MEDICAL STAFF BYLAWS

PENDER MEMORIAL HOSPITAL

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MEDICAL STAFF BYLAWS

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ARTICLE 1

DEFINITIONS

(1) "ALLIED HEALTH PROFESSIONALS" means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. Allied Health Professional are described as Category I Practitioners, Category II Practitioners or Category III Practitioners in the Medical Staff Bylaws documents:

- "CATEGORY I PRACTITIONER" means an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I Practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges as moonlighting residents.

- "CATEGORY II PRACTITIONER" means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.

- "CATEGORY III PRACTITIONER" means a type of Allied Health Professional who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 8 of this Policy, all aspects of the clinical practice of Category III Practitioners at the Hospital will be assessed and managed in accordance with Human Resources policies and procedures, and the provisions of this Policy specifically will not apply.

- Hereafter, except as otherwise expressly stated in this Policy and the Medical Staff Bylaws, the term "Allied Health Professional" will be limited to Category I Practitioners and Category II Practitioners.

  For ease of use, when applicable to Allied Health Professionals, any reference in this Policy to "appointment" or "reappointment" shall be interpreted as a reference to initial or continued permission to practice.

(2) "APPLICANT" means any individual who has submitted an application for initial appointment, reappointment, or clinical privileges.

(3) “BOARD” means the Board of Trustees of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(4) “PRESIDENT OF THE HOSPITAL” means the individual appointed by the Board to act on its behalf in the overall management of Hospital.

(5) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

(6) "COMPLETE” An application will be complete when all questions presented to the individual have been answered, all supporting documentation (including adequate responses from references and all information in the possession of third parties that has been deemed necessary for full and appropriate evaluation of the applicant’s qualifications) has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information.

(7) “DAYS” means calendar days, including weekends and holidays. Time limits referred to in these Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated otherwise.

(8) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

(9) “DEPARTMENT OF MEDICINE” includes the following specialty sections: Cardiology, Emergency Medicine, Family/Internal Medicine, Gastroenterology, Neurology, Pediatrics, Psychiatry, and Radiology.

(10) “DEPARTMENT OF SURGERY” includes the following specialty sections: Anesthesiology, General Surgery, Neurosurgery, Obstetrics/Gynecology, Ophthalmology, Orthopedics/Podiatry, Otolaryngology, Pathology/Laboratory Medicine, Plastic Surgery, Urology, and Vascular Surgery.

(11) “HOSPITAL” means Pender Memorial Hospital.

(12) “MEDICAL STAFF” means all physicians, dentists, and oral and maxillofacial surgeons who have been appointed to the Medical Staff by the Board.

(13) “MEDICAL STAFF LEADER” means any medical staff officer, any medical staff committee chair or member, or any chairperson of a clinical department or specialty section.

(14) “MEDICAL STAFF MEMBER” means a physician, dentist, or oral and maxillofacial surgeon who has been granted Medical Staff appointment by the Board.

(15) “MEDICAL STAFF SERVICES” means the Medical Staff Services department at the Hospital or any delegated Credentials Verification Organization (“CVO”).

(16) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(17) “ORAL AND MAXILLOFACIAL SURGEON” means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(18) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed on a Hospital patient.

(19) "PEER REVIEW COMMITTEES” includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

(20) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(21) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA.

(22) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the HCQIA.

(23) “RESTRICTION” means a professional review action based on clinical competence or professional conduct which results in the inability of a practitioner to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree before privileges can be exercised).

(24) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(25) "SUPERVISING/COLLABORATING PHYSICIAN" means a member with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II Practitioner or Category III Practitioner and to accept full responsibility for the actions of the Category II Practitioner or Category III Practitioner while he or she is practicing in the Hospital.

(26) "SUPERVISION" means the supervision of (or collaboration with) a Category II Practitioner or Category III Practitioner by a supervising physician, that may or may not require the actual presence of the supervising physician, but that does require, at a minimum, that the supervising physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Category II Practitioner or Category III Practitioner is credentialed and will be consistent with any applicable written supervision or collaboration agreement.

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

(28) "TELEMEDICINE" is the provision of clinical services to patients by practitioners from a distance via electronic communications.

ARTICLE 2

MEDICAL STAFF CATEGORIES AND MEMBERSHIP

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff will consist of members of the Medical Staff who are involved in at least 25 patient contacts at the Hospital during the year.

An applicant for initial appointment may be appointed to the Active Staff category based on his or her expressed, expected practice patterns. Eligibility to continue in the category at the time of reappointment will be assessed based on the member's actual practice patterns during the prior term.

Unless an Active Staff member can demonstrate to the satisfaction of the MEC at the time of reappointment that his or her practice patterns have changed and that he or she will satisfy the activity requirements of this category, any member who has fewer than 25 patient contacts during each year of his or her appointment term will not be eligible to request Active Staff status at the time of his or her reappointment. The member must select another staff category that best reflects his or her relationship to the Medical Staff and the Hospital in order to have an application for reappointment processed.

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients;

(b) vote in general and special meetings of the Medical Staff and applicable committee meetings;

(c) hold office, serve on Medical Staff committees, and serve as committee chair; and

(d) exercise clinical privileges granted.

2.A.3. Responsibilities:

(a) Active Staff members must assume all the responsibilities of the Active Staff, including:

(1) serving on committees, as requested;

(2) as requested by the Hospital and Medical Staff leadership, providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients;

(3) participating in the professional practice evaluation and performance improvement processes;

(4) accepting inpatient consultations, when requested; and

(5) paying application fees.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who:

(a) are involved in 24 or less patient encounters during the year; and

(b) are members of the active staff or associate staff at another hospital, unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement.

Unless a Courtesy Staff member can demonstrate to the satisfaction of the MEC at the time of reappointment that his or her practice patterns have changed and that he or she will satisfy the activity requirements of this category, any Member who has more than 24 patient contacts per year during the previous two-year appointment term will be automatically transferred to Active Staff status, effective upon notice to the practitioner.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may admit patients;

(b) may attend and participate in Medical Staff meetings (without vote);

(c) may not hold office or serve as committee chair, unless waived by the Medical Executive Committee;

(d) may exercise such clinical privileges as are granted;

(e) may be invited to serve on committees (with vote);

(f) as requested by the Hospital and Medical Staff leadership, must provide specialty coverage for the Emergency Department and accept referrals from the Emergency Department for follow-up care of patients, unless specifically excused from this obligation by the Medical Executive Committee;

(g) must cooperate in the professional practice evaluation and performance improvement processes; and

(h) must pay application fees.

2.C. HONORARY STAFF

2.C.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who are no longer traditional members of the Medical Staff, but who have been granted Honorary Staff status upon retiring from the practice of medicine. To be eligible for Honorary Staff status, a practitioner must be a member of the Medical Staff in good standing at the time of their retirement and have been a member of the Medical Staff for at least 10 years immediately prior to their retirement. For purposes of this section, a member is in good standing if he or she is not under investigation or subject to a formal performance improvement plan, nor are his or her clinical privileges restricted or suspended, nor is there a pending adverse professional review recommendation involving the individual.

(b) Honorary Staff status is a courtesy and honor, bestowed by the Hospital Board after receiving the recommendation of the MEC. Once an individual has been granted Honorary Staff status, that status is ongoing unless discontinued through action of the Board. Since Honorary Staff practitioners do not provide patient care services at the Hospital and are not granted clinical privileges as a matter of course, there is no need for an Honorary Staff member to submit a reappointment application, nor be re-credentialed.

2.C.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients, nor be granted clinical privileges (except in disasters and emergencies, in which case they will be credentialed as set forth in these Bylaws);

(b) may attend Medical Staff meetings (without vote);

(c) may serve on committees (with vote), if appointed or elected;

(d) may attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

2.D. TELEMEDICINE STAFF

The Telemedicine Staff will consist of members of the Medical Staff who have been granted telemedicine privileges by the Board, in accordance with these Bylaws. Telemedicine Staff members:

(a) may not hold office or serve as committee chair, may not vote;

(b) are excused from providing specialty coverage for the Emergency Department for unassigned patients except as required under their contract with the Hospital;

(c) must cooperate in the professional practice evaluation and performance improvement processes; and

(d) must pay application fees.

2.E. AFFILIATE STAFF

2.E.1. Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

(a) desire to be associated with, but who do not intend to establish a practice at, the Hospital;

(b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital; and

(c) satisfy the qualifications for appointment set forth in the Medical Staff Bylaws, but are exempt from the qualifications pertaining to response times, location within the geographic service area, emergency call, and coverage arrangements.

2.E.2. Prerogatives and Responsibilities:

Granting of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to a hearing or appeal. Community Affiliate Staff members:

(a) may serve on committees (with vote), including as committee chair;

(b) may attend educational activities sponsored by the Medical Staff and the Hospital;

(c) may refer patients to members of the Medical Staff for admission and care;

(d) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

(e) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(f) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(g) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders for inpatients, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital;

(h) may refer patients to the Hospital's diagnostic facilities and order such tests;

(i) are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(j) must pay application fees.

2.F. MEDICAL STAFF APPLICATION FEES

(1) Medical Staff and clinical privilege application fees will be set and retained by the Hospital and shall be assessed at the time an application is filed. Failure to submit the applicable application fee shall result in the application not being processed.

2.G. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

ARTICLE 3

MEDICAL STAFF LEADERSHIP

3.A. QUALIFICATIONS

Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the Medical Staff, committee chair, Board member, or as the chairman of a clinical department or specialty section (unless waived by the MEC and Board). They must:

(1) be an Active Staff member in good standing;

(2) have no pending adverse recommendations concerning appointment or clinical privileges;

(3) be willing to faithfully discharge the duties and responsibilities of the position;

(4) participate in any Medical Staff leadership training required by the MEC; and

(5) have demonstrated an ability to work well with others.

3.B. MEDICAL STAFF OFFICERS

The officers of the Medical Staff are the Chief of Staff and Vice Chief of Staff ("the Medical Staff Officers"), who are elected by the Medical Staff, subject to ratification by the Board, and who shall perform the duties outlined in this Section. 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 are also *not* medical staff officers.

3.B.1. Chief of Staff:

The duties of the Chief of Staff are to:

(a) serve as a member of the Board of Trustees;

(b) act in coordination and cooperation with the Chief Medical Officer, the President of the Hospital, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(c) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the President of the Hospital, Chief Medical Officer, and the Board;

(d) call, preside at, and be responsible for the agenda of meetings of the Medical Staff and the MEC;

(e) promote adherence to the Bylaws, policies, rules and regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(f) perform functions authorized in these Bylaws and other applicable policies, including collegial intervention in the Medical Staff Bylaws.

3.B.2. Vice Chief of Staff:

The duties of the Vice Chief of Staff are to:

(a) assume the duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) automatically succeed the Chief of Staff should the office become vacated for any reason during the Chief of Staff's term of office; and

(c) perform any other duties that may be assigned by the Chief of Staff, the MEC, or the Board.

3.B.3. Election:

(a) Except as provided below, the election of officers will take place at a meeting of the Medical Staff. If there are two or more candidates for any office or position, the vote will be by written ballot.

(b) If any voting Member of the Medical Staff is unable to attend the meeting, the Member may vote by absentee ballot. The absentee ballots must be returned to the Medical Staff Office by noon on the date of the meeting. The absentee ballots will be counted prior to the meeting and will be included in the vote at the meeting.

(c) In the alternative, the Chief of Staff may determine that the election will be held by written ballot returned to the Medical Staff Office. Ballots may be returned in person or by mail, facsimile, or e-mail. All ballots must be received in the Medical Staff Office by the date specified, which shall be no sooner than 10 days after the date that the ballots are distributed.

(d) The candidates receiving a majority of the votes cast will be elected, subject to Board confirmation.

(e) If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes. In the event that the run-off results in a tie, the Board of Directors may choose between the remaining candidates.

3.B.4. Term of Office:

(a) Officers will assume office on the first day of the Medical Staff year.

(b) Officers will serve for two-year terms and may be reelected.

3.B.5. Vacancies:

(a) If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve until the end of the unexpired term of the Chief of Staff.

(b) If there is a vacancy in the office of Vice Chief of Staff, the MEC will appoint an individual to the office until a special election can be held. The appointment will be effective upon approval by the Board.

3.B.6. Removal:

(a) Removal of an elected officer may be effectuated by a three-fourths vote of the MEC or by the Board for:

(1) failure to comply with applicable policies, Bylaws, or the Rules and Regulations;

(2) failure to perform the duties of the position held;

(3) conduct detrimental to the interests of the Medical Staff or the Hospital;

(4) an infirmity that renders the individual incapable of fulfilling the duties of that office; or

(5) failure to continue to satisfy any of the criteria for Medical Staff Officers set forth in these Bylaws.

(b) Prior to scheduling a meeting to consider removal, a representative from the MEC or Board will meet with and inform the individual of the reasons for the proposed removal proceedings.

(c) The individual will be given at least ten days' special notice of the date of the meeting at which removal is to be considered. The individual will be afforded an opportunity to address the MEC or the Board, as applicable, prior to a vote on removal.

(d) Removal will be effective when approved by the Board.

3.C. CLINICAL DEPARTMENTS AND SECTIONS

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

- Table 1 on page 19 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.

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.

3.C.1. 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.

3.C.2. Qualifications for Chairpersons

A clinical department or specialty section 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 or board eligible in the specialty they are to lead;

(c) on the active or courtesy staff of a system hospital for at least one year, unless an exception is granted by the Chief of Staff;

(c) a medical staff member of the clinical department or section he/she is to lead; and

(d) able successfully to perform the responsibilities of the position.

3.C.3. Terms for Chairpersons

Chairpersons serve for two- year terms, beginning on January 1st, unless they resign or are removed before the end of their term. There are no term limits, but a medical staff member who is on the medical staff of more than one Novant Health system hospital may only serve as chairperson for one hospital during a term unless approved by the MEC.

3.C.4. Nomination and Election of Chairpersons

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

(a) Nominations of qualified candidates for chairpersons:

(1) 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 3.C.2. for chairperson qualifications). The nominating committee is composed of the Chief of Staff, one or two past Chiefs of Staff (if available), the CMO and the hospital President. The CMO 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. Any nominating committee member who satisfies more than one potential voting category of membership on the committee shall have only one vote and shall qualify

as a voting member regardless of whether they also satisfy another category of membership which is non-voting.

(2) Nominations from the medical staff members of the department
Voting members of the department also may nominate qualified candidates for chairperson (*see* section 3.C.2. for chairperson qualifications). These nominations must:

(i) be in writing;

(ii) be signed by at least 10% of the voting members of the department;

(iii) include a statement from the candidate that he/she is willing to serve as chairperson; and

(iv) be submitted to the medical staff office at least 3 *business* days before the medical staff or department meeting.

(b) 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 or a medical staff meeting. 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.

3.C.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) assist with 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) assist with integrating the department, section or service into the primary functions of the organization;

(f) participate in coordinating and integrating interdepartmental/ sectional and intradepartmental/
sectional services;

(g) participate in developing and implementing policies and procedures that guide and support the provision of care, treatment, and services;

(j) assist in recommending a sufficient number of qualified and competent persons to provide care, treatment, and services;

(h) assist in 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;

(i) continuously assessing and improving the quality of care, treatment, and services;

(j) maintaining quality control programs, as appropriate;

(n) participate in providing orientation and continuing education to all persons in the department or section;

(o) assist in reviewing and recommending space and other resources as needed by the department or service;

(k) 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 governing documents;

(l) assist in monitoring compliance with medical staff and hospital policies and procedures; and

(m) making regular reports on the department's activities to the credentials committee.

3.C.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 3.C.2. 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.

3.C.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:

(1) not performing the chairperson's duties;

(2) not maintaining the qualifications for chairpersons; or

(3) 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.

(1) 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 3.D.2. 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.

(2) 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. 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 <u>cannot</u> vote by proxy or ballot to remove a chairperson*.

<u>3.C.8. Department Meetings and Taking Action</u>

(a) 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.

(b) 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.

(c) 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. All actions taken apply to all practitioners assigned to the department, including those who did not attend the meeting or vote.

(1) 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.

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.

(d) 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.

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.

3.D. MEDICAL STAFF COMMITTEES

3.D.1. Performance Improvement Functions

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following and shall accomplish these tasks through the Medical Executive Committee or such other committees which may from time to time be created in accordance with these Bylaws:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on applicable accreditation-related and Centers for Medicare & Medicaid Services measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) healthcare associated infections;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of patients' medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, which are set forth in Article 9 of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

3.D.2. Medical Executive Committee

(1) Membership on the MEC

The Medical Executive Committee is comprised of the following members. Non-voting members are designated by an asterisk* and are full members of the MEC even though they do not have voting rights.

- Chief of Staff;
- Immediate past Chief of Staff;
- Department Chairpersons:
  - Department of Medicine Chairperson;
  - Department of Surgery Chairperson;
- A Hospitalist team representative to be nominated by the nominating committee of the MEC (but not if a hospitalist is on the MEC as a Department Chairperson);
- Chief Medical Officer*;
- Chief Clinical Officer*;
- Chief Nursing Officer*;
- Pharmacy Representative*;
- Medical Staff Office Manager (or designee)*; and
- Hospital President*

The Chief of Staff will serve as the chair, with vote. Other individuals may be invited to Medical Executive Committee meetings as guests, without vote. Any MEC member who satisfies more than one potential voting category of membership on the MEC shall have only one vote and shall qualify as a voting member regardless of whether they also satisfy another category of membership which is non-voting.

(2) Duties of the MEC

The Medical Executive Committee is delegated the primary authority over activities related to the Medical Staff and to performance improvement activities. This authority may be modified by amending these Bylaws and related policies. The Medical Executive Committee is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(b) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual clinical privileges and scope of practice;

(iii) applicants for Medical Staff appointment and reappointment;

(iv) delineation of clinical privileges for each practitioner privileged through the Medical Staff process;

(v) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(vi) the mechanism by which Medical Staff appointment may be terminated;

(vii) hearing procedures; and

(viii) reviewing reports and recommendations from Medical Staff Officers, Medical Staff committees and other groups, as appropriate;

(c) consulting with Administration on quality-related aspects of contracts for patient care services;

(d) providing oversight and guidance with respect to continuing medical education activities;

(e) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) requesting professional reviews and investigations and collegial action or corrective action, as needed;

(h) providing oversight in the process of analyzing and improving patient satisfaction;

(i) ensuring that the Bylaws and applicable policies are reviewed and updated periodically;

(j) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;

(k) recommending clinical services, if any, to be provided by telemedicine;

(l) reviewing and approving all standing orders for consistency with nationally recognized and evidence-based guidelines;

(m) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies

(n) meeting as often as necessary to fulfill its responsibilities; and

(o) maintaining a permanent record of its proceedings and action.

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.

3.D.3. Credentials Committee

(1) Membership of the Credentials Committee
The Credentials Committee shall be comprised of the following members. Non-voting members are designated with an asterisk* and are full members of the Credentials Committee even though they do not have voting rights.

- Chief of Staff;
- Chairperson of the Department of Medicine;
- Chairperson of the specialty section of Emergency Medicine;
- Chairperson of the specialty section of Family/Internal Medicine;
- Chairperson of the Department of Surgical Services;
- Outcomes Manager*;
- Hospital President*
- Chief Medical Officer*; and
- Medical Staff Office Manager (or designee)*

The Chief of Staff may invite additional Chairpersons, Medical Staff Members, Practitioners, or Hospital personnel to attend a particular Credentials Committee meeting (as guests, without vote) as needed in order to assist the Credentials Committee in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the Credentials Committee. The

Chief of Staff will serve as Chair of the Credentials Committee. Any Credentials Committee member who satisfies more than one potential voting category of membership on the Credentials Committee shall have only one vote and shall qualify as a voting member regardless of whether they also satisfy another category of membership which is non-voting.

(2) Duties of the Credentials Committee
The Credentials Committee is responsible for the following:

(a) review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) when requested to do so, review information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or granted clinical privileges and, as a result of such review, make a written report of its findings and recommendations;

(b) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including clinical privileges for new procedures and clinical privileges that cross specialty lines; and

(c) monitor the initial focused professional practice evaluation and ongoing professional practice evaluation processes.

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.

3.D.4. Other Medical Staff Committees

(a) The Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional standing committees to perform one or more staff functions. The Medical Executive Committee may also dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

(b) Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special ad hoc committee will be performed by the Medical Executive Committee.

(c) Ad hoc committees may be created, and their members and chair will be appointed by the Chief of Staff and the Medical Executive Committee, unless otherwise specifically stated in these Bylaws or other relevant policy. Ad hoc committees will confine their activities to the purpose for which they were appointed and will report to the Medical Executive Committee.

3.E. MEDICAL STAFF MEETINGS

(a) Except as provided in these Bylaws, the Medical Staff and its committees will meet as often as needed to perform their designated functions.

(b) Regular meetings of the Medical Staff will be scheduled by the Chief of Staff, by providing notice of the date, time, and place to all members of the Medical Staff at least 14 days in advance of the meeting.

(c) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the Medical Executive Committee, the President, or the chair of the Board by providing notice of the date, time, place, and agenda to all members of the Medical Staff at least 48 hours in advance of the meeting. Posting may not be the sole mechanism for providing notice of a special meeting. No business will be transacted at any special meeting except that which is stated in the meeting notice.

(d) Attendance at, or participation in, any meeting will constitute a waiver of an individual's notice of the meeting.

(e) For any regular or special meeting of the Medical Staff or committee, those voting members present (but not fewer than two members) will constitute a quorum. Once a quorum has been established, the business of the meeting may continue and any actions taken will be binding, even if the number of voting members decreases during the course of the meeting.

(f) The chair of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff or committee.

(g) The chair of the relevant body has the discretion to conduct a meeting in person, by telephone conference, or by videoconference. A member of the Medical Staff participating in a meeting by this means is deemed to be present in person at the meeting. Further, as an alternative to a formal meeting, the chair may also present

voting members with a question by mail, facsimile, e-mail, hand-delivery with their votes returned to the chair by the method designated in the written document. In such cases, a quorum for purposes of these votes will be the number of responses returned to the chair by the date indicated. The question raised will be determined in the affirmative and will be binding if a majority of the responses returned has so indicated.

(h) The chair shall have the authority to rule definitively on all matters of procedure. While Robert's Rules of Order may be used for reference, in the discretion of the chair, it shall not be binding. Rather, specific provisions of these Bylaws and Medical Staff or committee custom shall prevail at all meetings.

(i) Recommendations and actions taken by the Medical Staff and committees will ideally be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the voting members. Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. There shall be no proxy voting.

(j) Minutes of Medical Staff and committee meetings will be prepared. They will include a record of the attendance of members and the recommendations made. A copy will be forwarded to the MEC and President of the Hospital, who will cause a permanent file of the minutes of meetings to be maintained by the Hospital.

3.F. PEER REVIEW PROTECTIONS

All professional review activity will be performed by medical review committees. Medical review committees are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq. and North Carolina's statutes and regulations, including N.C. Gen. Stat. §§ 90-21.22A and 131E-95. Medical Review Committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) the Medical Staff Leaders, experts or consultants retained to assist in professional review activity; and any individual or body acting for or on behalf of a medical review committee.

3.G. CONFIDENTIALITY

All professional review activity (including oral and written communications, reports, recommendations, actions, and minutes) will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized by the President of the Hospital or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or any Allied Health Professional who becomes aware of a breach of confidentiality is encouraged to inform the President of the Hospital or the Chief of Staff (or the Vice Chief of Staff, if the Chief of Staff is the person committing the alleged breach).

3.H. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff officers, committee chairs, committee members, chairpersons of services, and their authorized representatives, whenever they are acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Corporate Bylaws.

3.I. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff or Allied Health Professional member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES
OF MEMBERSHIP & PRIVILEGES

4.A. QUALIFICATIONS

4.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must, as applicable:

(a) have a current, unrestricted license to practice in North Carolina that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration; unless specifically not required per Pender Memorial Hospital specialty specific privilege.

(c) be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have never had Medical Staff or Allied Health Professional appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(g) have never resigned Medical Staff or Allied Health Professional appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;

(h) have never been terminated from a post-graduate training program (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(i) since the beginning of medical training (e.g., residency), have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts, (v) sexual misconduct, (vi) moral turpitude, or (vii) child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse;

(j) agree to fulfill all responsibilities regarding emergency call for their specialty;

(k) have an appropriate coverage arrangement, as determined by the MEC, with other members of the Medical Staff for those times when the individual will be unavailable;

(l) document compliance with all applicable training and educational protocols that may be adopted by the MEC and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;

(m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;

(n) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;

(o) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital, during the last two years;

(p)[1] have successfully completed:

(i) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;

(ii) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(iv) for Allied Health Professional, have satisfied the applicable training requirements as established by the Hospital.

(q)[1] be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Foot and Ankle Surgery ("ABFAS"), as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training; and

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1 These residency training and board certification requirements will be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing members will be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

(s) if seeking to practice as a Category II Practitioner, must have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of North Carolina law and Hospital policy.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver must be submitted to Medical Staff Services. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in their discretion, consider the application form and other information supplied by the applicant.

(c) The Credentials Committee will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted; only that processing of the application can begin.

4.A.3. Factors for Evaluation:

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

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.A.4. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed, reappointed or be granted or exercise particular clinical privileges merely because he or she:

(a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff or Allied Health Professional appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

4.A.5. Employment Policies Not Applicable:

Appointment and clinical privileges, and the process for considering an individual's request for the same, are not part of the employment process and it is understood that the Hospital's employment policies and processes, are not applicable.

4.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, or national origin.

4.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, & CLINICAL PRIVILEGES

4.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and maintenance of clinical privileges, every individual specifically agrees to the following:

(a) to provide continuous and timely care;

(b) that he or she is subject to and shall abide by the Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

(c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) to be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. "Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the MEC. Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:

(1) respond within 15 minutes, via phone, to a call or page from the Hospital; and

(2) appear in person to attend to a patient within 45 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

(e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the MEC, or document the clinical reasons for variance;

(f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(h) to use the Hospital sufficiently to allow continuing assessment of current competence;

(i) to seek consultation whenever necessary;

(j) to complete in a timely manner all medical and other required records;

(k) to conduct himself or herself in a cooperative and professional manner;

(1) to promptly pay any applicable dues, assessments, or fines;

(m) to utilize the Hospital's electronic medical record system;

(n) to satisfy continuing medical education requirements;

(o) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;

(p) to comply with all applicable training and educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(q) to maintain a current NHRMC e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Professional information to the member and the primary mechanism of providing Notice to the individual;

(r) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

(s) if the individual serves or plans to serve as a Supervising Physician to a Category II Practitioner or Category III Practitioner, that he or she will abide by the conditions of practice set forth in Article 8; and

(t) if the individual is a Category II Practitioner or Category III Practitioner, that he or she will abide by the conditions of practice set forth in Article 10.

4.B.2. Burden of Providing Information:

(a) All individuals have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Individuals have the burden of providing evidence that all the statements made, and all information provided in support of the application are accurate and complete.

(c) Applicants are responsible for providing a Complete application, including adequate responses from references and all information requested from third parties for a proper evaluation.

(d) An incomplete application will not be processed. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(e) Applicants and members are responsible for notifying the Chief of Staff or the President of the Hospital of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:

(i) any information on the application form;

(ii) any threshold eligibility criteria for appointment or clinical privileges;

(iii) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

(iv) changes in professional liability insurance coverage;

(v) the filing of a professional liability lawsuit against the practitioner;

(vi) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(vii) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and

(viii) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health).

4.C. APPLICATION

4.C.1. Information:

(a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the MEC.

(b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.

(c) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

4.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and President of the Hospital will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

4.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

(a) Conditions Prerequisite to Application and Consideration:

As a condition of (i) having a request for application considered or (ii) applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

(i) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, or clinical privileges are granted;

(ii) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and

(iii) survive for all time, even if appointment, reappointment, or clinical privileges is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, or clinical privileges, or the individual's qualifications for the same, including, but not limited to:

(i) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or Medical Staff policies and rules and regulations;

(iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System:

The individual authorizes the Hospital and any other organization under common ownership, control, or management to share credentialing and peer review information with one another.

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(d) Hearing and Appeal Procedures:

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

(e) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Allied Health Professionals, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or North Carolina law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Allied Health Professional, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 5

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

5.A. APPLICATION FORMS

(a) Prospective applicants will be sent the application form and a copy of these Medical Staff Bylaws.

(b) A completed application form with copies of all required documents must be returned to Medical Staff Services within 30 days after receipt. The application must be accompanied by the application fee.

(c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

5.B. INITIAL REVIEW OF APPLICATION

(1) As a preliminary step, the application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to submit Complete applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(2) Medical Staff Services will oversee the process of gathering and verifying relevant information and confirming that all references and other information deemed pertinent have been received.

(3) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.

(4) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: the MEC, the Credentials Committee, the Chief of Staff, the Chief Medical Officer, the Chairperson of the relevant department (if applicable), or the President of the Hospital.

5.C. REVIEW BY THE CHAIRPERSON OF THE SERVICE

Medical Staff Services will transmit the complete application and all supporting materials to the Chairperson of each department in which the applicant seeks clinical privileges (as applicable). In the absence of a Chairperson for the department in which the applicants seek to practice, the application shall be transmitted to the Chief of Staff, who shall perform the review set forth in this section in lieu of a Chairperson. The Chairperson of the department or Chief of Staff, as applicable, will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges. The report will be on a form provided by Medical Staff Services. The Chief Nursing Executive will also review and report on the applications for all advanced practice registered nurses.

5.D. CREDENTIALS COMMITTEE REVIEW

(a) The Credentials Committee will consider the report prepared by the Chairperson of the department or Chief of Staff, as applicable, and will make a recommendation.

(b) The Credentials Committee may use the services of an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Credentials Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.

5.E. MEC RECOMMENDATION

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MEC will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the MEC is to appoint and/or grant the privileges requested, the recommendation will be forwarded to the Board.

(c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC will forward its recommendation to the President of the Hospital, who will promptly send special notice to the applicant. The President of the Hospital will then hold the application until after the applicant has completed or waived a hearing and appeal.

5.F. BOARD ACTION

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

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source for additional research or information; or

(3) modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the MEC. If the Board's determination remains unfavorable, the President of the Hospital will promptly send special notice that the applicant is entitled to request a hearing

(d) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

5.G. TIME PERIODS FOR PROCESSING

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

CLINICAL PRIVILEGES

6.A. CLINICAL PRIVILEGES

6.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract.

(d) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

6.A.2. Privilege Waivers:

(a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)

(b) In limited circumstances, the Hospital may consider a waiver of the requirement that clinical privileges be granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to Medical Staff Services. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.

(d) The following factors, among others, may be considered in deciding whether to grant a waiver:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(3) the expectations of members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(e) If the Board grants a waiver related to privileges, it will specify the effective date. In addition, the Board will determine whether the individual granted the waiver must continue to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the Emergency Medicine physician(s) in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

6.A.3. Relinquishment of Individual Clinical Privileges:

A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of clinical privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

6.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief of Staff, the President of the Hospital will act on the request.

6.A.5. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the Chairperson of the relevant department (if applicable) and the Credentials Committee, addressing the following

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Chairperson of the relevant department (if applicable) and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) The Credentials Committee will forward a recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

6.A.6. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., the Chairperson of the relevant department, if applicable, or individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If he or

she does so, the Credentials Committee may also develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee will forward his or her recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

6.A.7. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral and maxillofacial surgeons with appropriate clinical privileges may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, in accordance with the delineated clinical privileges granted by the Credentials Committee and MEC. If admission to the Hospital is required, arrangements should be established in advance of the patient's admission to ensure that a physician on the Medical Staff is available to assist should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician or

oral and maxillofacial surgeon with appropriate clinical privileges who is a member of the Medical Staff before dental or oral surgery may be performed. If admission to the Hospital is required, arrangements shall be established in advance of the patient's admission to ensure that a physician on the Medical Staff is available to respond should any medical issue arise with the patient.

(c) The dentist or oral and maxillofacial surgeon will be responsible for the oral surgery care of the patient, including, in accordance with the clinical privileges granted by the Credentials Committee and MEC, an appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

6.A.8. Clinical Privileges for Podiatrists:

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

6.A.9. Physicians in Training:

(a) Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or

day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the MEC or its designee. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Individuals who are in training who wish to moonlight (outside of the training program) may do so only if granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program training requirements. Loss of employment by the Hospital in the training program will result in the automatic relinquishment of any clinical privileges, without a right to the hearing and appeal procedures.

6.A.10. Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.

(b) Requests for initial or renewed Telemedicine privileges will be processed through one of the following options, as determined by the President in consultation with the Chief of Staff:

(1) A request for Telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Professional applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting Telemedicine privileges is practicing at a distant hospital that participates in Medicare or a Telemedicine entity (as that term is defined by Medicare), and the hospital or Telemedicine entity is accredited by the Joint Commission[2], a request for Telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or Telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or Telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or Telemedicine entity must provide:

2 The requirement that the telemedicine entity be Joint Commission accredited shall apply only so long as Pender Memorial Hospital maintains accreditation through the Joint Commission.

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

This information received about the individual requesting Telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for Telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Telemedicine privileges, if granted, will be for a period of not more than two years.

(d) Individuals granted Telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing Telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

6.A.11. Focused Professional Practice Evaluation for Initial Privileges:

(a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused

professional practice evaluation by a physician(s) designated by the Credentials Committee.

(b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.

(c) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

6.B. TEMPORARY CLINICAL PRIVILEGES

(1) Temporary privileges may be granted by the President of the Hospital, upon recommendation of the Chief of Staff, as follows:

(a) 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:

(i) all required information has been received and raises no concerns;

(ii) 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;

(iii) the applicant meets all qualifications and conditions of appointment set out in these bylaws;

(iv) a query from the National Practitioner Data Bank has been obtained and evaluated;

(v) 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

(vi) the department chairperson and the credentials committee have recommended that clinical privileges be granted.

(b) To a non-applicant, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

(ii) when necessary to prevent a lack of services in a needed specialty area;

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff or Allied Health Professional.

(2) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.

(3) The grant of temporary clinical privileges will not exceed 120 days.

(4) For non-applicants who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

(a) the individual must notify Medical Staff Services at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(b) the individual must inform Medical Staff Services of any change that has occurred to the information provided on the application form for locum tenens privileges.

(5) Prior to any temporary clinical privileges being granted, the individual must agree in writing that he or she is subject to and shall abide by the Bylaws, policies, and Rules and Regulations of the Medical Staff and the Hospital and any revisions or amendments thereto.

(6) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the President of the Hospital at any time, after consulting with the Chief Medical Officer, Chief of Staff, or the Chairperson of the relevant department (if applicable).

(7) The Chief of Staff or Chief Medical Officer will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

6.C. EMERGENCY SITUATIONS

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

(2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the Chief Medical Officer or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

6.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President of the Hospital or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer Category I Practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical

Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff or Allied Health Professional member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer Category I Practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

6.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS

(1) From time to time, the Hospital may enter into contracts or arrangements with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract or arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution or other arrangement limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioners except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) Prior to the Hospital entering into any exclusive contract described in paragraph (2) in a specialty area that has not previously been subject to such a contract or arrangement, the Board will request the MEC to comment on the matter. The MEC (or a subcommittee of its members appointed by the Chief of Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and will neither be disclosed to the MEC nor be discussed as part of the MEC's review.

(4) After receiving the MEC's report, the Board will determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:

(a) The affected member will be given at least 30 days' advance notice of the exclusive contract or Board resolution and have the right to meet with the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.

(b) At the meeting, the affected member will be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.

(c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member will be notified that he or she is ineligible to continue to exercise

the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(d) The affected member will not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.

(e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or arrangement, the terms of the contract or arrangement will control.

ARTICLE 7

PROCEDURE FOR REAPPOINTMENT

7.A. TERMS OF INITIAL APPOINTMENT CONTINUE TO APPLY

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

7.B. REAPPOINTMENT CRITERIA

7.B.1. Eligibility for Reappointment:

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

(a) completed all medical records such that he or she is not delinquent, as per the Medical Staff Rules and Regulations and Hospital policy, at the time he or she submits the application for reappointment or renewal of clinical privileges and, further, must have not been deemed delinquent (sufficient to result in voluntary relinquishment of any privileges) more than four times during the prior term of medical staff membership or clinical privileges;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff and Allied Health Professional responsibilities;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) paid any applicable application fee; and

(f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application will be considered complete and processed further.

7.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors considered at the time of initial appointment or the initial grant of privileges will be taken into account. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments and emergency call, if applicable;

(c) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients or staff; and

(f) other reasonable indicators of continuing qualifications.

7.C. REAPPOINTMENT PROCESS

7.C.1. Reappointment Application Form:

(a) Appointment terms will not extend beyond two years.

(b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 30 days.

(c) Failure to return a completed application within 30 days may result in the assessment of an additional reappointment application fee. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(d) Medical Staff Services will oversee the process of gathering and verifying relevant information. Medical Staff Services will also be responsible for confirming that all relevant information has been received.

(e) The application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

7.C.2. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

7.C.3. Potential Adverse Recommendation:

(a) If the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

ARTICLE 8

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS OR ALLIED HEALTH PROFESSIONALS

8.A. OVERVIEW AND GENERAL PRINCIPLES

8.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

(a) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to address and resolve questions that may be raised about members of the Medical Staff and the Allied Health Professional. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) automatic relinquishment of appointment and clinical privileges;

(6) leaves of absence;

(7) precautionary suspension; and

(8) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health

policy, peer review policy) or should be referred to the MEC or another medical staff committee (such as a standing or ad hoc peer review committee) for further action.

8.A.2. Documentation:

(a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) Any documentation of a meeting that is prepared by Hospital or Medical Staff Leaders to memorialize a meeting with an individual and the discussion held at that meeting will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

8.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the President of the Hospital.

8.A.4. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and President of the Hospital, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the MEC that the individual failed to attend the meeting.

8.A.5. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

8.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Professional Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Professional, the Supervising Physician (if any) will be notified and may be invited to participate.

8.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Hospital Administration but are not mandatory.

(3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

(d) communicating expectations for professionalism and behaviors that promote a culture of safety;

(e) informational letters of guidance, education, or counseling; and

(f) Performance Improvement Plans.

8.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

8.D. MANDATORY MEETING

(1) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.

(2) Notice will be given at least five days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

8.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

(3) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

8.F. AUTOMATIC RELINQUISHMENT

Any of the occurrences described below, in this Section 8.F., will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

Except as provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

8.F.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, may result in automatic relinquishment of all clinical privileges.

8.F.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

8.F.3. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction,

plea of guilty or plea of no contest pertaining to any felony or misdemeanor involving the following will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

8.F.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff or President of the Hospital of any change in any information provided on an application for initial appointment or reappointment may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the MEC, or any other authorized committee may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

8.F.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

8.F.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the MEC and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

8.F.7. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the

Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

8.F.8. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time allowed pursuant to the Medical Staff Rules and Regulations will result in automatic resignation from the Medical Staff and automatic relinquishment of all clinical privileges without the option for reinstatement.

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (d) below.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the Chairperson of the relevant department (if applicable), the Chief Medical Officer, the Chief of Staff, and the President of the Hospital. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, the full MEC, and the full Board for review, recommendation, and action.

(e) Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Professional.

8.G. ACTIONS OCCURRING AT OTHER HOSPITALS AND FACILITIES WITHIN THE SYSTEM

(1) Each hospital, health care facility, or other organization that provides health care services and which is under common ownership, control, or management with the Hospital (hereinafter "facilities within the System") is authorized to share information regarding the implementation or occurrence of any of the following actions with any of the facilities within the System at which an individual has a pending application for employment, appointment to the medical staff, or clinical privileges or at which the individual maintains medical staff appointment, clinical privileges, or any other permission to care for patients:

(a) a professional review action;

(b) automatic relinquishment of appointment or clinical privileges;

(c) any involuntary modification of appointment or clinical privileges; and

(d) a Performance Improvement Plan.

(2) Upon receipt of notice that any of the actions set forth in (1) have occurred at, or been implemented by, any of the facilities within the System, that action will automatically and immediately take effect at the facility receiving notice;

(3) The effectiveness of an action any of the facilities within the System, as set forth above, may be waived by the Board of the particular facility after consulting with its physician leaders. The automatic effectiveness of the action, as set forth in (2), will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

(a) in exceptional circumstances;

(b) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or hospital operations; and

(c) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Hospital or other facility where

the action first occurred. The burden is on the Practitioner to provide evidence showing that a waiver is appropriate.

(4) Neither the automatic effectiveness of any action set forth in (1) at any of the facilities within the System, nor the denial of a waiver pursuant to this Section, will entitle any individual to any procedural rights (including advance notice or additional peer review), formal investigation, hearing, or appeal.

8.H. LEAVES OF ABSENCE

8.H.1. Initiation:

(a) A leave of absence of up to one year must be requested in writing and submitted to the President of the Hospital. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.

(b) The President of the Hospital will determine whether a request for a leave of absence will be granted, after consulting with the Chief of Staff and the Chairperson of the relevant department. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff must report to the President of the Hospital any time they are away from Medical Staff or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the President of the Hospital, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

8.H.2. Duties of Member on Leave:

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues will continue

during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

8.H.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the Chairperson of the relevant department (if applicable), the Chief Medical Officer, the Chief of Staff, and the President of the Hospital.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, the full MEC, and the full Board.

(c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Professional appointment and clinical privileges unless an extension is granted by the President of the Hospital. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

8.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

8.I.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President of the Hospital, the Chief of Staff, the Chairperson of the relevant department, the Chief Medical Officer, the MEC, the Board, or the Board Chair is authorized to: (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being

reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the President of the Hospital and the Chief of Staff. A precautionary suspension will remain in effect unless it is modified by the President of the Hospital or MEC.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).

(f) The relevant Supervising Physician will be notified when the affected individual is a member of the Allied Health Professional.

8.I.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the MEC will review the reasons for the suspension.

(b) As part of this review, the individual will be invited to meet with the MEC. In advance of the meeting, the individual may submit a written statement and other information to the MEC.

(c) At the meeting, the individual may provide information to the MEC and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the MEC will determine whether the precautionary suspension should be continued, modified, or lifted. The MEC may also determine whether to begin an investigation.

(e) If the MEC decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

8.J. INVESTIGATIONS

8.J.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the Chairperson of the relevant department (if applicable), the Chief Medical Officer, the President of the Hospital, or the Chair of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or

(4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Professionals, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Professional member, the matter will be referred to the Chief of Staff or the President of the Hospital.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the MEC.

If the question pertains to a member of the Allied Health Professional, the Supervising Physician may also be notified.

(d) To preserve impartiality, the person to whom the matter is directed will not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the Chief of Staff.

(e) No action taken pursuant to this section will constitute an investigation.

8.J.2. Initiation of Investigation:

(a) The MEC will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the MEC.

(b) The MEC will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the MEC, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the Board, or an ad hoc committee that it appoints.

8.J.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Professional. The Investigating Committee will not include any individual who:

(1) is in direct economic competition with the individual being investigated;

(2) is professionally associated with, a relative of, or involved in a formal or extensive referral relationship with, the individual being investigated;

(3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(4) actively participated in the matter at any previous level.

(b) Whenever the question raised concerns the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).

(c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any individual on the Investigating Committee to the President of the Hospital, the Chief of Staff, or Chief Medical Officer. The objections must be in writing. The President of the Hospital, Chief of Staff, or Chief Medical Officer will review the objection and determine whether another individual should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is

not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the MEC with its findings, conclusions, and recommendations.

8.J.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the MEC that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the President of the Hospital, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the President of the Hospital will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 9

HEARING AND APPEAL PROCEDURES

9.A. INITIATION OF HEARING

9.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment or clinical privileges;

(3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(4) restriction of clinical privileges for more than 30 days that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting, (e.g., a mandatory concurring consultation requirement); or

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(b) No other recommendation or action will entitle the individual to a hearing.

(c) If the Board determines to take any of these actions without an adverse recommendation by the MEC, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "MEC" will be interpreted as a reference to the "Board."

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

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

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

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence or for an extension of a leave;

(h) removal from the on-call roster or any reading or rotational panel;

(i) the voluntary acceptance of a performance improvement plan option;

(j) determination that an application is incomplete;

(k) determination that an application will not be processed due to a misstatement or omission; or

(l) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

9.A.3. Notice of Recommendation:

The President of the Hospital will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

9.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the President of the Hospital, including the name, address, and telephone number of the

individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

9.A.5. Notice of Hearing and Statement of Reasons:

(a) The President of the Hospital will schedule the hearing and provide to the individual requesting the hearing, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

(b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

9.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

9.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The President of the Hospital, after consulting with the Chief of Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as Chair.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff or Allied Health Professional, or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Allied Health Professional or laypersons not affiliated with the Hospital).

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.

(5) The Hearing Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The President of the Hospital, after consultation with the Chief of Staff, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the President of the Hospital, after consulting with and obtaining the agreement of the Chief of Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may participate in that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) Objections:

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

9.A.8. Counsel:

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

9.B. PRE-HEARING PROCEDURES

9.B.1. General Procedures:

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

9.B.2. Time Frames:

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

(a) the pre-hearing conference will be scheduled at least 14 days prior to the hearing;

(b) the parties will exchange witness lists and proposed exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed exhibits must be provided at least five days prior to the pre-hearing conference.

9.B.3. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Allied Health Professional. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Professional members whose names appear on the MEC's witness list or in documents provided

pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees, Medical Staff members or Allied Health Professional members, and confirmed their willingness to meet. Any employee, Medical Staff or Allied Health Professional member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

9.B.4. Pre-Hearing Conference:

(a) The Presiding Officer will require the individual and the MEC (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(b) All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

9.B.5. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

9.B.6. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

9.C. THE HEARING

9.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

9.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

9.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

9.C.4. Order of Presentation:

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

9.C.5. Admissibility of Evidence:

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

9.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Hospital or the Chief of Staff.

9.C.7. Presence of Hearing Panel Members:

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

9.C.8. Failure to Appear:

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

9.C.9. Postponements and Extensions:

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

9.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

9.D.1. Basis of Hearing Panel Recommendation:

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

9.D.2. Deliberations and Recommendation of the Hearing Panel:

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

9.D.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the President of the Hospital. The President of the Hospital will send by special notice a copy of the report to the individual who requested the hearing. The President of the Hospital will also provide a copy of the report to the Chief of Staff.

9.E. APPEAL PROCEDURE

9.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President of the Hospital in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

9.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

9.E.3. Time, Place and Notice:

Whenever an appeal is requested, the Chair of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

9.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the MEC and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

9.F. BOARD ACTION

9.F.1. Final Decision of the Board:

(a) The Board will take final action within 30 days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable).

(c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the Chief of Staff.

(e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

9.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

ARTICLE 10

10.A. CONDITIONS OF PRACTICE FOR ALLIED HEALTH PROFESSIONALS

10.A.1. Category II Practitioners and Category III Practitioners in the Hospital Setting:

(a) Category II Practitioners and Category III Practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II Practitioners and Category III Practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II Practitioners and Category III Practitioners in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of Category II Practitioners and Category III Practitioners in the Hospital setting:

(1) Admitting Privileges. Category II Practitioners and Category III Practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(2) Consultations. Category II Practitioners and Category III Practitioners may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. A Category II Practitioner or Category III Practitioner may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).

(3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact a Category II Practitioner or Category III Practitioner prior to the Supervising Physician. Category II Practitioners and Category III Practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician) must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct a Category II Practitioner or Category III Practitioner to see the patient, gather data, and order tests for further review by the Supervising Physician. However,

the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact a Category II Practitioner or Category III Practitioner prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

(5) Daily Inpatient Rounds. A Category II Practitioner or Category III Practitioner may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

10.A.2. Oversight by Supervising Physician:

(a) Category II Practitioners and Category III Practitioners may function in the Hospital only so long as they have a Supervising Physician.

(b) Any activities permitted to be performed at the Hospital by a Category II Practitioner or Category III Practitioner will be performed only under the oversight of the Supervising Physician.

(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Category II Practitioner or Category III Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the Category II Practitioner's or Category III Practitioner's clinical privileges or scope of practice will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

(d) As a condition of clinical privileges or scope of practice, a Category II Practitioner or Category III Practitioner and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them.

10.A.3. Questions Regarding the Authority of a Category II Practitioner or Category III Practitioner:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical

competence or authority of a Category II Practitioner or Category III Practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Category II Practitioner or Category III Practitioner. Any act or instruction of the Category II Practitioner or Category III Practitioner will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.

(b) Any question regarding the conduct or professional performance of a Category II Practitioner or Category III Practitioner will be reported to the Chief of Staff, the Chief Medical Officer, the Chairperson of the relevant department (if applicable), or the President of the Hospital for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician and may continue to consult with the Supervising Physician throughout the pendency of the matter, as relevant to the Supervising Physician's collaborative or supervisory relationship with the individual.

10.A.4. Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of a Category II Practitioner or Category III Practitioner in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Category II Practitioner or Category III Practitioner performs services or engages in any kind of activity in the Hospital.

(b) Supervising Physicians who wish to utilize the services of Category II Practitioners in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.

(c) The number of Category II Practitioners or Category III Practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will ensure that all appropriate filings have been made with the North Carolina Board of Nursing and/or North Carolina Medical Board regarding the supervision and responsibilities of the Category II Practitioner or Category III Practitioner, to the extent that such filings are required.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II Practitioner or

Category III Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Category II Practitioner or Category III Practitioner in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Category II Practitioner or Category III Practitioner will act in the Hospital only while such coverage is in effect.

10.B. PROCEDURAL RIGHTS FOR CATEGORY I PRACTITIONERS AND CATEGORY II PRACTITIONERS

10.B.1. Notice of Recommendation and Hearing Rights:

(a) In the event a recommendation is made by the MEC that a Category I Practitioner or Category II Practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(c) If the Category I Practitioner or Category II Practitioner wants to request a hearing, the request must be in writing, directed to the President of the Hospital, within 30 days after receipt of written notice of the adverse recommendation.

(d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

10.B.2. Hearing Committee:

(a) If a request for a hearing is made timely, the President of the Hospital, in consultation with the Chief of Staff, will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Hospital administration, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I Practitioner or Category II Practitioner, or any competitors of the affected individual.

(b) The President of the Hospital, in consultation with the Chief of Staff, will appoint a Presiding Officer ("Presiding Officer"), who may be legal counsel to the Hospital. The role of the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer will maintain decorum throughout the hearing.

(c) As an alternative to a Hearing Committee in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, and/or compliance with Medical Staff rules, regulations and/or policies, and does not involve issues of clinical competence, the President of the Hospital, in consultation with the Chief of Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

10.B.3. Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(c) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Category I Practitioner or Category II Practitioner will be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The Category I Practitioner or Category II Practitioner and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present

at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The Category I Practitioner or Category II Practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(g) The Category I Practitioner or Category II Practitioner and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

10.B.4. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the President of the Hospital. The President of the Hospital will send a copy of the written report and recommendation by special notice to the Category I Practitioner or Category II Practitioner and to the MEC.

(b) Within ten days after notice of such recommendation, the Category I Practitioner or Category II Practitioner and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(d) The request for an appeal will be delivered to the President of the Hospital by special notice.

(e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the President of the Hospital will forward the report and recommendation, the supporting

information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

10.B.5. Appellate Review:

(a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(b) The Category I Practitioner or Category II Practitioner and the MEC will each have the right to present a written statement on appeal.

(c) At the sole discretion of the Appellate Review Committee, the Category I Practitioner or Category II Practitioner and a representative of the MEC may also appear personally to discuss their position.

(d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

(e) The Category I Practitioner or Category II Practitioner will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

10.C. PROCEDURAL RIGHTS FOR CATEGORY III PRACTITIONERS

(1) In the event a recommendation is made by the MEC that a Category III Practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a meeting with the MEC.

(2) If a meeting is requested, the meeting will be scheduled to take place within a reasonable time frame. The meeting will be informal and will not be considered a hearing. The Supervising Physician and the Category III Practitioner will both be permitted to attend this meeting. However, no counsel for either party will be present.

(3) Following this meeting, the MEC will make a recommendation to the Board, which will take final action on the matter.

ARTICLE 11

CONFLICTS OF INTEREST

(a) When performing a function outlined in this Policy, the Bylaws, the Allied Health Professional Policy, or the Medical Staff Rules and Regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict) or the committee Chair. The Chief of Staff or committee Chair will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that an individual is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(d) The fact that any individual chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 12

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Hospital or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.

(c) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 13

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

(a) patient identification;

(b) chief complaint;

(c) history of present illness;

(d) review of systems, to include at a minimum:

- cardiovascular;
- respiratory;
- gastrointestinal;
- neuromusculoskeletal; and
- skin;

(e) personal medical history, including medications and allergies;

(f) family medical history;

(g) social history, including any abuse or neglect;

(h) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

(i) data reviewed;

(j) assessments, including problem list;

(k) plan of treatment; and

(l) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion will be documented in the plan of treatment.

In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(3) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided that the patient has been reassessed within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

(4) When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. The admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient's heart rate, respiratory rate and blood pressure.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) For patients undergoing surgery or an invasive procedure, if a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record. For patients admitted for medical management, rather than surgery or an invasive procedure, a new history and physical examination must be recorded within 24 hours after admission.

(3) The update of the history and physical examination will be based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) In the case of readmission of a patient, previous records will be made available by the Hospital for review and use by the attending physician.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay and Outpatient Documentation Requirements

A short stay "history and physical" note may be utilized for (i) ambulatory or same day procedures or treatments, or (ii) short stay observations which do not meet inpatient criteria. These notes will document the chief complaint or reason for the procedure or treatment, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

(e) Physician Certification Requirements

(1) For all inpatient admissions, the admitting and/or attending physician(s) will complete a certification that complies with federal regulations and Medicare reimbursement guidelines for Critical Access Hospitals. Such certification will

comply with all requirements set forth in the Medical Staff Rules and Regulations and any applicable Hospital policies.

ARTICLE 14

ADOPTION AND AMENDMENTS

14.A. ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter contained herein.

14.B. AMENDMENTS

(1) Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting Members of the Medical Staff. Proposed amendments may be voted upon at any meeting if notice has been provided at least 7 days prior to the meeting.

(2) Amendments to the Medical Staff Rules and Regulations and other policies affecting Medical Staff members and others who have been granted clinical privileges may be proposed by a petition signed by 25% of the voting Members of the Medical Staff. No prior notice is required.

(3) In the alternative, proposed amendments may be presented to the voting staff by the chair, via written or electronic ballot, which must be returned to the Medical Staff Office by the date indicated by the chair. The total number of ballots returned shall constitute the quorum.

(4) To be adopted, amendments must receive a majority of the votes cast. Amendments will be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the Medical Staff, the Medical Staff may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President of the Hospital within two weeks after receipt of a request.

(6) Unilateral amendment of these Bylaws is not permitted by the MEC, the Medical Staff, or the Board.

(7) Amendments to Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies are to be distributed or otherwise made available to Medical Staff members and those who hold clinical privileges in a timely and effective manner.

APPENDIX A

ALLIED HEALTH PROFESSIONALS

Types of Category I Practitioners currently authorized to practice at the Hospital are as follows:

- Podiatrists

Types of Category II Practitioners currently authorized to practice at the Hospital are as follows:

- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Certified Registered Nurse Anesthetists (CRNAs)

Types of Category III Practitioners currently authorized to practice at the Hospital are as follows:

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 cannot be less than two committee members	*Whichever is greater*: - At least 10% of the active members assigned to the department; OR - 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 ***medical staff members*** 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 ***cannot*** vote
Voting method	At a meeting with a quorum OR 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 OR 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	At a meeting with a quorum OR 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 OR 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 votes cast and removing an officer requires at least a 2/3 vote of all voting medical staff members)	Majority of votes cast (Removing an officer or a chairperson requires at least a 2/3 vote of all voting MEC members)	Majority of votes cast	Majority of votes cast (Removing a chairperson requires at least a 2/3 vote of all voting members assigned to the department/ section)