the rules for hearings in Article VI apply.

c. Recommendations and report

The investigating committee will prepare a report for the credentials committee that includes a summary of its meeting with the practitioner as well as its findings, conclusions and recommendations.

The investigating committee's report should contain a summary of its meeting with the practitioner.

3. Credentials committee review of recommendations

The credentials committee will review the investigating committee's recommendations and may accept, modify or reject them. The credentials committee will forward its findings and recommendations to the MEC, and the credentials committee chairperson will be available to the MEC to answer questions.

4. MEC

The MEC will review the credentials committee's recommendation and determine what recommendations to make to the Board of Trustees.

a. Recommendations that entitle a practitioner to a hearing

If the MEC's recommendation is ***adverse***, it entitles the practitioner to a hearing (*see* section 6-1, A, on page 94 for MEC recommendations that are considered adverse). The hospital president will send the practitioner written notice of the adverse recommendation as explained in section 6-1, B, on page 94, and the MEC's recommendation will be held and will not be sent to the Board of Trustees for final action until the hearing and appeals process in Article VI is complete ***or*** the practitioner has waived his/her right to a hearing and appeal.

When the MEC's recommendation to the Board of Trustees is ***not adverse***, but the Board of Trustees considers modifying it such that it ***is adverse*** per section 6-1, A, on

page 94, the practitioner is entitled to a hearing, and the hospital president will send the practitioner written notice of the adverse recommendation as explained in section 6-1, B, on page 94 and the Board of Trustees will not take final action until the hearing and appeals process in Article VI is complete ***or*** the practitioner has waived his/her right to a hearing and appeal.

b. Recommendations that do not entitle a practitioner to a hearing

If the MEC's recommendation is ***not adverse*** per section 6-1, A, on page 94, it does not entitle the practitioner to a hearing, and the MEC's recommendation takes effect immediately without Board of Trustees action and without the right to the hearing and appeals procedures in these bylaws. The MEC will prepare and transmit a report of the action taken and reasons supporting it to the Board of Trustees.

Section 5-3. Precautionary Suspensions

A. Grounds for precautionary suspension of privileges

All, or a portion, of a practitioner's clinical privileges may be precautionarily suspended at any time if failing to do so might result in imminent danger to the health and/or safety of any individual or to the orderly operations of the hospital. The chief of staff, a clinical department chairperson, the credentials committee chairperson and the hospital president each have the authority precautionarily to suspend clinical privileges. Precautionary suspensions are effective immediately and remain in effect until lifted or modified by the hospital president or the Board of Trustees. Precautionary suspensions must be reported immediately in writing to the chief of staff, the credentials committee chairperson and the hospital president.

Clinical privileges may be precautionarily suspended if failing to do so might result in imminent danger to the health and/or safety of any individual or to the orderly operations of the hospital.

Precautionary suspensions are interim precautionary steps in a professional review activity, but they are not complete professional review actions in and of themselves and do not imply any final finding of responsibility for the situation that caused the suspension.

B. Investigation following precautionary suspension

After clinical privileges have been precautionarily suspended, an investigation must be conducted per the investigation procedures in section 5-2, C on page 88 within a reasonable time period that ***cannot exceed 14 days***. If the investigation cannot be completed within 14 days, the reasons for the delay must be explained to the Board of Trustees (or its committee) so that it may consider whether or not to lift the precautionary suspension.

When clinical privileges have been precautionarily suspended, an investigation must be conducted within 14 days. If the investigation cannot be completed within 14 days, the Board of Trustees must consider whether or not to lift the precautionary suspension.

C. Care of practitioner's patients

The department chairperson or chief of staff will assign the suspended practitioner's hospital patients to another member of the medical staff with appropriate clinical privileges. The patient's wishes will be considered. This assignment will be effective until the patients are discharged. All medical staff members have a duty to cooperate in enforcing suspensions and in caring for a suspended practitioner's hospital patients.

ARTICLE VI – HEARINGS & APPEALS

Article VI explains the hearing and appeal procedures available to applicants and practitioners who are the subject of an adverse recommendation made by the MEC or by the Board of Trustees when the MEC's recommendation to the Board of Trustees was favorable.

ARTICLE VI – HEARINGS & APPEALS
Table of Contents

ARTICLE VI – HEARINGS & APPEALS

Section 6-1. Hearings

A. Adverse recommendations

Applicants and practitioners who are the subject of an ***adverse recommendation*** are entitled to request a hearing. A recommendation is *only* considered adverse when the MEC recommends, for reasons related to professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of patients, that the Board of Trustees:

1. deny an applicant's request for initial appointment to the medical staff and/or initial clinical privileges;
2. deny a practitioner's request for reappointment to the medical staff; renewal of clinical privileges and/or additional clinical privileges;
3. restrict and/or suspend all, or some, of a practitioner's clinical privileges for more than 30 days, or terminate clinical privileges or membership; and/or
4. require a practitioner to obtain a consultation from a consultant whose approval is required in order for the practitioner to proceed with clinical care for more than 30 days.

The recommendations listed above also are considered ***adverse*** when made by the Board of Trustees, for reasons related to professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of patient, when the MEC's recommendation to the Board of Trustees was ***not adverse***. ***No other recommendations or actions entitle applicants or practitioners to request a hearing***.

B. Notice of an adverse recommendation

When the MEC or Board of Trustees has made an ***adverse*** recommendation as explained in section 6-1, A, the hospital president will inform the applicant or practitioner of the adverse recommendation in writing by certified mail, return receipt requested. The notice must include:

1. the adverse recommendation made and the general reasons for it;
2. a statement that the applicant or practitioner has the right to request a hearing within 30 days of receipt of the notice;

3. a statement that the failure to request a hearing is a waiver of the hearing and appeal rights in this Article VI and that the adverse recommendation will become final; and
4. a copy of this Article VI on hearings and appeals.

C. Requesting a hearing

The applicant or practitioner has 30 days from the date the notice of adverse recommendation is received to request a hearing. ***The request for a hearing must be in writing and delivered to the hospital president either in person or by certified mail, return receipt requested.*** If a hearing is not requested as described within the 30 days, the applicant or practitioner is deemed to have ***waived*** the right to a hearing and to have accepted the adverse recommendation. The recommendation will become effective when the Board of Trustees takes final action on it.

An applicant or practitioner has 30 days to request a hearing in writing. If a hearing is not requested, the applicant or practitioner is deemed to have waived the right to request a hearing and to have accepted the adverse recommendation.

D. Scheduling a hearing

When a hearing has been requested as required by section 6-2, C, the hospital president will schedule the hearing to begin as soon as practical, but no sooner than 30 days after the notice of the hearing. The hearing may be scheduled earlier, however, if both of the parties specifically agree to an earlier date in writing. The hospital president will send a written notice to the applicant or practitioner by certified mail, return receipt requested that includes:

1. the time and date of the hearing and where it will be held;
2. a proposed list of witnesses who will testify or present evidence in support of the MEC or the Board of Trustees and a brief summary of the nature of the anticipated testimony (the applicant or practitioner must provide his or her witness list within 10 days of receiving the notice of the hearing as explained in section 6-1, F, 1, on page 98);
3. the names of the hearing panel members or the hearing officer, if known (*see* section 6-1, E, on page 96); and
4. a statement of the specific reasons for the adverse recommendation and a list of patient records and information that support the recommendation. This statement and list may be amended at any time, even during the hearing, as long as the additional material is relevant and the applicant or practitioner and his/her counsel have sufficient time to study the additional material and rebut it.

E. Appointing either a hearing panel or a hearing officer

When a hearing has been properly requested, the hospital president, in consultation with the chief of staff and the chairperson of the Board of Trustees if the hearing is the result of a Board of Trustees adverse recommendation, will appoint either a hearing panel *or* a hearing officer (*see* section 6-1, E, 1, directly below for the hearing panel and section 6-1, E, 2, on page 97 for the hearing officer). If a hearing panel is appointed, the hospital president also will select either a hearing panel chairperson or a presiding officer.

When a hearing has been properly requested, the hospital president will appoint either a hearing panel or a hearing officer.

If a hearing panel is appointed, the hospital president will select either a hearing panel chairperson or a presiding officer.

1. Hearing panel

A hearing panel must have at least three members. A majority of the hearing panel members must be:

- members of the medical staff who have not actively participated in the matter at issue at any previous level;
- physicians and/or lay people who are not connected with the hospital; or
- any combination of such persons.

Knowledge of the underlying matter does not prohibit anyone from serving as a hearing panel member. The panel may not include anyone who is in direct, economic competition with the applicant or practitioner or anyone who is professionally associated with, or related to, the applicant or practitioner.

When a hearing panel is appointed, the hospital president also will select either a hearing panel chairperson or a presiding officer.

a. Hearing panel chairperson

The hospital president may appoint one member of the hearing panel to serve as its chairperson. The chairperson is entitled to one vote and may be advised by legal counsel to the hospital. The hearing panel chairperson will:

i. ensure all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, with reasonable limits on the number of witnesses and duration of direct and cross examination that are applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

ii. maintain decorum throughout the hearing;

iii. determine the order of procedure throughout the hearing;

iv. make rulings on all questions that relate to procedural matters and the admissibility of evidence;

v. act so that all information reasonably relevant to the appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations; and

vi. conduct argument by counsel on procedural points outside the presence of the hearing panel, unless the panel members wish to be present.

b. Presiding officer

Instead of a hearing panel chairperson, the hospital president may appoint an attorney at law or other qualified person to serve as a presiding officer. The presiding officer performs all the duties assigned to the hearing panel chairperson in section 6-1, E, 1, a, on page 96. The presiding officer may be legal counsel to the hospital but must not act as a prosecuting officer or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and be a legal advisor to it but is not entitled to vote on the recommendations. Legal counsel may thereafter continue to advise the Board of Trustees on the matter.

2. Hearing officer

If a hearing officer is appointed instead of a hearing panel, all references to a hearing panel, the hearing panel chairperson or the presiding officer refer instead to the hearing officer, unless the context clearly requires otherwise.

As an alternative to a hearing panel, the hospital president, in consultation with the chief of staff and the chairperson of the Board of Trustees if the hearing is the result of a Board of Trustees adverse recommendation, may appoint a hearing officer to perform the functions that would otherwise be performed by the hearing panel. A hearing officer is preferably an attorney at law or some other individual capable of conducting the hearing. The hearing officer may not be anyone who is in direct, economic competition with the applicant or practitioner or anyone who is professionally associated with, or related to, the applicant or practitioner. The hearing officer cannot act as a prosecuting officer or as an advocate to either side at the hearing.

F. Pre-hearing discovery

There is no right to pre-hearing discovery. All objections to documents and/or witnesses, to the extent then reasonably known, must be submitted in writing to the hearing panel chairperson *before the hearing*. The hearing panel chairperson will not entertain later objections, unless the party offering the objection demonstrates good cause. Applicants and practitioners are not entitled to, will not be given access to, and will not be allowed to introduce, any evidence of any peer review records, minutes or other documents or

information that relate to other applicants or practitioners or actions taken or not taken with respect to other applicants or practitioners.

1. Witness lists

   Within 10 days of receiving the notice of the hearing, the applicant or practitioner must provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf and a brief summary of the nature of the anticipated testimony. The proposed list of witnesses who will testify or present evidence in support of the MEC or the Board of Trustees is provided to the applicant or practitioner in the notice of hearing as explained in section 6-1, D, on page 95. Hospital employees appearing on the MEC or Board of Trustees' witness list *cannot* be contacted by the applicant or practitioner, his/her attorney or anyone else acting on the applicant or practitioner's behalf, unless specifically agreed to by hospital counsel.

   In the discretion of the hearing panel chairperson, the witness list of either party may be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The hearing panel chairperson also has the authority to limit the number of witnesses (s*ee* section 6-1, E, 1, a, on page 96).

2. Documents

   The applicant or practitioner is entitled to copies of, or reasonable access to, the following documents, upon specific request, *if* a stipulation is signed by both parties that the documents will be maintained as confidential and not be disclosed or used for any purpose outside of the hearing:

   - all patient medical records referred to in the statement of reasons, at his/ her expense;
   - reports of experts relied on by the credentials committee or the MEC; and
   - any other documents relied on by the credentials committee or the MEC.

   Disclosure of any document per this subsection shall *not* constitute a waiver of the protections provided by state or federal peer review, credentialing or quality review or medical review statutes. Intentional disclosure of documents by the applicant, practitioner or his/her representative contrary to these procedures or applicable law constitutes independent grounds for disciplinary action, up to and including termination of medical staff membership and/or clinical privileges. Any and all documents produced hereunder shall be returned to the hospital or destroyed upon the completion of the hearing.

3. Exhibit lists

Before the hearing, on the date set by the hearing panel chairperson or the date agreed to by counsel for both sides, each party must provide the other party with a list of proposed exhibits.

G. Hearing procedure

1. Failure of the applicant or practitioner to appear and proceed

The applicant or practitioner's personal appearance at the hearing is required. If the applicant or practitioner fails to appear personally and proceed at the hearing without good cause, he/she is deemed to have waived the right to a hearing and to have accepted the adverse recommendation. The recommendation will become effective when the Board of Trustees takes final action on the matter.

2. Record of the hearing

A reporter will be present to make a record of the proceedings. The hospital is responsible for the costs of the reporter, and copies will be provided to the applicant or practitioner at his/her expense (see section 6-1, G, 3, a, b, below). The hearing panel may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the panel who is entitled to notarize documents in this State.

3. Rights of both sides

Subject to reasonable limits as determined by the hearing panel chairperson, both sides have the right to:

a. be represented by an attorney or other person of choice;
b. have a record made of the proceedings, copies of which may be obtained by the applicant or practitioner upon payment of any reasonable charges associated with its preparation;
c. call, examine, and cross-examine witnesses;
d. present evidence determined to relevant by the hearing panel chairperson, regardless of its admissibility in a court of law; and
e. submit a written statement or memorandum of points and authorities at the close of the hearing.

An applicant or practitioner who does not testify on his/her own behalf may be called and examined as if under cross-examination.

4. Admissibility of evidence

The hearing does *not* have to be conducted strictly according to the rules of law on examining witnesses or presenting evidence. Any relevant evidence will be admitted if it

is the sort of evidence upon which responsible people are accustomed to rely in the conduct of serious affairs, regardless of whether the evidence would be admissible in a court of law. The concern of the hearing panel is with the truth of the matter, providing adequate safeguards for the rights and fairness of both parties. The hearing panel is entitled to consider all other information that may be considered, pursuant to these bylaws, in connection with applications for appointment or reappointment and for clinical privileges.

The hearing panel also may question witnesses, call additional witnesses, and/or request documentary evidence if it deems it appropriate.

5. Burden of proof

The MEC or the Board of Trustees, depending upon whose recommendation prompted the hearing, bears the initial burden of presenting evidence in support of its recommendation and to present evidence that the recommendation is supported by a preponderance of the evidence.

6. Postponements

Requests for postponements or extensions of time beyond any time limit in this Article may be granted by the hearing panel chairperson on a showing of good cause.

7. Recesses and adjournment

The hearing panel chairperson may recess and reconvene the hearing 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 will be finally adjourned.

H. Hearing panel deliberations and written report

The hearing panel will conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed per section 6-1, E, 1, b, on page 97). Within 20 days of the hearing's final adjournment, the hearing panel will send the hearing record, a written report of its findings and recommendations and all supporting documentation to the hospital president. The hearing panel's decision must be based on the evidence produced at the hearing, including:

1. oral testimony of witnesses;
2. written statements or memoranda of points and authorities;
3. any information about the applicant or practitioner so long as the information was admitted into evidence at the hearing and the applicant or practitioner had an opportunity to comment on, and refute, it;
4. any all applications, references and accompanying documents;

5. other documented evidence, including medical records; and
6. any other evidence that has been admitted.

The hospital president will send the hearing panel's report and supporting documentation to the applicant or practitioner by certified mail, return receipt requested. The applicant or practitioner may request a copy of the hearing record at his or her expense. The hospital president will also send the report and supporting documentation to the MEC.

Either party may request an appeal within 10 days of receiving the hearing panel's report as described more fully in section 6-2, B, on page 102.

Section 6-2. Appeals

A. Grounds for an appeal

Either party may request an appeal for the grounds listed below:

1. there was substantial failure to comply with these bylaws such as to deny due process or a fair hearing;
2. the hearing panel's recommendations were made arbitrarily, capriciously or with prejudice; or
3. the hearing panel's recommendations were not supported by substantial evidence.

B. Requesting an appeal

An appeal must be requested for the grounds listed above in section 6-2, A, within 10 days of receiving the hearing panel's report (*see* section 6-1, H, on page 100 for the hearing panel's report). The request for an appeal must be in writing and delivered to the hospital president either in person or by certified mail. The request must include a brief statement of the reasons for appeal. If an appeal is not requested within 10 days as described, both parties are deemed to have waived the right to request an appeal and to have accepted the recommendation in the hearing panel's report, and the recommendation will take effect immediately and become final upon adoption by the Board of Trustees.

Either party may request an appeal in writing within 10 days of receiving the hearing panel's report. If an appeal is not requested, both parties are deemed to have waived the right to request a hearing and to have accepted the recommendations in the hearing panel's report.

C. Scheduling an appeal

When an appeal has been properly requested, the chairperson of the Board of Trustees will, within 10 days of receiving the request, schedule and arrange for the appellate review. The applicant or practitioner will be given written notice of the time, date and place of the appellate review by certified mail, return receipt requested. The appeal cannot be held *less* than 10 days, or *more* than 30 days, from the date of receipt of the request for appellate review.

If, however, the request for an appeal is from a practitioner who is under a current suspension, the appeal will be held as soon as arrangements may be reasonably made, but it must be held within 14 days of the receipt of the request for an appeal. The time for the appeal may be extended by the Board of Trustees chairperson for good cause.

D. Appointing an appeals panel

The Board of Trustees chairperson will appoint an appeals panel that is composed of at least three members, who are either Board of Trustees members or others, including but not limited to reputable persons outside the hospital, to consider the record upon which the hearing panel's recommendation was made and to recommend final action to the Board of Trustees. At least one member of the appeals panel must be a physician.

The appeals panel must have at least three members; at least one member must be a physician (MD/DO).

E. Appeal procedure

1. Each party has the right to present a written statement to the appeals panel in support of its position on appeal.
2. The appeals panel may, in its discretion, allow each party or its representative to appear personally and make oral argument.
3. The appeals panel may accept additional oral or written evidence, subject to the same rights of cross-examination, provided at the hearing panel proceedings. Additional evidence may be accepted *only* if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the appeals panel.

The appeals panel may allow oral argument but is not required to allow it.

F. Appeals panel written report

The appeals panel will send a written report of its recommendation on the matter to the Board of Trustees chairperson.

G. Final decision of the board of trustees

The Board of Trustees may refer the matter for further review and recommendation, or it may affirm, modify or reverse the appeal panel's recommendation. If referred for further review and recommendation, the recommendation must be made promptly to the Board of Trustees per its instructions. This further review process *cannot* exceed 30 days, unless the parties agree to a longer time period in writing.

Within 30 days of the Board of Trustees receipt of the appeal panel's written report or the recommendation resulting from the further review process explained directly above, the Board of Trustees must make a final decision on the matter and send a copy of its written final decision to the applicant or practitioner by certified mail, return receipt requested. A copy is also sent to the chairpersons of the credentials committee and the MEC.

The Board of Trustees decision is final, effective immediately and is not subject to further review.

H. Right to one appeal only

No applicant or practitioner is entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal.

ARTICLE VII – MISCELLANEOUS

Article VII explains when histories and physical examinations must be performed and documented.

ARTICLE VII – MISCELLANEOUS
Table of Contents

ARTICLE VII – MISCELLANEOUS

Section 7-1. Histories and Physical Examinations

A history and physical examination (H&P) must be completed and documented by a physician, oral surgeon or podiatrist, consistent with his/ her delineated clinical privileges, or by a category 2 APP upon the request of his/ her supervising physician for each patient no more than 30 days before, or 24 hours after, admission or registration, but before surgery or a procedure requiring anesthesia services. A podiatrist may complete and document a focused H&P of the foot and ankle and their related soft tissue structures to the level of the myotendinous junction, but a physician (MD/DO) must perform the rest of the H&P.

If an H&P was performed outside the hospital and completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but before surgery or a procedure requiring anesthesia services.

Associated details related to H&Ps, such as H&P content and co-signatures, are addressed in the medical staff's rules & regulations.

DEFINITIONS

Advanced practice providers – there are two categories of APPs:

- ***Category 1 APPs*** include psychologists (PsychD or PhD only), chiropractors and optometrists. These individuals have independent scopes of practice.
- ***Category 2 APPs*** include certified nurse midwives, certified registered nurse anesthetists, clinical pharmacist practitioners, nurse practitioners and physician assistants. These individuals exercise clinical privileges under the supervision of a physician (MD/DO).

APPs hold clinical privileges, but they are not members of the medical staff.

Applicant – an individual who is applying for membership on the medical staff and/or clinical privileges.

Board of trustees – the Board of Trustees or Board of Directors for Medical Park Hospital, Inc., d/b/a Novant Health Medical Park Hospital, that has the overall responsibility for the conduct of the hospital. The Board of Trustees is the governing body as described in The Joint Commission standards and the Medicare Conditions of Participation.

Chief clinical officer (CCO) – the chief clinical officer employed by Novant Health, Inc. or one of its subsidiaries or affiliates.

Collaborative practice agreement – the written statement between a category 2 APP and his/her supervising physician(s) that is required by North Carolina law and describes those medical acts, tasks and functions delegated to the category 2 APP by the primary supervising physician that are appropriate to the category 2 APP's education, qualification, training, skills, and competence.

Days – calendar days, unless it is specifically noted to be *business* days.

Dentist – an individual with a DDS degree who is fully licensed to practice dentistry in North Carolina.

Federal health care program – any plan or program that provides health benefits that are funded directly, in whole or in part, by the federal government or a state health care program (with the exception of the Federal Employees Health Benefits Program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

Hospital – Medical Park Hospital, Inc., d/b/a Novant Health Medical Park Hospital.

Hospital president – the individual appointed by the Board of Trustees to act

on its behalf in the overall administrative management of the hospital. The term also includes the president's designated representative.

Investigation – a formal investigation opened by the credentials committee per Article V, as reflected in the credentials committee's meeting minutes, regarding a practitioner's clinical competence; care and treatment of patients or management of a case; known or suspected violation of applicable ethical standards; known of suspected violation of medical staff, hospital or Board of Trustees bylaws, rules & regulations or policies (including, but not limited to, the hospital's quality assessment, risk management and utilization review programs); and/or behavior or conduct that is considered lower than the standards of the hospital or disruptive to the orderly operations of the medical staff or the hospital, including the inability of the practitioner to work harmoniously with others.

Ineligible person – any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

Investigating committee – the committee appointed by the credentials committee to conduct an investigation per Article V. The investigating committee may be the full credentials committee, a subcommittee of the credentials committee, or an ad hoc committee. If an ad hoc committee is used, it cannot have more than three (3) members, who may or may not be members of the medical staff, and cannot include partners, associates or relatives of the practitioner being investigated.

Medical staff – the formal organization of physicians, oral surgeons, dentists and podiatrists who have been appointed to the medical staff by the Board of Trustees.

Medical staff year – the period from May 1st to April 30th of each year.

Nominating committee – the nominating committee is composed of the chief of staff, vice-chief of staff, one or two past chiefs of staff (if available), the CCO and the hospital president. The CCO and hospital president are non-voting members.

Optometrist – an individual with an OD degree who is fully licensed to practice optometry in North Carolina and is certified by the National Board of Examiners in Optometry.

Oral surgeon – an individual with a DDS or DMD degree who is fully licensed to practice oral surgery in North Carolina and is board certified or board eligible by the American Board of Oral and Maxillofacial Surgery (ABOMS).

Patient encounter – attending a patient, admitting a patient, performing a consult on an inpatient, and performing an inpatient or an outpatient procedure (including procedures in the emergency department). Patients who are seen in the emergency department but are not admitted are not counted as a patient encounter.

Physician – an individual with an MD or DO degree who is fully licensed to practice medicine in North Carolina and is board eligible or board certified by an American Board of Medical Specialties member board or the American Osteopathic Association.

Podiatrist – an individual with a DPM degree who is fully licensed to practice podiatry in North Carolina and is board eligible or board certified by the American Board of Podiatric Medicine or the American Board of Foot and Ankle surgery.

Practitioner – a collective term used to refer to all the members of the medical staff and to all individuals who hold clinical privileges at the hospital.

Primary supervising physician – the physician who is accountable to the North Carolina Medical Board for a category 2 APP's medical activities and professional conduct at all times, whether the physician personally is providing supervision or the supervision is being provided by a back-up supervising physician.

Prospective applicant – an individual who has requested an application for membership on the medical staff and/or clinical privileges.

Psychologist – an individual with a PsychD or PhD degree who is fully licensed to practice psychology in North Carolina.

Review – the process used to determine whether an investigation, or other action, is needed to address concerns related to a practitioner's clinical competency or professional behavior.

Rules & regulations – the rules & regulations of the medical staff that have been adopted by the medical staff and approved by the Board of Trustees, as explained in these bylaws.

Unassigned patient call – the call schedule for patients who do not have a physician on the medical staff with appropriate privileges to manage the patient's condition.

Voting members of a department – the voting members of a department are the department chairperson and the active medical staff members who are assigned to the department. When a department only has affiliate medical staff members assigned to it, as in the case of departments that are largely outpatient based, such as family medicine or pediatrics, the voting members of the department are the department chairperson and the affiliate medical staff members assigned to the department.

Voting members of the MEC – all MEC members are voting members *except* for the CCO, hospital president, CNO, pharmacy

representative and the medical staff office manager.

Voting members of the medical staff – the voting members of the medical staff are:

- active staff members;
- current and former medical staff officers and department chairpersons; and
- current *medical staff members* of the credentials committee, a peer review committee, a quality or clinical improvement committee, or a best practice committee.

INDEX

D

E

F

G

H

I

L

M

N

O

P

Q

R

T

U

V

W

APPENDIX

Appendix 1. Meetings and Taking Action

	Medical Staff Meetings	MEC	Credentials Committee & Other Medical Staff Committees	Departments/ Sections
Meeting frequency	At least once each medical staff year (the medical staff year is from 5/1 to 4/30)	As often as needed to perform their functions, as determined by the chairperson	As often as needed to perform their functions, as determined by the chairperson	As often as needed to perform their functions, as determined by the chairperson
Meeting notice	By email to voting medical staff members at least 14 days before the meeting	May be given in any manner the chairperson determines appropriate	May be given in any manner the chairperson determines appropriate	May be given in any manner the chairperson determines appropriate
Quorum	At least 10% of voting medical staff members (present or represented by proxies)	Majority of voting members present at the meeting	Credentials Committee: Majority of voting members present at the meeting Other Medical Staff Committees: That number of voting committee members who are present at the meeting, but <u>cannot</u> be less than two committee members	*Whichever is <u>greater</u>*: - At least 10% of the active members assigned to the department; <u>OR</u> - Those active members assigned to the department who are present but must be at least 2.
Who may vote	Active staff; current/former medical staff officers; and current *<u>medical staff members</u>* of the credentials committee, a peer review committee, a quality/CI committee or a best practice committee	All members, including APP committee members, *except* for the CCO, hospital president, CNO, pharmacy representative and the medical staff office manager	Voting members (including APP committee members)	Active staff members of the department/ section and the chairperson (APPs *<u>cannot</u>* vote
Voting method	At a meeting with a quorum <u>OR</u> By ballot (must have at least 5 days to return ballots and at least 10% of ballots must be returned. Cannot vote by ballot to remove an officer)	At a meeting with a quorum <u>OR</u> By ballot (must have at least 5 days to return ballots and at least a majority of ballots must be returned. Cannot vote by ballot to remove an officer or chairperson)	At a meeting with a quorum <u>OR</u> By ballot (must have at least 5 days to return ballots and at least a majority of ballots must be returned)	At a meeting with a quorum <u>OR</u> By ballot (must have at least 5 days to return ballots and at least a majority of ballots must be returned. Cannot vote by ballot to remove a chairperson)
Proxy voting	Voting medical staff members may designate in writing another voting member to cast his/her proxy vote during a meeting	Not allowed (but is allowed for the MEC's executive committee)	Not allowed	Not allowed
Votes to Pass	Majority of votes cast (Bylaw amendments require at least 2/3 of votes cast and removing an officer requires at least a 2/3 vote of <u>all</u> voting medical staff members)	Majority of votes cast (Removing an officer or a chairperson requires at least a 2/3 vote of <u>all</u> voting MEC members)	Majority of votes cast	Majority of votes cast (Removing a chairperson requires at least a 2/3 vote of <u>all</u> voting members assigned to the department/ section)

Appendix 2. Clinical Departments & Specialty Sections

The medical staff's clinical departments and their sections, if any, are listed below.

1. **Department of Anesthesiology** with a specialty section of pain medicine (hospital-based department)
2. **Department of General Surgery**
3. **Department of Gynecology**
4. **Department of Medicine**
5. **Department of Neurosurgery**
6. **Department of Ophthalmology**
7. **Department of Oral Surgery**
8. **Department of Otolaryngology**
9. **Department of Pathology/ Laboratory Medicine** (hospital-based department)
10. **Department of Plastic Surgery**
11. **Department of Orthopedics**
12. **Department of Radiology** (hospital-based department)
13. **Department of Urology**

Appendix 3. MEC Membership

MEC membership is set out in the chart below. Non-voting members are designated by an asterisk and are full members of the MEC even though they do not have voting rights.*

1. Chief of staff
2. Vice-chief of staff
3. Immediate past chief of staff
4. Credentials committee chairperson
5. OR committee chairperson & CIC chairperson
6. Department chairpersons:
   a. Anesthesiology
   b. General Surgery
   c. Gynecology
   d. Medicine
   e. Neurosurgery
   f. Ophthalmology
   g. Oral Surgery
   h. Otolaryngology
   i. Pathology/ Laboratory Medicine
   j. Plastic Surgery
   k. Orthopedics
   l. Radiology
   m. Urology
7. At least one APP from APP category 2 to be selected by the nominating committee
8. CCO*
9. Hospital president*
10. CNO*
11. Pharmacy representative*
12. Medical staff office manager*

Appendix 4. Medical Staff Categories: Rights and Responsibilities

	Active	Courtesy	Consulting	Telemedicine	Affiliate	Locum Tenens
Required to take unassigned call	Yes[1]	No (but department chairperson may require it[1])	No (but department chairperson may require it[1])	No	No	No (but department chairperson may require it)
Request exemption from unassigned call	Yes - as allowed by medical staff rules & regulations	Yes - as allowed by medical staff rules & regulations (if required to take unassigned call by the chairperson)	Yes - as allowed by medical staff rules & regulations (if required to take unassigned call by the chairperson)	N/A	N/A	N/A
Attend & vote at medical staff meetings	Yes	Attend but not vote[2]	Attend but not vote[2]	Attend but not vote[2]	Attend but not vote[2]	No
Attend & vote at department/ section meetings	Yes	Attend but not vote (may vote if serving as the chairperson)	Attend but not vote (may vote if serving as the chairperson)	Attend but not vote	Attend but not vote (may vote if serving as the chairperson)	Attend but not vote
Serve & vote on medical staff committees	Yes	Yes	Yes	Yes	Yes	No
Eligible to be a medical staff officer	Yes	No	No	No	No	No
Eligible to be a department chairperson	Yes	No (but may if no active members of the department[3])	No (but may if no active members of the department[3])	No	No (but may if no active members of the department[3])	No

[1] For those departments/sections that provide unassigned patient call due to community need

[2] May vote if a former medical staff officer/department chairperson, or a current member of the credentials committee, or a peer review, quality/CI or best practice committee

[3] Department chairpersons do not have be members of the active staff for those departments that do not have active members assigned to them (*e.g.,* departments that are largely outpatient based, such as family practice and pediatrics).

Appendix 5. Policy References

1. Advance Directives (NH-RE-BE-240)
2. Conflict of Interest (NH-MS-208)
3. Conflict Management for Leaders and Leadership Groups (MH-LD-AD-270)
4. EMTALA (NH-PC-CC-1132)
5. Informed Consent (NH-RE-RI-120)
6. Peer Review (NH-MS-211)
7. Portable Do Not Resuscitate Orders and Medical Orders for Scope of Treatment (NH-RE-BE-220)
8. Procedural Verification, Site Marking and Time Out (NH-PC-PS-1655)
9. Professional Conduct (NH-MS-207)
10. Refusal of Care (NH-RE-RI-12)
11. Reportable Situations (NH-LD-LG-110)
12. Restraint and Seclusion (NH-PC-PS-1690)
13. Right to a Natural Death (NH-RE-BE-100)
14. Seasonal Influenza Vaccination (MH-MS-300)

Appendix 6. Bylaw Adoption & Approval Dates

Medical Staff	Board of Trustees
4/29/2017	5/24/2017
2/28/2019	3/12/2019
1/5/2021	2/24/2021
11/14/2022	11/30/2022