CaroMont Regional Medical Center

Medical Staff Bylaws

Approved by the Medical Executive Committee: June 20, 2022

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TABLE OF CONTENTS

BYLAWS OF THE MEDICAL STAFF

CAROMONT REGIONAL MEDICAL CENTER

ARTICLE I:
MISSION

The mission of CaroMont Health is to provide compassionate, exceptional and highly reliable care. Recognizing that the Medical Staff of CaroMont Regional Medical Center is responsible for the quality of medical and dental care in the Hospital, subject to the Board of Directors, the Medical Staff of CaroMont Regional Medical Center hereby organize themselves in conformity with these Bylaws of the Medical Staff of CaroMont Regional Medical Center ("Bylaws").

In promulgating these Bylaws, it is the intent of the Medical Staff to comply fully with all laws, regulations and accrediting standards that are or may hereafter be applicable to the Hospital. Where these Bylaws and associated Medical Staff Documents may be interpreted differently, they are to be construed in a manner that most nearly accomplishes compliance with the intent.

ARTICLE II:
DEFINITIONS

The following definitions apply to terms used in these Bylaws:

"**Board of Directors**" or "**Board**" means the Board of Directors of Gaston Memorial Hospital, Incorporated which does business as CaroMont Regional Medical Center, CaroMont Regional Medical Center – Belmont and CaroMont Regional Medical Center – Mt. Holly.

"**Chief Executive Officer**" or "**CEO**" means the CaroMont Health President/CEO who is individual appointed by the Board to act on its behalf in the overall management of the Hospital.

"**Clinical Privileges**" or "**Privileges**" means the rights granted to a Medical Staff member or a Privileged Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental or podiatry services specifically delineated to the applicant.

"**Hearing**" means the hearing procedures set forth in Article 12 of these Bylaws.

"**Hospital**" means Gaston Memorial Hospital, Incorporated d/b/a CaroMont Regional Medical Center,d/b/a CaroMont Regional Medical Center-Belmont, and d/b/a CaroMont Regional Medical Center – Mt. Holly, and all the activities, services and programs thereof.

"**Medical Executive Committee**" or "**MEC**" means the Executive Committee of the Medical Staff.

"**Medical Staff**" means all physicians and dentists who have been appointed to the Medical Staff by the Board of Directors.

"**Medical Staff Documents**" means all documents approved by the Medical Staff and Board of Directors for purposes of governance or the orderly operation of the Medical Staff, including, but

not limited to these Bylaws, the Organizational Manual, and all Medical Staff Policies as may now or hereafter be duly adopted and/or amended and in effect.

"**Notice**" means written communication by regular US Mail, e-mail, facsimile, or hand delivery.

"**Patient Contacts**" includes any admission, consultation, procedure, evaluation, treatment or service performed in the Hospital (including any outpatient department of the Hospital) and/or CaroMont Specialty Surgery, or a day on the Hospital call schedule. For radiologists and pathologists, any day onsite at the Hospital for four hours or more qualifies as a patient contact.

"**Physician**" includes both physicians and dentists, unless the context indicates otherwise.

"**Privileged Practitioners**" means all Podiatry and Advanced Practitioners (Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Practice Pharmacists, Nurse Practitioners, and Physician Assistants). Privileged Practitioners may obtain Clinical Privileges but do not qualify for Medical Staff Membership.

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

ARTICLE III
PURPOSES OF THE MEDICAL STAFF

At the direction of and as delegated by the Board of Directors, the Medical Staff has the following responsibilities:

a. To undertake that all patients admitted to or treated at the Hospital receive compassionate, exceptional and highly reliable care;

b. To develop a high level of professional performance by all members of the Medical Staff and Privileged Practitioners through the appropriate delineation of Clinical Privileges and the continuous review and evaluation of the clinical activities of each Medical Staff member and Privileged Practitioner;

c. To make recommendations to the Board of Directors regarding appointments and reappointments to the Medical Staff (including appropriate membership category) or as a Privileged Practitioner and regarding the delineation of Clinical Privileges;

d. To develop, administer, recommend amendments to, and enforce compliance with these Bylaws, the Organizational Manual, and Medical Staff Policies;

e. To establish, maintain, and enforce sound professional practices and initiate and pursue corrective action under these Bylaws to further quality patient care; and

f. To provide an organized means whereby issues concerning the Hospital may be discussed by the Medical Staff with the Board of Directors and CEO.

ARTICLE IV
QUALIFICATIONS AND RESPONSIBILITIES

Section 4.1 Overview

Hospital Medical Staff membership and the granting of Clinical Privileges to Physicians and Privileged Practitioners are a privilege extended only to individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws. The Board of Directors makes appointments to the Medical Staff, along with corresponding Clinical Privileges, to one of the categories listed below and grants Clinical Privileges to Physicians and Privileged Practitioners without regard to race, religion, color, age, sex, gender, creed, national origin, disability or sexual orientation.

Section 4.2 General Qualifications

All members of the Medical Staff and Privileged Practitioners shall meet the following general qualifications:

a. The individual currently maintains a valid license to practice in North Carolina.

b. The individual possesses the requisite professional education, training, experience and demonstrated ability to provide patient services.

c. The individual demonstrates a willingness to comply with the CaroMont Health Code of Conduct and Medical Staff Policies.

d. The individual must provide evidence of professional liability insurance coverage in such amounts and of such types as may be required by the Hospital, such coverage to be maintained continuously.

e. The individual is free from any significant physical or behavioral impairment that would materially impair his/her ability to provide patient care consistent with the privileges requested of and approved by the Board.

f. For members of the Medical Staff:

    1. Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education, a residency training program approved by the American Osteopathic Association, or dental surgery training program accredited by the Commission on Dental Education in a specialty in which the applicant seeks Clinical Privileges.

    2. Become board certified within five years (or seven years for Neurosurgery) of completion of residency or fellowship training by the appropriate specialty board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or American Dental Association (ADA), as applicable.

3. Maintain certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment in the area of primary specialty practice.

Section 4.3 Responsibilities

Each member of the Medical Staff and Privileged Practitioners will, as applicable:

a. Provide their patients with professional care that meets generally accepted standards of quality, provide for continuous care of their patients, and participate in quality improvement activities of the Hospital and Medical Staff;

b. Abide by the Medical Staff Bylaws and Medical Staff Policies;

c. Discharge such Medical Staff, Service Line, committee, and Hospital functions for which he/she is responsible;

d. Prepare and complete in a timely manner the medical records and all other required records of all patients he/she admits or to whom he/she providers care in the Hospital;

e. Abide by generally recognized standards of professional ethics;

f. Comply with CaroMont Health's Code of Conduct; and

g. Immediately inform the Chief of Staff and Medical Staff Office of any voluntary or involuntary suspension, revocation or termination of his/her license to practice, DEA registration, professional liability insurance, or changes in staff membership or privileges at any other healthcare institution or managed care panel;

ARTICLE V
MEDICAL STAFF CATEGORIES/PRIVILEGED PRACTITIONERS

Section 5.1 Categories

Individuals may seek membership in one of five (5) categories: Active Staff, Active Outpatient Staff, Associate Staff, Telemedicine Staff, and Privileged Practitioners.

Section 5.2 Active Staff

a. Qualifications.

1. Meet the qualifications outlined in Article 4.2;

2. Maintain availability for patient care and consultation within time guidelines determined by the Medical Staff;

3. Ensure the provision of continuous care to his/her patients as determined by the Medical Staff and Service Line; and

4. Have twelve (12) or more Patient Contacts per calendar year (or in the case of a new appointment, have an anticipated twelve (12) or more Patient Contacts per calendar year.

b. Prerogatives. Active Staff Members may:

1. Exercise those Clinical Privileges granted by the Board;

2. Vote on all matters presented to the Medical Staff and at meetings of the Medical Staff Committees to which he/she is appointed;

3. Be elected as a Medical Staff officer or At-Large Member of the Medical Executive Committee and sit on or act as chair of any Medical Staff Committee to which he/she is appointed by the Chief of Staff or Medical Executive Committee, unless otherwise specified in these Bylaws; and

4. Attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff functions.

c. Responsibilities. In addition to those responsibilities set forth in Article 4.3, Active Staff Members must:

1. Actively participate in and carry the organizational and administrative functions of the Medical Staff, including, but not limited to, performance improvement, peer review, utilization management and credentialing;

2. Participate in on-call coverage of the emergency service and other coverage as determined by Medical Staff or Hospital policies; and

3. Attend Medical Staff Meetings.

d. Exclusions. Practitioners exclusively practicing Telemedicine privileges are not eligible for Active Staff.

Section 5.3 Active Outpatient Staff

a. Qualifications. Meet the qualifications outlined in Article 4.2.

b. Prerogatives. Active Outpatient Staff Members may:

1. Vote on all matters presented to the Medical Staff and at meetings of the Medical Staff Committees to which he/she is appointed;

2. Sit on or act as chair of any Medical Staff Committee to which he/she is appointed by the Chief of Staff or MEC, unless otherwise specified in these Bylaws; and

3. Attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff functions.

c. Responsibilities. In addition to those responsibilities set forth in Article 4.3, Active Outpatient Staff Members must attend regular and special meetings of the Medical Staff.

d. Exclusions. However, members of the Active Outpatient Staff may not run for an elected Medical Staff position, serve as a Medical Staff Officer, be granted Clinical Privileges at the Hospital or admit/treat patients at the Hospital. Members of the Active Outpatient Staff may visit their patients when hospitalized and review their medical records but may not write orders, make medical record entries, or actively participate in the provision or management of care to patients.

Section 5.4 Associate Staff

a. Qualifications.

1. Meet the qualifications outlined in Article 4.2;

2. Maintain availability for patient care and consultation within time guidelines determined by the Medical Staff;

3. Ensure the provision of continuous care to his/her patients as determined by the Medical Staff and Service Line; and

4. Have less than twelve (12) or more Patient Contacts per calendar year (or in the case of a new appointment, have less than twelve (12) anticipated Patient Contacts per calendar year. If a practitioner completes twelve (12) Patient Contacts in his/her first twelve (12) months on staff, his/her staff category will be automatically changed to Active Staff at the next regularly scheduled meeting of the Credentials Committee.

b. Prerogatives. Associate Staff Members may:

1. Exercise those Clinical Privileges granted by the Board;

2. Attend meetings of the Medical Staff and may sit on or act as chair of any Medical Staff Committee to which they are appointed by the Chief of Staff or MEC, unless otherwise specified in these Bylaws; and

3. Attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff functions.

c. Responsibilities. In addition to those responsibilities set forth in Article 4.3, Associate Staff Members must:

1. Actively participate in and carry the organizational and administrative functions of the Medical Staff, including, but not limited to, performance improvement, peer review, utilization management and credentialing;

2. Participate in on-call coverage of the emergency service and other coverage as determined by Medical Staff or Hospital Policies; and

3. Attend Medical Staff meetings.

d. Exclusions. Members of the Associate Staff may not run for an elected Medical Staff position or serve as a Medical Staff Officer. Members of the Associate Staff shall not have voting privileges at Medical Staff meetings or on Medical Staff Bylaws amendments but may vote on Committees to which they are appointed.

Section 5.5 Telemedicine Staff

Telemedicine privileges are defined as privileges for the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Telemedicine privileges shall include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to a patient using Telemedicine. Appointees to other categories of the Medical Staff are not required to apply for separate Telemedicine privileges in order to use electronic communication or other communication technologies to provide or support clinical care at a distance.

a. Qualifications. Meet the qualifications outlined in Article 4.2.

b. Prerogatives. Telemedicine Staff Members may:

1. Exercise those Clinical Privileges granted by the Board; provided, however that Telemedicine Staff are not entitled to admit patients to the Hospital;

2. Attend meetings of the Medical Staff; and

3. Attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff functions.

c. Responsibilities. In addition to those responsibilities set forth in Article 4.3, Associate Staff Members must:

1. Be responsible for providing services by Telemedicine at the request of Members of the Medical Staff; provided, however, that a practitioner who has Telemedicine privileges may not act as the primary Practitioner responsible for the patient's care;

2. Actively participate in and carry the organizational and administrative functions of the Medical Staff, including, but not limited to, performance improvement, peer review, utilization management and credentialing; and

3. Attend Medical Staff meetings.

d. Exclusions. Members of the Telemedicine Staff may not run for an elected Medical Staff position or serve as a Medical Staff Officer. Members of the Telemedicine Staff shall not have voting privileges at Medical Staff meetings or on Medical Staff Bylaws amendments. Members of the Telemedicine Staff may not sit on or act as chair of any Medical Staff Committee.

Section 5.6 Privileged Practitioners

Privileged Practitioners may obtain Clinical Privileges but do not qualify for Medical Staff membership.

a. Qualifications.

1. Meet the qualifications outlined in Article 4.2; and

2. Meet the requirements of the Privileged Practitioners Policy.

b. Prerogatives. Privileged Practitioners may:

1. Exercise those Clinical Privileges granted by the Board; provided, however that Privileged Practitioners are not entitled to admit patients to the Hospital;

2. Privileged Practitioners may sit on any Medical Staff Committee to which they are appointed by the Chief of Staff or MEC, unless otherwise specified in these Bylaws; and

3. Attend all educational programs presented by the Medical Staff and/or Hospital and applicable Medical Staff functions.

c. Responsibilities. In addition to those responsibilities set forth in Article 4.3, Privileged Practitioners must actively participate in and carry the organizational and administrative functions of the Medical Staff, including, but not limited to, performance improvement, peer review, utilization management and credentialing.

d. Exclusions.

1. Privileged Practitioners may not run for an elected Medical Staff position or serve as a Medical Staff Officer. Privileged Practitioners shall not have voting privileges at Medical Staff meetings or on Medical Staff Bylaws amendments but may vote on Committees to which they are appointed.

2. Privileged Practitioners are not members of the Medical Staff and do not have resources to the Hearing rights set forth in Article XII of these Bylaws. However, in the event that a Privileged Practitioner's privileges are terminated, restricted, suspended, revoked or reduced because of demonstrated incompetence or unprofessional conduct that may adversely affect patient care, the Privileged Practitioner will be notified of the action and the reasons therefore, and may request

that such action be reviewed by the Medical Executive Committee. At any such review meeting, the Privileged Practitioner (and the Active Staff member who is a party to their collaborative practice or supervising physician agreement, if applicable) may be present and participate in the review. The Privileged Practitioner will be entitled to a written explanation at the conclusion of the review, but will not be entitled to any further review, Hearing or appeal.

Section 5.8 Change in Staff Category

Pursuant to a request by the Medical Staff member and/or upon a recommendation by the Credentials Committee, the MEC may recommend a change in Medical Staff category of a member consistent with the requirements of these Bylaws and Medical Staff Policies. The Board must approve any change in category. Determinations regarding assignment of Medical Staff category are not subject to review under the procedural and Hearing provisions set forth in Article XII of these Bylaws.

Section 5.9 No Entitlement to Appointment

No individual is entitled to be appointed or reappointed to the Medical Staff or to be granted particular Clinical Privileges merely because he or she:

a. Is licensed to practice a profession in this or any other State;

b. Is a member of any particular professional organization;

c. Has had in the past, or currently has, medical staff appointment or privileges at any hospital or health care facility;

d. Resides in the geographic service area of the Hospital; or

e. Is affiliated with, or under contract with, any managed care plan, insurance plan, HMO, PPO, or other entity.

ARTICLE VI
CLINICAL PRIVILEGES

Section 6.1 Overview

Medical Staff and Privileged Practitioners may be granted Clinical Privileges corresponding to the categories identified in Article V and in accordance with their education, training, licensure/certification, experience and competence as set forth in this Bylaws and applicable Medical Staff Policies. In addition, the Board may grant other Clinical Privileges as set forth in this Article. Practitioners are entitled to only those Clinical Privileges delineated in their medical staff application and delineation of privileges form.

Upon appointment to the Medical Staff and/or the granting of Clinical Privileges, the Practitioner will be placed upon a Focused Professional Practice Evaluation (FPPE) in accordance with Medical Staff Policy. In addition, when a Practitioner who is an existing member of the Medical

Staff or has privileges at Hospital is granted new or additional privileges, the Practitioner will be placed on a Focused Professional Practice Evaluation (FPPE) in accordance with Medical Staff Policy.

Section 6.2 Physicians in Training

From time to time, there may be physicians in training at the Hospital. Their function and protocols shall be governed by Medical Staff Policies; provided, however, that physicians in training at the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific Clinical Privileges. Rather, they shall be permitted to perform only those clinical functions set out in training protocols developed by the director of the physician in training program(s) and approved by the Credentials Committee and the Board. Program director(s) are responsible for verifying the qualifications and credentials of each physician in training permitted to function at the Hospital. Care of patients by physicians in training shall be under the supervision of a member of the Active Staff and must be provided in conformance with all Medical Staff Policies.

Section 6.3 Additional Categories of Privileges

In addition to the Clinical Privileges that are granted in accordance with Medical Staff membership or to Privileged Practitioners, the Board authorizes the following categories of privileges that are available to Physicians or Privileged Practitioners. None of the following categories of privileges entitle the Practitioner to Medical Staff membership, to vote on Medical Staff matters, or serve on Medical Staff Committees. However, the Practitioner is bound by these Bylaws and all Medical Staff Policies. Neither the denial nor termination of these additional categories of privileges shall entitle the individual to any of the procedural rights provided in these Bylaws unless such denial or termination is based on a determination of clinical incompetence or unprofessional conduct.

a. Temporary Privileges.

   1. Temporary privileges may only be granted by the CEO for a limited period of time not to exceed 120 days for qualified applicants. Temporary privileges are granted only in the following circumstances: (i) on a case-by-case basis when an important patient care need requires an immediate authorization to practice while the full credentials information of the practitioner is verified and approved; (ii) for the purpose of proctoring, teaching or learning a procedure; or (iii) to a new applicant for Medical Staff membership or privileges who was approved by the Credentials Committee and is awaiting review and approval by the Medical Executive Committee and the Board. Physicians providing intellectual proctoring at the Hospital shall not be granted temporary privileges but shall be approved through the mechanisms set forth in the Medical Staff Policies.

   2. The Medical Staff Office shall verify appropriate information to include the individual's current licensure, DEA registration, current clinical competence and judgment, training and experience, character, ethical standing, behavior, ability to safely and competently exercise the privileges requested and professional liability insurance coverage and shall query the National Practitioner Data Bank before a final decision is made to grant temporary privileges.

   3. Temporary privileges shall expire at the end of the time period for which they are granted.

4. For good cause show (after consulting with the Chief of Staff), the CEO may terminate, revoke, suspend, restrict or reduce Temporary Privileges. Members of the Medical Staff or Privileged Practitioners with Temporary Privileges do not have recourse to the procedural or Hearing procedures set forth in Article XII relative to any matter concerning Temporary Privileges.

b. Emergency Privileges. In an emergency, a Member of the Medical Staff or a Privileged Practitioner, to the degree permitted by his/her license, may provide any type of patient care, treatment or services necessary as a life-saving measure or to prevent serious harm. In such an emergency, a Practitioner may use all Hospital facilities, seek assistance from all Hospital personnel, and request any consultation.

c. Disaster Privileges. In situations where the Hospital has activated its Emergency Management Plan and the Hospital is unable to meet immediate patient needs, the CEO, Chief Physician Executive or Chief of Staff has the option to grant Disaster Privileges to volunteer health care providers. The CEO, Chief Physician Executive, or Chief of Staff may grant Disaster Privileges upon completion of a brief information form and presentation of the volunteer health care provider's valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

   1. Valid professional license or certification to practice in the State of North Carolina, any other US State, or any US territory that clearly identifies professional designation;

   2. Primary source verification of licensure (if this cannot be completed within 72 hours of volunteer health care provider's arrival, it shall be performed as soon as possible);

   3. A current picture identification card from a health care organization that clearly identifies a professional designation;

   4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

   5. Identification indicating that the individual has been granted authority by a government entity to render patient care in emergency circumstances; or

   6. Confirmation by a member of the Medical Staff or Privileged Practitioner with personal knowledge regarding practitioners identity and qualifications for practice.

   Practitioners granted Disaster Privileges shall be provided with identification which readily identifies their status. The Hospital will determine within seventy-two (72) hours of the Practitioner's arrival whether Disaster Privileges should continue. As soon as the immediate situation is under control or within seventy-two (72) hours of the Practitioner's arrival, whichever comes first, the Medical Staff Office will verify the credentials via the same process as established under the Bylaws for granting Temporary Privileges. If verification of credentials cannot be completed within seventy-two (72) hours of the Practitioner's arrival due to extraordinary circumstances, the Hospital will document the reason verification could not be completed, evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment and services, and evidence of the Hospital's attempt to verify credentials as soon as possible.

ARTICLE VII
ORGANIZATION OF THE MEDICAL STAFF

Section 7.1 Overview

The Medical Staff of the Hospital is a non-departmentalized organization that carries out its responsibilities through the work of its Committees and Service Lines and by those individuals assigned specific tasks.

Section 7.2 Medical Staff Officers

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, and the Immediate Past Chief of Staff.

Section 7.3 Eligibility Criteria for Medical Staff Officers

Only those members of the Active Staff in good standing who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff:

a. Must have served on the Active Staff for at least two years;

b. Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges;

c. Utilize CaroMont Regional Medical Center-Main or CaroMont Regional Medical Center-Belmont as their primary hospital;

d. Not presently serve as a medical staff officer, board member or medical director at any other hospital; and

e. Have previously served on Medical Staff Committees (preferred but not required).

Section 7.4 Chief of Staff Duties

The Chief of Staff shall:

a. Act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

b. Communicate the views, policies and needs of the Medical Staff and report on the activities of the Medical Staff to the Board and the CEO;

c. Call and preside at all meetings of the Medical Staff and Medical Executive Committee;

d. Appoint the membership and chairs of all standing and special Medical Staff Committees, except the Medical Executive Committee;

e. Serve as an *ex officio* member of all Medical Staff Committees;

f. Serve as the public spokesperson for the Medical Staff;

g. Enforce the Bylaws of the Medical Staff and all Medical Staff policies and procedures, and implement and monitor sanctions or corrective action taken pursuant to these Bylaws; and

h. Serve as a member of the Board of Directors.

Section 7.5 Chief of Staff-Elect Duties

The Chief of Staff-Elect shall:

a. Assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

b. Serve on the Medical Executive Committee;

c. Serve as Chair of the Credentials Committee;

d. Assume such additional duties as assigned to him or her by the Chief of Staff or the Medical Executive Committee;

e. Attend CaroMont Health Board of Director meetings as a non-voting member; and

f. Become Chief of Staff upon completion of his or her term.

Section 7.6 Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall:

a. Serve on the Medical Executive Committee;

b. Function in an advisory capacity to the other Medical Staff leaders;

c. Assume such additional duties as assigned to him or her by the Chief of Staff or the Medical Executive Committee;

d. Attend CaroMont Health Board of Director meetings as a non-voting member;

e. Serve as Chair of Board Quality and Safety Committee if so appointed by the Board of Directors; and

f. Serve as Chair of the Medical Staff Nominating Committee.

Section 7.7 Term of Office

Officers shall serve for a term of two (2) years or until a successor has taken office.

Section 7.8 Nominations for Medical Staff Officers and At-Large Members of the MEC

There shall be a Nominating Committee for all general and special elections each year. The Nominating Committee shall be comprised of two most recent former Chiefs of Staff and three members of the Active Staff appointed by the Chief of Staff. The Immediate Past Chief of Staff will serve as the chair of the Committee, if available. If either of the two most Immediate Past Chiefs of Staff are not available, the Chief of Staff may appoint another former Chief of Staff. In identifying nominees for elected positions, the Committee shall consider the following:

a. The applicant's clinical and leadership experience;

b. The applicant's experience at Hospital and in the community; and

c. The benefit to the Medical Staff of diverse leadership with regard to specialty, practice location, gender, age, race/ethnicity, and employment arrangement.

The Nominating Committee shall convene at least sixty (60) days prior to the General Medical Staff meeting at which the election will be held. The Nominating Committee will submit to the Chief of Staff the names of one or more qualified nominees for the Chief of Staff-Elect and At-Large members of the Medical Executive Committee. Notice of the nominees shall be provided to the Medical Staff at least forty-five (45) days prior to the election.

Section 7.9 Election of Medical Staff Officers and At-Large Members of the MEC

Officers and At-Large members of the Medical Executive Committee shall be elected at a General Medical Staff meeting using processes set forth by the Medical Executive Committee. The winner of each election will be the individual who receives the greatest number of votes from medical staff members present and eligible to vote. Voting by proxy is not permitted. Elections for officers and At-Large members of the Medical Executive Committee will take place in the third calendar quarter of the year as scheduled by the Medical Executive Committee and the winners will be announced as soon as practicable. The newly elected Medical Staff officers and At-Large members of the Medical Executive Committee will be eligible to assume office on January 1 following the election, unless such elected officer is fulfilling a partial term in which case the elected officer shall start immediately.

Section 7.10 Removal of Medical Staff Officers and At-Large Members of the MEC

a. An officer of the Medical Staff and At-Large members of the Medical Executive Committee may be removed by a two-thirds vote of the Medical Executive Committee or a two-thirds vote of the Medical Staff. Grounds for removal shall include, but not be limited to the following:

    1. Failure to comply with the Medical Staff Bylaws and/or Medical Staff policies and procedures;

    2. Failure to perform the duties of the position held;

    3. Conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

    4. An infirmity that renders the individual incapable of fulfilling the duties of the office.

b. A proposal to remove an elected officer or At-Large members of the Medical Executive Committee may be received at any regular meeting of the Medical Executive Committee or the Medical Staff if it is supported by a petition signed by at least twenty (20) percent of the Medical Staff. The proposal must state the grounds for removal.

c. At least ten (10) days prior to the meeting at which the removal action will be considered, the individual shall be given written notice of the date of the meeting at which such removal shall be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Medical Staff, as applicable, prior to a vote on removal.

4. Automatic removal will occur (without a need for vote) in the event the individual's North Carolina medical license is suspended or revoked, the individual becomes ineligible for Active Staff membership, or the Board imposes against the individual disciplinary action recommended by the Medical Executive Committee.

Section 7.11 Vacancies

A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff-Elect, who shall serve until the end of the Chief's unexpired term. In the event that there is a vacancy in the office of Chief of Staff-Elect, the Medical Executive Committee shall appoint an individual to fill that office for the remainder of the term or until a special election can be held, at the discretion of the Medical Executive Committee.

ARTICLE VIII
MEDICAL STAFF COMMITTEES

Section 8.1 General

Committees are either standing or special. All committee members and committee chairs are appointed by the Chief of Staff. They shall be appointed for staggered, two-year terms and can be re-appointed for additional terms. The Chief of Staff and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees; provided, however, that the Chief of Staff shall be a voting member of the Medical Executive Committee

The presence of at least twenty-five (25) percent of a committee's members will constitute a quorum, except for meetings of the Medical Executive Committee and the Credentials Committee, where the presence of at least fifty (50) percent of the total Committee shall constitute a quorum. Minutes of each meeting are recorded and forwarded to the Medical Executive Committee. Robert's Rules of Order will govern all committee meetings.

Section 8.2 Medical Executive Committee

a. Composition. The Medical Executive Committee shall be comprised of the following members: Chief of Staff; Chief of Staff Elect; Immediate Past Chief of Staff; Chair, Peer Review Committee; Chair, Physician Health and Behavior Committee; Chair, CRMC Belmont Committee; and three members elected At Large by the Medical Staff (one of whom shall have a substantial practice at CaroMont Regional Medical Center-Belmont. In addition, the CEO shall serve *ex officio* as a member of the Medical Executive Committee without vote. The Chief of Staff shall serve as the chair of the Medical Executive Committee.

b. Duties.

   1. The Medical Staff delegates to the Medical Executive Committee authority to oversee the operations of the Medical Staff.

   2. The Medical Executive Committee shall be responsible for making recommendations to the Board of Directors its approval concerning:

      i. The structure of the Medical Staff;

      ii. The mechanisms used to review credentials and to delineate individual Clinical Privileges.

      iii. Recommendations of individuals for Medical Staff membership;

      iv. Participation of the Medical Staff in performance improvement activities;

v. The mechanisms for terminating Medical Staff membership; and

vi. The mechanism for Hearing procedures.

3. The Medical Executive Committee receives and acts on reports and recommendations from Medical Staff Committees and Service Lines and is empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities.

4. The Medical Executive Committee may adopt and amend Medical Staff Documents (except the Bylaws) and forward such actions to the Board of Directors for its approval.

5. The Authority delegated by the Medical Staff to the Medical Executive Committee in these Bylaws may be removed by amendment of these Bylaws, or by resolution of the Medical Staff, approved by a 2/3 vote of the voting members of the Medical Staff, taken at a Medical Staff meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee.

c. Removal. A member of the Medical Executive Committee may be removed from the Medical Executive Committee for the reasons described in and pursuant to the process outlined in Section 7.10, provided, however, that the member of the Medical Executive Committee who is the subject of removal shall not participate in any discussions with the Medical Executive Committee unless specifically requested to do so by the Committee. A member of the Medical Executive Committee so removed has no further appeal rights under these Bylaws.

d. Meetings. The Medical Executive Committee shall meet at least six (6) times per year, and as often as necessary to fulfill its responsibilities. It shall maintain a record of its proceedings and actions pursuant to current Hospital record retention policies.

Section 8.3 Creation of Committees

In accordance with the processes set forth in the Organizational Manual, the Medical Executive Committee may, by resolution and upon approval of the Board, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

Section 8.4 Performance Improvement Activities

Performance improvement activities are the way the Medical Staff works to improve the clinical and non-clinical processes that require Medical Staff leadership or participation. These activities shall be performed by such Committees, Service Lines or individuals as may be designated by the Medical Executive Committee which will have oversight of all clinical performance improvement activities. When the performance of a process is dependent primarily on the activities of individuals with Clinical Privileges, the Medical Staff shall provide leadership for, and participate in, process measurement, assessment and improvement, including but not limited to (1) medical assessment and treatment of patients; (2) use of medications; (3) use of blood and blood components; (4) operative and other procedures; (5) efficiency of clinical practice patterns; (6) professional conduct; and (7) significant departures from established patterns of clinical

practice. A description of the standing Committees that carry out monitoring and performance improvement activities, including their composition, duties and reporting requirements is contained in the Organizational Manual.

Section 8.5 Patient Care Process Improvement Activities

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include but are not limited to: (1) education of patients and families; (2) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and (3) accurate, timely, and legible completion of patients' medical records.

Section 8.6 Special Task Forces

The Medical Executive Committee may create special task forces to address specific matters. The Chief of Staff shall appoint the chair and all members of the special task forces. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE IX
MEDICAL STAFF AND COMMITTEE MEETINGS

The Medical Staff shall meet at least annually on date(s) determined by the Chief of Staff. In addition, special meetings of the Medical Staff may be called by the Chief of Staff or at the request of the Board or the Medical Executive Committee. Notice of any meeting shall be deemed sufficient if notice is provided to the Medical Staff in writing (including by electronic means) at least forty-eight (48) hours prior thereto. For any Medical Staff meeting, the voting members present shall constitute a quorum so long as at least three voting members are present.

Minutes of all meetings of the Medical Staff and its committees shall be prepared and shall include a record of the attendance of members, the recommendations made, and the votes taken on each matter. The minutes shall be authenticated by the Committee Chair, or in the case of meetings of the Medical Staff, the Chief of Staff. A summary of all recommendations and actions of Medical Staff Committees shall be transmitted to the Medical Executive Committee and the CEO. The Medical Staff and all committees shall maintain minutes pursuant to current Hospital record retention policies.

ARTICLE X
MEDICAL STAFF DOCUMENTS AND BYLAWS AMENDMENT PROCESS

Section 10.1 Medical Staff Documents

There are three (3) types of Medical Staff Documents:

a. Medical Staff Bylaws: The Medical Staff Bylaws describe the organizational structure of the Medical Staff at CaroMont Regional Medical Center and set forth its rules for governance and scope of responsibility.

b. Organizational Manual: The Organizational Manual more specifically details the organization of the Medical Staff and the work of the Medical Staff Committees.

c. Medical Staff Policies: The Medical Staff may adopt policies as may be necessary to implement more specifically the general principles in these Bylaws and to promote the work of the Medical Staff and mission of CaroMont Health. All members of the Medical Staff and all Privileged Practitioners are required to comply with Medical Staff policies.

Section 10.2 Amendment to Medical Staff Bylaws

Any Medical Staff Committee or Service Line may propose an amendment to the Medical Staff Bylaws. The Medical Executive Committee may utilize, at its discretion, any Special Committee to review proposed Bylaws changes, suggest modifications to proposed changes, or recommend adoption or rejection of the proposed changes. The Medical Executive Committee shall vote on any proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the Medical Executive Committee, all members of the Medical Staff eligible to vote shall be provided with a description of the proposed amendment(s) by email or mail at least thirty (30) days prior to the expected vote on the proposed amendment(s). The Medical Staff vote on the proposed amendments may be conducted in a manner determined by the Medical Executive Committee. To be adopted, the proposed amendment(s) must be approved by a majority of the eligible Medical Staff members who cast votes and the Board must subsequently ratify the amendment(s).

Section 10.3 Amendment to Medical Staff Policies and the Organizational Manual

Medical Staff Policies and the Organizational Manual may be adopted, amended, repealed or added by vote of the Medical Executive Committee. Once adopted, amended, repealed or added by the Medical Executive Committee, such Policy(s) or the Organizational Manual changes will be provided to the Medical Staff prior to consideration by the Board. Adoption of and changes to the Medical Staff Policies shall become effective only when approved by the Board. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Policies or Organizational Manual. However, in cases where an urgent amendment is necessary to comply with applicable laws, regulations or accrediting standards, the Medical Executive Committee may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee.

ARTICLE XI
INVESTIGATIONS AND CORRECTIVE ACTIONS

Section 11.1 General Procedures

a. The proceedings under this Article XI are administrative, non-adversarial matters and do not include a hearing; none of the procedural rules set forth in Article XII shall apply. The initiation of these proceedings shall be considered an investigation by the Medical Staff.

b. Any documents, reports, requests, and written notices referenced in this Article XI may be delivered in person, by email, or by certified mail (return receipt requested) to the designated recipient.

c. If the deadline pursuant to which an action must be taken under this Article XI falls on a weekend or holiday, the deadline will be extended to the next workday. In addition, any deadline or time period in this Article XI may be extended by the Chief of Staff upon good cause shown, either upon request or his/her own accord.

Section 11.3 Precautionary Suspension

a. The CEO, in conjunction with the Chief of Staff, shall have the authority to suspend all or any portion of an individual's Clinical Privileges whenever failure to take such action may result in the potential imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. Such suspension shall be effective immediately upon imposition by the CEO and Chief of Staff and the Medical Staff Member or Privileged Practitioner shall be notified immediately. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation of the concerns raised.

b. As soon as practicable but no longer than fourteen (14) days after the precautionary suspension is imposed, the Medical Executive Committee review the matter resulting in the precautionary suspension and determine whether there is sufficient information to warrant a recommendation or proceed under the investigative procedure set forth in Section 11.3 of these Bylaws. The suspended individual may request a meeting with the Medical Executive Committee to discuss the circumstances leading to the suspension. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual under investigation may have a support person or legal counsel present at the meeting, but neither the support person or legal counsel shall not be permitted to participate in the meeting.

c. In the event a summary suspension exceeds fourteen (14) days, the individual shall be given notice of a right to hearing as set forth in Article XII.

Section 11.3 Investigations

a. Initial Review. Whenever the activities or professional conduct of any member of the Medical Staff or Privileged Practitioners are considered detrimental to patient care, to be lower than the standards of the Medical Staff, or to be disruptive to the operations of the Hospital, the matter shall be referred in writing to the Chief of Staff, Chief Physician Executive/designee, or the CEO. The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised in credible and, if so, shall forward it in writing to the Medical Executive Committee.

b. Initiation of Investigation. The Medical Executive Committee shall review the matter and determine whether to conduct an investigation. If the Medical Executive Committee determines that an investigation is warranted, the Medical Executive Committee shall promptly inform the individual that an investigation has begun. The investigation is concluded when the process has been completed (including any hearing or appeal permitted under Article XII) or the Medical Staff member concurs in any actions taken.

c. Investigative Procedure. Once a determination has been made to begin an investigation, the Medical Executive Committee shall (i) investigate the matter itself, (ii) request that Credentials, Peer Review, or Physician Health and Behavior Committee, as appropriate, conduct the investigation, or (iii) appoint an Ad Hoc committee to conduct the investigation (collectively, an "Investigating Committee"). If an Ad Hoc committee is appointed to investigate the conduct, absent exigent circumstances, the members of the Ad Hoc committee should be composed of at least three Medical Staff members.

1. The Investigating Committee shall have the authority to conduct interviews of individuals with direct knowledge of the issues under review, including the Medical Staff member or Privileged Practitioner under investigation (as described more fully below) and review and consider any relevant documents and medical records. If the Investigating Committee determines that it needs expert review of medical records or clinical issues, the Chief Physician Executive or designee will assist the Committee in identifying an internal or external resources, as appropriate to the circumstances.

2. As part of the Investigating Committee's investigation, the individual under investigation will be offered at least one opportunity to meet with the Investigating Committee. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual under investigation may have a support person or legal counsel present at the meeting, but neither the support person nor legal counsel shall not be permitted to participate in the meeting. The individual's failure to cooperate with the Investigating Committee in scheduling this meeting shall constitute a waiver of the right to meet with the Investigating Committee.

3. The Investigating Committee shall make a reasonable effort to complete the investigation and issue its findings within thirty (30) days of being requested to perform the investigation. This time frame is intended to serve as a guideline, and as such, shall not be deemed to create any right for an individual to have an investigation completed within such time period. In the event the Investigating Committee is unable to complete the investigation and issue its findings within this time frame, the Investigating Committee shall advise the individual of the approximate date on which it expects to complete the investigation.

4. The findings and recommendations of the Investigating Committee shall be submitted to the Medical Executive Committee for review. A copy of any written findings and recommendations shall be shared with the individual under investigation. The Chief of Staff shall determine, in his or her sole discretion, what or whether other information or documents considered or created by the Investigating Committee or Medical Executive Committee are shared with the individual under investigation. Information or documents considered or created by the Investigating Committee or Medical Executive Committee that are not shared with the individual under investigation shall be maintained as confidential and peer review privileged material.

d. <u>Recommendation</u>.

1. Upon receipt of the findings and recommendations from the Investigating Committee, the Medical Executive Committee, at its next regularly scheduled meeting, or at an earlier meeting if deemed appropriate and necessary within the discretion of the Chief of Staff, considers the findings. At least one representative of the Investigating Committee will attend this meeting for the purpose of answering any questions about the process or the findings. The individual under investigation has the right to either (1) meet with the Medical Executive Committee at the meeting at which it considers the Investigating Committee's findings and prior to action on those findings; or (2)

submit a written statement to the Medical Executive Committee at least three (3) calendar days prior to the meeting at which the Medical Executive Committee considers the findings. If the individual under investigation meets with the Medical Executive Committee, the individual will be introduced and may then address the Medical Executive Committee, after which the Committee members may have the opportunity to ask the individual questions and the individual may respond. The individual under investigation may have a support person or legal counsel present at the meeting, but neither the support person nor legal counsel shall not be permitted to participate in the meeting. The individual's failure to cooperate with the Medical Executive Committee in scheduling this meeting shall constitute a waiver of the right to meet with the Medical Executive Committee.

2. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from the Investigating Committee or may request additional information before action is taken. Possible actions include, but are not limited to: determining no action is justified; issuing a letter of guidance or counsel; issuing a letter of warning or reprimand; imposing terms of probation or a requirement for monitoring or consultation; recommending additional training or education; recommending reduction of Clinical Privileges, recommending suspension of clinical privileges for a term; recommending that an already imposed suspension of Clinical Privileges be terminated, modified, or sustained; or recommending that the individual's Medical Staff membership and/or clinical privileges be indefinitely suspended or revoked.

3. Any recommendation by the Medical Executive Committee may become effective immediately if the Medical Executive Committee determines that the failure to act may result in imminent danger to the health of any individual, subject to reversal by the Board of Directors through the Hearing and Appellate Procedure set forth in Article XII.

Section 11.4 Automatic Relinquishment, Suspension or Restriction

a. In the following instances, an individual's Clinical Privileges and Medical Staff membership, if applicable, shall be automatically suspended, limited, terminated or inactivated without Hearing or appeal rights described in Article 12 of these Bylaws and the action shall take effect immediately. The individual shall notify the CEO or Chief of Staff immediately of circumstances giving rise to such action.

   1. Licensure and DEA Registration. When an individual's license to practice medicine, prescribe controlled substances (if required for the individual's Clinical Privileges), or engage in similar practices is expired, then the individual's Clinical Privileges and Medical Staff membership, if applicable, shall be suspended until the license or DEA registration is renewed. If the license or DEA registration is not renewed within thirty (30) days, the individual's clinical privileges and Medical Staff membership, if applicable, shall be terminated. If the individual's license or DEA registration is revoked or suspended, then the individual's Clinical Privileges and Medical Staff membership, if applicable, shall be terminated. If the individual's license or DEA registration is restricted, then the individual's clinical privileges and Medical Staff membership, if applicable, shall be suspended pending further review and recommendation by the Credentials Committee and approval by the Medical Executive Committee. When licensure or DEA registration is reinstated within thirty (30) days of

suspension for non-renewal, the individual shall provide the Medical Staff Office with documentation which demonstrates reinstatement and the individual's Clinical Privileges will automatically reinstate without further review. The Medical Staff Office will notify the Chief of Staff and Chief Physician Executive.

2. Professional Liability Insurance Coverage. The Clinical Privileges and Medical Staff membership, if applicable, of any individual whose professional liability insurance is lapsed for any reason, or whose coverage is not maintained in the minimum amount required under these Bylaws, shall be suspended until evidence of coverage is provided. If evidence of coverage is not provided within thirty (30) days, the individual's clinical privileges and Medical Staff membership, if applicable, shall be terminated. When professional liability insurance is reinstated within thirty (30) days of suspension, the individual shall provide the Medical Staff Office with documentation which demonstrates reinstatement and the individual's Clinical Privileges will automatically reinstate without further review. The Medical Staff Office will notify the Chief of Staff and Chief Physician Executive/designee.

3. Exclusion from Federal or State Programs. If any individual is excluded from Medicare, Medicaid, or other federal or state health care programs, the individual's Clinical Privileges and Medical Staff membership, if applicable, shall be terminated.

4. Medical Records. If any individual fails to comply with the Medical Staff Medical Records Policy, the individual's Clinical Privileges and Medical Staff membership, if applicable, shall be suspended until all delinquent records are completed. The individual's clinical privileges and Medical Staff membership shall be reinstated in accordance with the Medical Records Policy.

5. Mandatory Vaccinations. If any individual fails to comply with a mandatory vaccination policy, the individual's Clinical Privileges and Medical Staff membership, if applicable, shall be suspended. In the case of influenza, the individual may be suspended until the published flu season ends. For all other mandatory vaccinations, if the individual does not comply with the mandatory vaccination policy, the individual shall be given the opportunity to meet with the Medical Executive Committee to determine further action.

6. Criminal Activity. If any individual has been convicted or pled guilty or no contest to a misdemeanor involving moral turpitude or to a felony shall be suspended automatically upon such indictment, conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effective until the matter is resolved by subsequent action of the Board of Directors through reinstatement or corrective action, as appropriate.

7. Failure to Provide Requested Information. Failure of an individual to provide information pertaining to his/her qualifications for Medical Staff appointment or Clinical Privileges, or to attend a conference within fifteen (15) days of a written request from the Credentials Committee, Medical Executive Committee, the CEO, or any other Medical Staff Committee authorized to request such information shall result in the suspension of the individual's clinical privileges and Medical Staff membership, if applicable. Such suspension shall remain in effect until the matter is resolved as determined by the requesting Committee.

b. Restatement. Reinstatement for suspensions other than those described in 11.3.a(1)-(2) will be reviewed by the Credentials Committee which will forward its recommendations regarding the request to reinstate the individual's Clinical Privileges and Medical Staff membership, if applicable, to the Medical Executive Committee. The Medical Executive Committee will consider the information and make a recommendation to the Board of Directors. The Board of Directors may accept the recommendation from the Medical Executive Committee or make its own determination on the reinstatement of Clinical Privileges and Medical Staff membership, if applicable.

Section 11.5 Leaves of Absence

a. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Chief of Staff. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reason(s) for the leave. Any absence from the Medical Staff and/or from patient care responsibilities for more than sixty (60) days shall require an individual to request a leave of absence.

b. The Credentials Committee will review the request and make a recommendation to the Medical Executive Committee as to whether the request for a leave of absence should be granted. After reviewing the matter, the Medical Executive Committee shall make a recommendation to the Board of Directors who shall determine whether to grant the leave.

c. At least thirty (30) days prior to the conclusion of the leave of absence, if the circumstances allow, the individual shall request reinstatement of his/her Clinical Privileges and Medical Staff membership by notifying the Chief of Staff in writing. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by documentation from the individual's physician that the individual is physically and/or mentally capable of resuming his/her clinical privileges and Medical Staff responsibilities. The Credentials Committee shall refer the matter to the Medical Executive Committee for a recommendation. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

d. The Medical Executive Committee shall provide the Board with a recommendation regarding reinstatement of the individual's Clinical Privileges and Medical Staff membership. The Board may approve reinstatement in the same or a different Medical Staff category and may limit or modify the individual's clinical privileges. In the event the Medical Executive Committee's recommendation would entitle the individual to request a Hearing, the individual will be provided notice and the procedures set forth in Article 12 of these Bylaws will apply.

e. A leave of absence that exceeds one (1) year shall result in automatic termination of the individual's Clinical Privileges and Medical Staff membership, with no right to a Hearing or appeal, unless an extension is granted by the Board of Directors. Extensions will only be considered in extraordinary cases where the extension is in the best interests of the Hospital.

f. Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for leave, or where a request for an extension is not granted, the requesting individual may meet with the Medical Executive Committee to discuss the request. However, the decision of the

Medical Executive Committee, subject to approval by the Board, is final, with no right to a Hearing or appeal.

ARTICLE XII
HEARING AND APPELLATE REVIEW PROCEDURE

Section 12.1 General Procedures

a. Any documents, reports, requests, and written notices referenced in this Article XII may be delivered in person, by email or by certified mail (return receipt requested) to the designated recipient.

b. The Hearing contemplated herein may be held remotely via telecommunication if circumstances warrant, as determined in the sole discretion of the Chief of Staff.

c. If the deadline pursuant to which an action must be taken under this Article XII falls on a weekend or holiday, the deadline will be extended to the next workday. In addition, any deadline or time period in this Article XII may be extended by the Chief of Staff upon good cause shown, either upon request or his/her own accord.

Section 12.2 Right to Hearing

a. Events that Trigger Hearing Rights. A member of the Medical Staff is entitled to a Hearing whenever the Medical Executive Committee recommends any of the following actions be taken against him/her based upon the Medical Staff member's clinical competence or professional conduct:

   1. The denial of Medical Staff appointment or reappointment;

   2. The revocation of Medical Staff membership or Clinical Privileges;

   3. The suspension of Medical Staff membership for a period exceeding fourteen (14) days; or

   4. The restriction, denial, reduction, or suspension of Clinical Privileges for a period exceeding fourteen (14) days.

b. Events that Do Not Trigger Hearing Rights. None of the following actions shall entitle a Medical Staff member to a Hearing and they shall take effect without Hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her Medical Staff Office file:

   1. Actions that are not based on the professional competence or professional conduct of the individual.

   2. Actions that do not adversely affect the individual's Medical Staff membership or privileges, including but not limited to issuance of a letter of guidance, warning or reprimand.

   3. Denial or failure to process an application for Medical Staff membership or Clinical Privileges when the applicant does not satisfy the basic qualifications for membership as set forth in these Bylaws or the criteria established for Clinical Privileges as

established by the Medical Executive Committee or as set forth in Medical Staff Documents.

4. Termination, suspension or restriction of Medical Staff membership or privileges, or the denial or failure to process an application for reappointment to the Medical Staff or Clinical Privileges, when the individual does not satisfy the basic qualifications for membership as set forth in these Bylaws or the criteria established for Clinical Privileges as established by the Medical Executive Committee or as set forth in Medical Staff Documents.

5. Voluntary or automatic termination, suspension, restriction or resignation of membership or Clinical Privileges as described in these Bylaws.

6. Termination or limitation of temporary or disaster privileges.

7. Imposition of a requirement for general consultation requirements, monitoring, additional training or continuing education.

8. Imposition of a precautionary or disciplinary suspension, restriction or reduction of Clinical Privileges or Medical Staff membership that does not exceed fourteen (14) days.

9. Denial of or failure to consider any requested waiver of a requirement in these Bylaws, any requested extension of time periods as set forth in these Bylaws; or any request for leave of absence, or for an extension of a leave of absence.

10. Determination that an application is incomplete or untimely.

11. Determination that an application will not be processed or will be terminated due to a misstatement or omission.

12. Any recommendation voluntarily accepted by the individual.

13. A change in Medical Staff category to which a Medical Staff member is appointed.

14. Any other action that does not meet the requirements set forth in Section 12.2(a) of these Bylaws.

Section 12.3 Notice of Recommendation

When a recommendation is made, which, according to these Bylaws entitles a Medical Staff member to a Hearing prior to a final decision by the Board of Directors, the affected Medical Staff member will promptly be given written notice by the CEO. The notice will contain:

a. A statement of the recommendation made and the general reasons for it;

b. Notice that the Medical Staff member has the right to request a Hearing on the recommendation within fifteen (15) calendar days upon receipt of the notice; and

c. A copy of this Article XII outlining the right in the Hearing.

Section 12.4 Request for Hearing

The Medical Staff member has fifteen (15) calendar days following his/her receipt of such notice to file a written request for a Hearing with the CEO. The failure of the Medical Staff member to request a Hearing constitute a waiver of his/her right to such a Hearing and to any appellate review to which he/she might otherwise be entitled. If such a right to a Hearing is waived, the recommendation becomes effective against the Medical Staff member immediately.

Section 12.5 Notice of Hearing

a. The CEO will schedule a Hearing as soon as practicable. The Hearing date will not be less than thirty (30) calendar days from the date on which the notice of Hearing is forwarded to the Medical Staff member, unless an earlier date is agreed upon in writing by the parties.

b. The CEO will forward the written notice of Hearing to the Medical Staff member. The notice of Hearing will include:

    1. The date, time, and location of the Hearing;

    2. The names of the Hearing Panel members/Hearing Officer, if known; and

    3. 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 Medical Staff member's qualifications.

Section 12.6 Appointment of Hearing Panel, Presiding Officer, or Hearing Officer

a. When a Hearing is requested, the CEO, after consulting with the Chief of Staff, may appoint: (1) a Hearing Panel that will be composed of not less than three (3) members; or one (1) person to serve as Hearing Officer. As determined within the sole discretion of the CEO, the Hearing Officer or Hearing Panel will be composed of Medical Staff members, other physicians, laypersons, or any combination of the above, none of whom will have actively participated in the consideration of the matter at any previous level or are in direct economic competition with the Medical Staff member requesting the Hearing. Knowledge of the matter will not preclude any individual from serving as Hearing Officer or a member of the Hearing Panel.

b. In the case of the appointment of a Hearing Panel, the CEO, in consultation with the Chief of Staff, will designate one member of the Hearing Panel as Chair or, in lieu of a Hearing Panel Chair, the CEO, in consultation with the Chief of Staff, may appoint a Presiding Officer who may be an attorney. The President Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but will not be entitled to vote on its recommendations.

c. The Hearing Panel Chair, the Hearing Officer, or the Presiding Officer, as applicable (hereinafter referenced as "Hearing Panel Chair") retains the discretion to determine the structure, format, and procedure for the Hearing (including the discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence) with the goals of:

1. Ensuring that all participants in the Hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, but subject to limitation based on a reasonable number of witnesses and duration of direction and cross examination, applicable to both sides as may be necessary to avoid excessive or irrelevant testimony or to prevent undue delay or abuse of the Hearing process; and

2. Maintaining decorum throughout the Hearing.

The Hearing Panel Chair may be advised by legal counsel to the Hospital regarding the Hearing procedure.

Section 12.7 Pre-Hearing Procedure

a. There is no right to discovery in connection with the Hearing. However, the Medical Staff member is entitled to obtain or review the following documents, provided that: (1) the Medical Staff member makes a specific, written request for the documents at least two (2) weeks prior to the date of the pre-Hearing conference described more fully below; and (2) the Medical Staff member executes a stipulation that such documents will be maintained as confidential and will not be disclosed or used for any purpose outside of the Hearing and any subsequent appeal:

   1. Copies of, or reasonable access to, all patient records identified in the notice of Hearing, as revised or supplemented, at the Medical Staff member's expense;

   2. Non-privileged reports of experts or other documents relied upon to support the recommendation or action by the Medical Executive Committee;

   3. Non-privileged, redacted copies of relevant committee minutes; and

   4. Copies of any other documents relied upon by the Executive Committee.

   The provision of this information is not intended to waive any privilege under applicable peer review protection laws.

b. The Hearing Chair will require the Medical Staff member (and/or his/her counsel), and counsel for the Medical Executive Committee to participate in a pre-Hearing conference for the purpose of resolving all procedural questions in advance of the Hearing. The Hearing Chair shall specifically require the parties to present at, or before, the pre-Hearing conference:

   1. The names of their respective counsel who will appear at the Hearing;

   2. Copies of all documentary evidence, including any expert reports the Medical Staff member intends to rely on the Hearing, and any objections to such documents reasonably known at the time; and

   3. The names of all witnesses and a brief statement of their anticipated testimony.

c. Witnesses and documents not provided and agreed upon pursuant to the pre-Hearing conference will be excluded from the Hearing unless admitted for good cause shown (and subject to any conditions that may be imposed) in the sole discretion of the Hearing Chair.

d. The pre-Hearing conference shall be scheduled on a date that permits the Medical Staff member to submit a request for documents and receive those documents at least two (2) weeks prior to the pre-Hearing conference.

Section 12.8 Hearing Procedure

a. Failure to Appear: A Medical Staff member who fails to appear at the Hearing, without good cause, is deemed to have waived his/her rights to a Hearing and to have voluntarily accepted the recommendation or decision in question, which thereupon shall be transmitted to the Board for final action.

b. Recording: The Hearing shall be recorded as determined by the Hearing Chair, and may include the use of a court reporter, electronic recording unit, or any other method that ensures a fair and complete record. The cost of a court reporter or other electronic recording will be borne by the Hospital, but a copy of the transcript or recording will be provided to the Medical Staff member requesting the Hearing at the Medical Staff member's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents the State of North Carolina.

c. The Medical Executive Committee or its counsel shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the Medical Staff member or his/her representative to present evidence. Subject to reasonable limits determined by the Hearing Chair, each party has the right to:

   1. Be represented by an attorney or other person of his/her choice;
   2. Call and examine witnesses, to the extent they are available and willing to testify;
   3. Introduce documentary evidence;
   4. Cross-examine witnesses on any relevant matters;
   5. Rebut any evidence; and
   6. Submit a written statement at the close of the Hearing.

d. If the Medical Staff member does not testify on his/her own behalf, s/he may be called as a witness by the Medical Executive Committee's representative and examined as if under cross-examination.

e. Hearing Panel members or the Hearing Chair may question the witnesses, call additional witnesses, or request additional documentary evidence.

f. Admissibility of Evidence: The Hearing need not be conducted in accordance with any rules of evidence. Any relevant evidence, if it is the sort of evidence upon which reasonable persons customarily rely in the conduct of serious affairs, may be considered in the sole discretion of the Hearing Chair, regardless of the admissibility of such evidence in a court of law. Prior to or at any time during the Hearing, each party is entitled to submit a memoranda concerning any issue of law, procedure, or fact, and such memoranda will become a part of the Hearing record.

g. The Hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or Chief of Staff.

h. Either party may request a postponement or extension of time which may be permitted by the Hearing Chair, in their sole discretion, upon a showing of good cause.

Section 12.9 Hearing Conclusion, Deliberations, and Recommendations

a. The Hearing Chair may, in their sole discretion, recess the Hearing and reconvene at a later date for the convenience of the participants or for the purposes of obtaining new or additional evidence or consultation.

b. Upon conclusion of the presentations of all the evidence or upon a decision by the Hearing Chair that the remaining evidence will be cumulative or irrelevant, the Hearing will be closed.

c. The Hearing Panel's or Hearing Chair's, as applicable, recommendation will uphold the recommendation of the Medical Executive Committee unless it finds that the Medical Staff member who requested the Hearing has proved, by clear and convincing evidence, that the recommendation by the Medical Executive Committee was arbitrary, capricious or otherwise without reasonable basis.

d. Within twenty (20) calendar days after final adjournment of the Hearing (which will be designated as the time the Hearing Chair receives the Hearing transcript or any post-Hearing memoranda, whichever is later; provided that the Hearing Chair may determine that the Hearing transcript is not necessary in order to adjourn the Hearing), the Hearing Panel will conduct its deliberations and will render a recommendation, accompanied by a report, that will contain a concise written statement of the reasons for the recommendation.

e. The Hearing Chair will deliver the written report and recommendation to the CEO who will forward it, along with all supporting documentation, to the Board of Directors for further action. The CEO will also deliver a copy of the report and recommendation to the Medical Staff member and the Medical Executive Committee.

Section 12.10 Appellate Review

a. Within ten (10) calendar days after receipt of notice of the written report and recommendation, either the Medical Staff Member or the Medical Executive Committee may request an appellate review. The request shall be in writing to the CEO and will include a statement of the grounds for appeal and the specific facts or circumstances that justify further review. If an appellate review is not requested in this manner, both parties will be deemed to have waived appellate review and accepted the written report and recommendation as final.

b. The grounds for appeal shall be limited to the following:

    1. The during or prior to the Hearing, there was substantial and material failure to comply with these Medical Staff Bylaws so as to deny due process or a hair Hearing; or

    2. The recommendation of the Hearing Panel was arbitrary, capricious, a result of prejudice, or not supported by credible evidence.

c. If an appeal is requested as set forth in this Section, the Chair of the Board of Directors shall schedule and arrange for an appeal. The Medical Staff member shall be given notice of the time, places, and date of the appeal. The appeal shall be held as soon as possible

as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

d. The Chair of the Board of Directors may appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation was made, or the Board may hear the appeal as a whole body.

e. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first (by a date determined by the Chair of the Board of Directors or Chair of the Review Panel) and the other party shall then have ten (10) days to respond.

f. Additional evidence will not be considered, absent (as determined in the sole discretion of the Chair of the Board of Directors), a compelling demonstration that such evidence was not developed at the time of the Hearing or that any opportunity to admit it at the Hearing was inappropriately denied.

g. As applicable, the Review Panel will recommend final action to the Board.

Section 12.11 Final Decision of the Board

a. Within thirty (30) calendar days after receipt of the Review Panel's recommendation, or the decision of the Board if the appeal was heard by the whole body, the Board of Directors will render a final decision in writing, including specific reasons, and will deliver copies to the Medical Executive Committee and, through the CEO, to the Medical Staff member, provided that the time period may be extended in the discretion of the Chair of the Board of Directors upon good cause shown. The Board of Directors may affirm, modify or reverse the recommendation of the Review Panel, refer the matter for further review and recommendation, or make its own decision in light of the Board of Directors' ultimate legal responsibility to make appointments and grant Clinical Privileges.

b. Except where the matter is referred for further action and recommendation, the final decision of the Board of Directors will be immediately effective and not subject to further Hearing or appellate review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the CEO in accordance with the instructions given by the Board of Directors. This further review process and the report back to the Board of Directions will not exceed thirty (30) calendar days except as the parties may otherwise stipulate or as extended in the discretion of the Chair of the Board of Directors upon good cause shown.

c. Notwithstanding any other provision set forth in these Medical Staff Bylaws, no Medical Staff member shall be entitled as a matter of right to more than one (1) Hearing and one (1) appellate review on any matter which has been considered by either the Medical Executive Committee or the Board of Directors.

ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASES

Section 13.1 Confidentiality and Peer Review Protection

To the maximum extent consistent with applicable law, the Medical Staff and its committees shall constitute medical review committees under North Carolina law, and information considered or generated by the Medical Staff, its committees, or its members shall be privileged and confidential, including but not limited to records, reports, minutes, discussions, and any other information collected, generated, utilized or provided for the purposes of evaluating or improving the quality and efficiency of patient care; reducing morbidity and mortality; investigating, evaluating or reviewing the qualifications or competence of Medical Staff applicants, members or persons who request or have Clinical Privileges; contributions to clinical teaching or research; or information containing protected health information of patients. Medical Staff members and others bound by these Bylaws shall not disclose such confidential information unless expressly required by law or with the written authorization of the Medical Executive Committee and CEO. Persons who violate this Section shall be subject to corrective action.

Section 13.2 Immunity and Indemnification

a. To the maximum extent allowed by law, no member or representative of the Medical Staff or Hospital shall be liable to any person for damages or other relief for any decision, opinion, action, omission, statement, or recommendation made within the scope of his/her duties as an official representative of the Medical Staff relating to or arising from the provision of information, opinion, or counsel, or relating to or arising from participating in any credentialing, privileging, quality improvement or peer review activities.

b. No member or representative of the Medical Staff or Hospital shall be liable to any person for damages or other relief by reason of providing information to another representative or to an appropriate state or federal regulatory agency, concerning any individual who applied for, holds, or has held Clinical Privileges or Medical Staff membership, provided that such representative acts in a factual manner, and provided further that such information will not be disclosed to any other hospital, health care facility, organization of health professionals, or individuals without that individua's express written consent.

c. All Medical Staff officers, committee chairs, committee members, and individual Medical Staff members or Privileged Practitioners who act for or on behalf of the Hospital in discharging their responsibilities and professional review activities pursuant to the Medical Staff Documents shall be indemnified when acting in those capacities, to the fullest extent permitted by law.

Section 13.3 Activities and Information Covered

a. Activities: The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to: applications and requests for appointment, privileges, or specified services; periodic reappraisals for reappointment, privileges, or specific services; correction action or disciplinary proceedings; hearings and appellate reviews; quality assessment and performance improvement or peer review; utilization review and improvement activities;

morbidity and mortality conferences; claims review; risk management and liability prevention activities; or other Hospital, committee or staff activities relate to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

b. Information: The immunity provided by this Article shall apply to all information which may relate to an individual's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that may directly or indirectly affect patient care.

Section 13.4 Releases

Each physician or Privileged Practitioner requesting appointment, reappointment, or Clinical Privileges shall, upon request of Hospital, execute general and specific releases when requested by the CEO, the Credentials Committee Chair, or their respective designees. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and it shall not be further processed.

Section 13.5 Cumulative Effect

Provisions in these Bylaws as well as the Medical Staff policies and procedures and Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XIV
MISCELLANEOUS PROVISIONS

Section 14.1 Medical Staff Year

The Medical Staff year is January 1 to December 31.

Section 14.2 History and Physical Requirements

The History and Physical Exam (H&P), when required, shall be performed and recorded by a physician, dentist, or Privileged Practitioner who has an active North Carolina license and has been granted Clinical Privileges by the Hospital. The H&P is the responsibility of the attending physician or his/her designee. Oral surgeons, dentists, and podiatrists are responsible for the H&P pertinent to their area of specialty. An H&P is required for all inpatient and observation admissions, prior to outpatients undergoing invasive procedures in the Hospital's surgical suites, certain procedures performed in Imaging Services and the Cath Lab, and other areas that perform invasive procedures.

The H&P must be completed and documented in the medical record no more than thirty (30) days before, or within twenty-four (24) hours after, a hospital inpatient or observation admission, but prior to an operative or high-risk procedure requiring anesthesia services is performed. If an H&P was completed within thirty (30) days prior to inpatient or observation admission, an update documenting examination of the patient and any changes in the patient's condition is completed within twenty-four (24) hours after admission, but prior to an operative or high-risk procedure requiring anesthesia services is performed. The update note must document any changes identified or include language such as "patient examined and no changes."

Section 14.3 Conflict Management and Resolution

In the event of conflict between the Medical Staff (as represented by written petition signed by at least twenty (20%) of the voting members of the Medical Staff) and Medical Executive Committee, including but not limited to any conflict involving amendments to these Bylaws or the adoption or amendment of any Medical Staff Policy, the conflict resolution process set forth in this Section shall be followed.

a. The Medical Staff (through the written petition referenced above) must submit a request to meet in writing to the Chief of Staff and CEO. The request must generally describe the conflict. The Chief of Staff shall set the time and place for the meeting, which shall be held within ten (10) days of receipt of the written request. The written request will identify up to three (3) members of the Active Medical Staff to serve as representatives (the "Medical Staff Representatives"). The meeting shall be attended by the Medical Staff Representatives, the members of the Medical Executive Committee, the CEO, and other members of administration as necessary.

b. The Chief of Staff and CEO shall co-chair the meeting. Each person attending the meeting shall have an opportunity to exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee present at the meeting and a majority vote of the Medical Staff Representatives.

c. If the matter is not resolved through the meeting referenced above, then the Medical Staff Representatives and up to three (3) members of the Medical Executive Committee may address the Board of Directors during the open forum at the Board of Directors' next regulatory scheduled meeting. If the conflict requires immediate action, the CEO and/or Chair of the Board of Directors may, in his/her sole discretion, call an emergency meeting of the Board Executive Committee during which the two groups of representatives may present their concerns. The Board of Directors shall have final decision-making authority to resolve the conflict.

Section 14.4 Technical and Insignificant Deviations

Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws and any other Medical Staff Documents shall not invalidate the action taken.

Section 14.5 Exhaustion of Remedies

If an adverse action is taken or recommended, the individual must exhaust the remedies afforded by these Bylaws before resorting to legal action.