

**MEDICAL STAFF BYLAWS  
OF  
CAROMONT REGIONAL MEDICAL CENTER**

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## TABLE OF CONTENTS

### CHAPTER I

	<u>PAGE</u>
<b>1. GENERAL</b> .....	8
1.A PURPOSE.....	8
1.B DEFINITIONS .....	8
1.C ORGANIZATION AND STRUCTURE.....	9
1.D TIME LIMITS .....	9
1.E DELEGATION OF FUNCTIONS .....	9
1.F MEDICAL STAFF DUES.....	10
<b>2. MEDICAL STAFF MEMBERSHIP</b> .....	11
2.A MEDICAL STAFF QUALIFICATIONS .....	11
2.B. PRIVILEGED PRACTITIONER QUALIFICATIONS.....	12
2.C. RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP AND/OR PRIVILEGED PRACTITIONERS.....	13
2.D. MEDICAL STAFF CATEGORIES .....	15
2.D.1 Active Category .....	15
2.D.1 Active Outpatient Category .....	16
2.D.2. Associate Category .....	17
2.D.3 Honorary Category .....	18
2.E. NO ENTITLEMENT TO APPOINTMENT .....	19
2.F. NON-DISCRIMINATION .....	20
2.G. REQUIREMENTS FOR ADMITTING PATIENTS .....	20
<b>3. OFFICERS</b> .....	21
3.A DESIGNATION .....	21
3.B ELIGIBILITY CRITERIA .....	21

3.C	DUTIES .....	21
3.C.1.	Chief of Staff.....	21
3.C.2	Chief of Staff Elect .....	22
2.C.3.	Immediate Past Chief of Staff.....	22
3.D	NOMINATIONS .....	23
3.E	ELECTION.....	23
3.F	TERM OF OFFICE .....	24
3.G	REMOVAL.....	24
3.H	VACANCIES .....	25
<b>4.</b>	<b>CLINICAL ORGANIZATION OF THE MEDICAL STAFF .....</b>	<b>26</b>
4.A	Organization .....	26
4.B	OPTIONAL CLINICAL INTEREST GROUP .....	26
<b>5.</b>	<b>MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT, PEER REVIEW, AND CREDENTIALING FUNCTIONS .....</b>	<b>27</b>
5.A	APPOINTMENT .....	27
5.B	EXECUTIVE COMMITTEE .....	27
5.B.1.	Composition .....	27
5.B.2	Duties .....	28
5B.3	Meetings.....	29
5.C	PERFORMANCE IMPROVEMENT ACTIVITIES .....	29
5.D	PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS.....	30
5.E	CREATION OF STANDING COMMITTEES .....	30
5.F	SPECIAL TASK FORCES .....	30
<b>6.</b>	<b>MEETINGS .....</b>	<b>31</b>

6.A	MEDICAL STAFF YEAR .....	31
6.B	MEDICAL STAFF MEETINGS .....	31
	6.B.1 Regular Meetings .....	31
	6.B.2 Special Meetings .....	31
6.C	COMMITTEE MEETINGS .....	31
	6.C.1 Regular Meetings .....	31
	6.C.2 Special Meetings .....	31
6.D	PROVISIONS COMMON TO ALL MEETINGS .....	31
	6.D.1 Notice of Meetings.....	31
	6.D.2 Quorum and Voting .....	32
	6.D.3 Agenda .....	32
	6.D.4 Rules of Order.....	33
	6.D.5 Minutes, Reports and Recommendations .....	33
	6.D.6 Confidentiality .....	33
	6.D.7 Attendance Requirements .....	33
<b>7.</b>	<b>CONFLICT OF INTEREST .....</b>	<b>34</b>
<b>8.</b>	<b>BOARD CONFIRMATION AND INDEMNIFICATION.....</b>	<b>35</b>
<b>9.</b>	<b>AMENDMENTS TO THE BYLAWS .....</b>	<b>36</b>
<b>10.</b>	<b>MEDICAL STAFF DOCUMENTS.....</b>	<b>37</b>
	10.A MEDICAL STAFF BYLAWS .....	37
	10.B MEDICAL STAFF POLICIES.....	37
	10.C ORGANIZATIONAL MANUAL.....	37
	10.D <b>PROCEDURES FOR ADOPTING AND AMENDING THE MEDICAL STAFF DOCUMENTS.....</b>	<b>37</b>
	10.D.1 Amendments to all Other Medical Staff Policies .....	37
	10.D.2 Medical Staff and Medical Executive Committee Conflict Resolution.....	38
<b>11.</b>	<b>APPOINTMENT TO THE MEDICAL STAFF.....</b>	<b>39</b>
	11.A GENERAL CONDITIONS OF APPOINTMENT .....	39
	11.A.1 Qualifications.....	39
	11.A.2 Basic Responsibilities and Requirements for Applicants and Members Of the Medical Staff.....	39
	11.A.3 Burden of Providing Information .....	41
	11.B FACTORS FOR EVALUATION.....	42

11.C	APPLICATION .....	42
11.C.1	Information.....	42
11.C.2	Grant of Immunity and Authorization to Obtain/Release Information.....	43
11.D	PROCEDURE FOR INITIAL APPOINTMENT .....	44
11.D.1	Request for Application .....	44
11.D.2	Initial Review of Application .....	45
11.D.3	Steps to Be Followed for All Initial Applicants .....	46
11.D.4	Use of Subject Matter Experts .....	46
11.D.5	Credentials Committee Procedure .....	47
11.D.6	Executive Committee Procedure .....	47
11.D.7	Board Action.....	48
11.D.8	Time Periods for Processing.....	49
11.E	CONFIRMATION OF COMPETENCY TO HOLD ASSIGNED PRIVILEGES .....	49
11.E.1	Focused Professional Practice Evaluation .....	49
11.E.2	Use of Ongoing Professional Practice Evaluation .....	49

**12. CLINICAL PRIVILEGES**

12.A	CLINICAL PRIVILEGES.....	51
12.A.1	General.....	51
12.A.2	Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons .....	52
12.A.3	Clinical Privileges for New Procedures.....	53
12.A.4	Clinical Privileges That Cross Specialty Lines .....	54
12.A.5	Clinical Privileges After Age 72.....	54
12.A.6	Physicians in Training .....	55
12.B	TEMPORARY CLINICAL PRIVILEGES .....	55
12.B.1	Eligibility to Request Temporary Clinical Privileges.....	55
12.B.2	Supervision Requirements .....	56
12.B.3	Termination of Temporary Clinical Privileges .....	56
12.C	EMERGENCY SITUATIONS.....	56
12.D	DISASTER MANAGEMENT STAFF PRIVILEGES .....	57
12.D.1	Eligibility to Request Clinical Privileges in an Officially Declared Emergency.....	57
12.D.2	Supervision Requirements .....	58
12.D.3	Termination of Emergency Clinical Privileges .....	58
12.E	HISTORY AND PHYSICALS .....	59

**13. PROCEDURE FOR REAPPOINTMENT**

13.A PROCEDURES FOR REAPPOINTMENT ..... 60  
13.A.1 Eligibility for Reappointment ..... 60  
13.A.2 Factors for Evaluation..... 60  
13.A.3 Reappointment Process..... 62  
13.A.4 All Applications for Reappointment..... 62  
13.A.5 Time Periods for Processing..... 63

**14. QUESTIONS INVOLVING MEDICAL STAFF MEMBERS**

14.A COLLEGIAL INTERVENTION ..... 64  
  
14.B PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES..... 65  
14.B.1 Grounds for Precautionary Suspension..... 65  
14.B.2 Executive Committee Procedure..... 65  
14.B.3 Care of Suspended Individual’s Patients ..... 65  
  
14.C INVESTIGATIONS ..... 66  
14.C.1 Initial Review ..... 66  
14.C.2 Initiation of Investigation..... 66  
14.C.3 Investigative Procedure..... 67  
14.C.4 Recommendation ..... 68  
  
14.D AUTOMATIC RELINQUISHMENT ..... 70  
14.D.1 Action by Government Agency or Insurer ..... 70  
14.D.2 Events Resulting in Automatic Suspension or Termination..... 70  
14.D.3 Reinstatement of Clinical Privileges ..... 72

14.E LEAVES OF ABSENCE..... 72

**15. HEARING AND APPEAL PROCEDURES ..... 74**

15.A INITIATION OF HEARING ..... 74  
15.A.1 Grounds for Hearing ..... 74  
15.A.2 Actions Not Grounds for Hearing..... 75  
  
15.B THE HEARING..... 75  
15.B.1 Notice of Recommendation ..... 75  
15.B.2 Request for Hearing ..... 76  
15.B.3 Notice of Hearing..... 76  
15.B.4 Hearing Panel, Presiding Officer, and Hearing Officer ..... 76

15.C	PRE-HEARING AND HEARING PROCEDURE .....	78
	15.C.1 Witness List.....	78
	15.C.2 Provision of Relevant Information.....	79
	15.C.3 Pre-Hearing Conference.....	80
	15.C.4 Failure to Appear .....	80
	15.C.5 Record of Hearing .....	80
	15.C.6 Rights of Both Sides and the Hearing Panel at the Hearing .....	80
	15.C.7 Admissibility of Evidence.....	81
	15.C.8 Post-Hearing Statement.....	81
	15.C.9 Persons to be Present.....	81
	15.C.10 Postponements and Extensions .....	81
15.D	HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS.....	81
	15.D.1 Order of Presentation .....	81
	15.D.2 Basis of Hearing Panel Recommendation .....	81
	15.D.3 Deliberations and Recommendation of the Hearing Panel.....	82
	15.D.4 Disposition of Hearing Panel Report .....	82
15.E	APPEAL PROCEDURE .....	82
	15.E.1 Time for Appeal .....	82
	15.E.2 Grounds for Appeal.....	82
	15.E.3 Time, Place and Notice .....	82
	15.E.4 Nature of Appellate Review.....	83
	15.E.5 Final Decision of the Board .....	83
	15.E.6 Further Review.....	83
	15.E.7 Right to One Hearing and One Appeal Only .....	84
<b>16.</b>	<b>CONFIDENTIALITY AND PEER REVIEW PROTECTION.....</b>	<b>85</b>
<b>17.</b>	<b>ADOPTION .....</b>	<b>86</b>

## ARTICLE 1

### GENERAL

#### 1.A. PURPOSE

The Medical Staff of CaroMont Regional Medical Center has adopted these Bylaws for the purpose of describing the organizational structure of the Medical Staff and the rules for governance. 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 the manner that most nearly accomplishes compliance with the intent.

It is also the intent of the Medical Staff to be bound by these Bylaws and the associated Medical Staff Documents. Failure to abide by these Bylaws and the associated Medical Staff Documents shall be grounds for disciplinary action, as described herein.

#### 1.B: DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

- (1) **“BOARD”** means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital.
- (2) **“CHIEF EXECUTIVE OFFICER”** or **“CEO”** means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (3) **“CLINICAL PRIVILEGES”** means the authorization granted by the Board to render specific patient care services.
- (4) **“DENTIST”** means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (5) **“EXECUTIVE COMMITTEE”** means the Executive Committee of the Medical Staff.
- (6) **“HOSPITAL”** means CaroMont Regional Medical Center, Incorporated.
- (7) **“MEDICAL STAFF”** means all physicians and dentists who have been appointed to the Medical Staff by the Board.
- (8) **“MEDICAL STAFF DOCUMENTS”** means all documents approved by the Medical Staff and the Board for purposes of governance or the orderly operation of the Medical Staff, including but not limited to these Bylaws,

Organizational Manual and all Medical Staff Policies as may now or hereafter be duly adopted and in effect.

- (9) **“NOTICE”** means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (10) **“PATIENT CONTACTS”** includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in the Hospital, an outpatient department of the Hospital, and/or CaroMont Specialty Surgery.
- (11) **“PHYSICIAN”** includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (12) **“SPECIAL NOTICE”** means hand delivery, certified mail/return receipt requested, or overnight delivery service providing receipt.
- (13) **“Privileged Practitioner” includes all Podiatry and Advanced Practitioners (Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives)**

#### **1.C. ORGANIZATION AND STRUCTURE**

The Medical Staff shall be organized as a non-departmentalized entity which accomplishes its work through designated individuals, committees, and Service Lines.

#### **1.D. TIME LIMITS**

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

#### **1.E. DELEGATION OF FUNCTIONS**

When a function is to be carried out by a person or committee, the person or the committee, through its Chair, may delegate performance of the function to one or more qualified designees.

**1.F. MEDICAL STAFF DUES**

- (a) Annual Medical Staff dues shall be as recommended by the Executive Committee and may vary by category. No dues will be assessed without Medical Staff approval.
- (b) Dues shall be payable annually upon request, if applicable. Failure to pay dues shall result in ineligibility to apply for reappointment.
- (c) Signatories to the Hospital's Medical Staff account shall be the Chief of Staff and Secretary.

## ARTICLE 2

### **MEDICAL STAFF MEMBERSHIP AND PRIVILEGED PRACTITIONERS**

Individuals may apply for membership in one of the following four categories of the Medical Staff: Active, Active Outpatient, Associate or Honorary. In addition, Privileged Practitioners may apply for privileges and if granted, shall be bound by these Bylaws. The procedure to be followed for appointment, reappointment, hearing and appeal shall be established in these Bylaws.

#### **2.A. MEDICAL STAFF QUALIFICATIONS**

All members of the Medical Staff shall meet the following standard qualifications:

- (a) have a current, unrestricted license to practice in North Carolina provided, however, that upon recommendation of the Credentials Committee and MEC and by action of the Board, individuals with certain restrictions may be considered for Medical Staff membership;
- (b) have never had a license to practice revoked by and state licensing agency;
- (c) have never had a license to practice suspended by any state licensing agency, unless compliance with this criterion is waived upon recommendation of the Credentials Committee;
- (d) have a current, unrestricted DEA registration, provided, however, that upon recommendation of the Credentials Committee and MEC and by action of the Board, individuals with certain restrictions may be considered for Medical Staff membership;
- (e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Board;
- (f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other governmental payer program;
- (g) have never had medical staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, unless compliance with this criterion is waived upon recommendation of the Credentials Committee and MEC and by action of the Board;
- (h) have never been convicted of any felony, unless compliance with this criterion is waived upon recommendation of the Credentials Committee and MEC and by action of the Board;

- (i) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or a residency training program approved by the American Osteopathic Association in a specialty in which the applicant seeks clinical privileges, or a dental surgery training program accredited by the Commission on Dental Education of the American Dental Association. (This requirement is applicable only to those individuals who apply for initial staff appointment on or after January 1, 2010);
- (j) become certified within five years of completion of residency or fellowship training by the appropriate specialty board of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Board equivalent, or the American Board of Oral and Maxillofacial Surgery, as applicable.
- (k) maintain certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment; and,
- (l) be able to work harmoniously with others so as not to disrupt the delivery of quality healthcare or the orderly operation of the Hospital.

Subspecialty board certified physicians will not be required to maintain their board certification in their primary specialty if:

- (a) Their subspecialty board does not compel maintenance of primary specialty board certification as an ongoing requirement for subspecialty board certification; and
- (b) The practitioner’s practice at the Hospital is primarily limited to those privileges and activities specific to his or her subspecialty.

## **2.B . PRIVILEGED PRACTITIONER QUALIFICATIONS**

All Privileged Providers shall meet the following standard qualifications:

- (a) have a current, unrestricted license or certification to practice his or her profession in the State of North Carolina (as applicable);
- (b) when applicable to his or her practice, have current, unrestricted DEA registration;
- (c) be located close enough to the Hospital to provide timely and continuous care for patients in the Hospital;
- (d) be covered by current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospital;

- (e) have not been excluded or precluded from participation in Medicare or Medicaid;
- (f) have never been convicted of any felony or any misdemeanor, unless compliance with this qualification is waived;
- (g) have never had clinical privileges or scope of practice denied, revoked, relinquished or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct unless compliance with this qualification is waived;
- (h) satisfy all additional eligibility qualifications relating to his/her specific area of practice; and
- (i) be able to document or provide evidence of his/her:
  - (1) background, education, relevant training, experience, and current demonstrated clinical competence;
  - (2) adherence to the ethics of his or her profession;
  - (3) good reputation and character;
  - (4) ability to perform the scope of practice requested competently and safely; and
  - (5) ability to work harmoniously with others sufficiently so as not to disrupt the delivery of quality healthcare or the orderly operation of the Hospital.

**2.C. RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP AND/OR PRIVILEGED PRACTITIONERS**

Each member of the medical staff and each privileged practitioner (as applicable) must continuously comply with the provisions of these Bylaws, medical staff and hospital manuals, and policies. Members and privileged practitioners must:

- a. Provide for the continuous and timely care to all patients for whom the practitioner has responsibility;
- b. Provide, with or without request, new and updated information to Caromont Health as it occurs, pertinent to any question found on the initial application or reappointment forms;
- c. Appear for personal interviews (in person or by teleconference) in regard to an application for initial appointment or reappointment as requested by an officer or committee of the medical staff;
- d. Abide by all applicable state and federal laws regarding healthcare fraud and abuse;

- e. Refrain from deceiving patients as to the identity of any individual providing treatment or services;
- f. Seek appropriate consultation whenever necessary to promote adequate quality of care. Such consultation may be appropriate when the diagnosis is obscure after ordinary diagnostic procedures have been completed; when there is doubt as to the choice of therapeutic measures to be used; when special skills of other physicians may be needed; when a patient is not a good risk for an operation, therapeutic or diagnostic procedure; when requested by the patient or his family; or when otherwise required by medical staff or hospital policies;
- g. Complete in a manner consistent with medical staff policies all medical and other required records, inputting all information required by the Hospital;
- h. Satisfy continuing medical education requirements as may be required under policies adopted from time to time by the Medical Staff;
- i. Supervise the work of any dependent non-physician practitioner or allied health professional under the individual's direction;
- j. Pay all fees and dues assessed by the medical staff;
- k. Treat Hospital employees, patients, visitors, and other Practitioners and professionals in a dignified and courteous manner at all times.

Furthermore, each member of the medical staff and each privileged practitioner by accepting medical staff appointment or clinical privileges agrees:

- l. To abide by these bylaws and medical staff manuals, medical staff policies, and hospital policies and procedures;
- m. That if there is any material misstatement in, or material omission from, an application for appointment or reappointment the Caromont Health may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed by the Board to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal;
- n. To participate in and collaborate with the peer review, risk management and performance improvement activities of the medical staff and Caromont Health. These include monitoring and evaluation tasks performed as part of the medical staff and hospital efforts to meet quality standards such as those established by the Joint Commission, the Centers for Medicare and Medicaid Services (CMS), and other governmental agencies and public and private insurers;
- o. To assist the hospital in fulfilling its responsibilities for providing emergency and charitable care in accordance with policies passed by the MEC and Board;
- p. To provide patient care and management only within the parameters of his or her professional competence, as reflected in the scope of clinical privileges granted the practitioner by the Board;
- q. To undergo a Fitness for Duty Evaluation as requested by the Hospital Chief Executive Officer and Chief of Staff, or their designee, when it appears necessary to protect the well-being of patients and/or staff, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing practitioner health or impairment;

- r. To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that practitioner's clinical privileges;
- s. To hold harmless and agree to refrain from legal action against any individual, the medical staff, or Hospital that appropriately shares peer review and performance information with a legitimate health care entity or state medical board assessing the credentials of the member;
- t. To abide by any applicable codes of conduct adopted by the medical staff and/or Hospital, including corporate compliance policies and codes of ethics;
- u. To abide by all local, state and federal laws and regulations, Joint Commission standards, and state licensure and professional review regulations and standards, as applicable to the practitioner's professional practice;
- v. To maintain the capability to receive email communication from the Hospital and members of the Medical Staff and to agree to utilize any electronic health record tools implemented by the Hospital for use with hospitalized patients or utilized in the Hospital's ambulatory facilities; and
- w. To provide patients with a quality of care that meets at all times the professional standards and requirements of the medical staff and Hospital.
- x. Except for emergencies when there is no other provider available, physicians should not treat medically or surgically, or prescribe for themselves, their family members or significant others. Such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. The Chief of Staff, or their designee, has final determination if question is raised.

## **2.D. Categories of Medical Staff Membership**

The Medical Staff shall be divided into the following categories:

- Active
- Active Outpatient
- Associate
- Honorary

Category status for each medical staff member will be recommended by the MEC at the time of appointment or reappointment. The Board will ratify MEC recommendations for medical staff category.

### **2.D.1 Active Medical Staff Category**

- a. **QUALIFICATIONS:** Appointees to this category must:

Be a physician or dentist appointed to the medical staff, who maintains primary clinical practice in a service area of the Hospital (as defined by the Hospital CEO or Board) and is involved in at least 12 patient contacts per calendar year. A patient contact is defined as any inpatient admission, consultation or attending visit, treatment of a patient in a Hospital outpatient clinic or observation unit, a

procedure performed in any Hospital clinical facility, or a day on the Hospital call schedule. For radiologists and pathologists, any day onsite at the hospital for four hours or more will qualify as a patient contact, with the burden of requesting active status resting with the member. Active category status will be assigned at reappointment time based on contact activity during the previous calendar year. Members may be appointed to this category at initial appointment where it is anticipated they will meet this criterion. However, if a practitioner has not completed 12 contacts in his/her first twelve months on staff, his/her category staff will be changed to Associate. Practitioners exclusively exercising telemedicine privileges will not be eligible for the Active category.

b. PREROGATIVES: Appointees to this category may:

- 1) Exercise those clinical privileges granted by the Board.
- 2) Vote on all matters presented to the medical staff and at meetings of medical staff committees to which they are appointed.
- 3) Be elected as a medical staff officer 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.
- 4) Attend all educational programs presented by the medical staff and/or Hospital and applicable medical staff social functions.

c. RESPONSIBILITIES: Appointees to this category must:

- 1) Meet the basic responsibilities of medical staff membership, as defined in Article 2.C above and contribute to the organizational and administrative affairs of the medical staff.
- 2) Actively participate in recognized functions of medical staff appointment as required or requested, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees through Focused Professional Practice Evaluation (FPPE), credentialing activities, medical records completion and the discharge of other medical staff functions, including medical staff committee and clinical service obligations as may be required from time to time.
- 3) Comply with the Medical Staff Bylaws and with all applicable rules, regulations, policies and procedures of the medical staff and Hospital.
- 4) Participate in providing any emergency department call coverage or other patient coverage arrangements as defined in medical staff or Hospital policies.
- 5) Perform such further duties as may be required under these Bylaws or medical staff policies, procedures, rules and regulations, as each may be amended from time to time.

#### 2.D.2 **Active Outpatient Medical Staff Category**

a. QUALIFICATIONS: Appointees to this category must:

Be a physician who initially meets the criteria for Active Staff membership but have a written agreement with CaroMont Inpatient Physicians or other Active Staff members of the Medical Staff in similar practices to provide care to their patients who are seen in the Hospital's Emergency Department or otherwise admitted to the Hospital.

b. PREROGATIVES: Appointees to this category may:

- 1) Vote on all matters presented to the medical staff and at meetings of medical staff committees to which they are appointed to sit on or chair.
- 2) Not run for an elected medical staff position or serve as a medical staff officer.
- 3) Attend all educational programs presented by the medical staff and/or Hospital and applicable medical staff social functions.
- 4) May not be granted clinical privileges and may not admit or 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.

c. RESPONSIBILITIES: Appointees to this category must:

- 1) Meet the basic responsibilities of medical staff membership, as defined in Article 2.C above and contribute to the organizational and administrative affairs of the medical staff. At reappointment, the Medical Staff Office shall verify that individuals continue to meet all requirements for Active Outpatient Staff, including verification of the written coverage arrangement. Members of the Active Outpatient Staff will not be required to go through the full reappointment process.
- 2) Comply with the Medical Staff Bylaws and with all applicable rules, regulations, policies and procedures of the medical staff and Hospital.
- 3) Perform such further duties as may be required under these Bylaws or medical staff policies, procedures, rules and regulations, as each may be amended from time to time.

### 2.D.3 **Associate Medical Staff Category**

a. QUALIFICATIONS: Appointees to this category must:

Be a physician or dentist appointed to the medical staff and not otherwise appointed to the Active Category. Members will be appointed to this category at initial appointment where it is anticipated they will not meet the criteria for Active Category. However, if a practitioner has completed 12 contacts in his first twelve months on staff, his category staff will be changed to Active. Medical staff members who have not had 12 patient contacts (as defined in 2.D.1a above) in the

twelve months prior to reappointment will be reappointed to the Associate Category. Practitioners exclusively exercising telemedicine privileges will be appointed to the Associate Category.

b. PREROGATIVES: Appointees to this category 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. Members of the Associate category shall *not* have voting privileges at general medical staff meetings or on medical staff bylaw amendments but may vote on committees to which they are appointed.
- 3) Not run for an elected medical staff position or serve as a medical staff officer.
- 4) Attend all educational programs presented by the medical staff and/or Hospital and applicable medical staff social functions.

c. RESPONSIBILITIES:

- 1) Meet the basic responsibilities of medical staff membership, as defined in Article 2.3, and contribute to the organizational and administrative affairs of the medical staff.
- 2) Actively participate in recognized functions of medical staff appointment as required or requested, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees through Focused Professional Practice Evaluation (FPPE), credentialing activities, medical records completion and the discharge of other medical staff functions, medical staff committee and clinical service obligations as may be required from time to time.
- 3) Comply with the Medical Staff Bylaws and with all applicable rules, regulations, policies and procedures of the medical staff and Hospital.
- 4) Participate in providing emergency department call coverage and other patient coverage arrangements as defined in policies adopted by the MEC and Hospital Board.
- 5) Perform such further duties as may be required under these Bylaws or medical staff policies, procedures, rules and regulations, as all may be amended from time to time.

#### 2.D.4 Honorary

a. QUALIFICATIONS:

The honorary category is restricted to those individuals the medical staff wishes to honor, including, but not limited to clinical professionals who have a history of participation in medical staff and/or Hospital affairs and those

who may have had a past medical staff leadership role. Honorary members who are not in the active practice of medicine or do not seek Hospital privileges do not need to meet the eligibility requirements listed in 2.1 above.

b. PREROGATIVES: Appointees to this category may:

- 1) Not admit or exercise clinical privileges at the Hospital.
- 2) Not vote at any meetings of the medical staff and not run for election or serve as a medical staff officer.
- 4) Be invited to attend education and social functions of the Hospital and medical staff as appropriate
- 5) Be appointed as voting members of committees when interested so that the medical staff may take advantage of their unique experience or talents.

c. RESPONSIBILITIES:

- 1) Practitioners in the honorary medical staff category shall conduct themselves in a professional manner consistent with medical staff and Hospital policies and codes of conduct. Practitioners must follow Hospital and medical staff policies wherever applicable to their activities.

#### 2.4.3 Change in Staff Category

Pursuant to a request by the medical staff member, upon a recommendation by the Credentials Committee or pursuant to its own action, the MEC may recommend a change in medical staff category of a member consistent with the requirements of these Bylaws. The Board must approve any change in category. Determinations regarding assignment of medical staff category are not subject to review under the due process provisions of these bylaws found in Articles 14 and 15.

#### 2.4.4 Limitation of Prerogatives

The prerogatives of medical staff membership set forth in these Bylaws are general in nature and may be subject to limitation or restriction by special conditions attached by the Board to a member's appointment, reappointment or privileges, by state or federal law or regulations, by other provisions of these Bylaws or medical staff and Hospital policies or by commitments, contracts or agreements of the Hospital.

### **2.E. NO ENTITLEMENT TO APPOINTMENT**

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

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;

- (c) has had in the past, or currently has, medical staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

## **2.F. NONDISCRIMINATION**

No individual shall be denied appointment to the Medical Staff on the basis of sex, race, creed, or national origin.

## **2.G. REQUIREMENTS FOR ADMITTING PATIENTS**

Any Medical Staff member who admits a patient to the hospital must complete a history and physical that complies with the requirements specified in the Medical Staff Bylaws and Medical Record Policy.

## **ARTICLE 3**

### **OFFICERS**

#### **3.A. DESIGNATION**

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

#### **3.B. ELIGIBILITY CRITERIA**

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

- (a) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years;
- (b) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (c) utilize CaroMont Regional Medical Center as their primary hospital;
- (d) not presently be serving as a medical staff officer, board member, or department chair at any other hospital and shall not so serve during their term of office;
- (e) be willing to faithfully discharge the duties and responsibilities of the position;
- (f) have served on Medical Staff committees; and
- (g) have demonstrated an ability to work well with others.

The medical staff Nominating Committee (described in 3D below) will have sole discretion to determine the applicability of these criteria to particular candidates seeking office.

#### **3.C: DUTIES**

##### **3.C.1. Chief of Staff**

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, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Executive Committee;
- (d) chair and actively vote on the Executive Committee and be a member of all other Medical Staff committees (*ex officio* without vote);
- (e) promote adherence to the bylaws and policies of the Medical Staff and the Hospital;
- (f) recommend Medical Staff representatives to Hospital committees;
- (g) perform all functions authorized in all applicable policies of the Medical Staff, including the collegial intervention steps outlined in the Credentialing Policy;
- (h) be the designated spokesperson for the Medical Staff in external professional and public relations; and
- (i) serve as a voting member of the Board of Directors.

### **3.C.2. Chief of Staff-Elect**

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 Executive Committee;
- (c) serve as Chair of the Credentials Committee;
- (d) appoint all committee chairs and committee members;
- (e) assume all such additional duties as are assigned to him or her by the Chief of Staff or the Executive Committee; and
- (f) become Chief of Staff upon completion of his or her term.

### **3.C.3. Immediate Past Chief of Staff**

The Immediate Past Chief of Staff shall:

- (a) serve on the Executive Committee;

- (b) function in an advisory capacity to the other Medical Staff leaders; and
- (c) assume all such duties as may be assigned by the Chief of Staff or the Executive Committee.

### **3.D. NOMINATIONS**

The two most immediate Past Chiefs of Staff and three other members of the Active Staff appointed by the Chief of Staff shall be the Nominating Committee for all general and special elections each year. If the two most recent past chiefs are not available to serve, the COS may appoint another past chief(s) in their place. In identifying nominees for elected positions, the Committee shall take into consideration the following considerations:

The applicable experience of a candidate in leadership and clinical roles;

The applicable experience of a candidate at the hospital and its community;

The benefit to the medical staff of diverse leadership with regard to specialty, practice locations (e.g. hospital vs. community), gender, generation, race/ethnicity, and practice arrangement (e.g. hospital employed vs. private practice.)

The Nominating Committee shall convene at least 60 days prior to the general staff meeting at which the results of the election shall be announced. The Nominating Committee will submit to the Chief of Staff the names of one or more qualified nominees for the office of Chief of Staff-Elect. Notice of the nominees shall be provided to the Medical Staff at least 45 days prior to the election. Nominations may also be submitted to the Chief of Staff by written petition signed by at least ten percent of Active Staff members at least 30 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must (by determination of the Nominations Committee) meet the qualifications for the position for which he or she has been nominated. Nominations from the floor shall not be accepted.

### **3.E. ELECTION**

- (a). The officers of the medical staff shall be elected either from a floor vote at the general medical staff meeting, or by using a secret ballot which may be distributed to eligible voting members of the medical staff at a general medical staff meeting. The decision for the voting process or mechanics of distributing ballots and counting votes will be determined by the MEC. The winner of an election shall be the individual who receives the greatest number of votes from the medical staff members eligible to vote. Voting by proxy is not permitted.
- (b). The newly elected officers of the medical staff shall be eligible to assume office on January 1<sup>st</sup> following the election.
- (c). Elections for officers will take place in the third calendar quarter of the year as scheduled by the MEC and the winners announced.

### **3.F. TERM OF OFFICE**

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

### **3.G. REMOVAL**

- (a) Removal of an elected officer or an at-large member of the Executive Committee may be effectuated by a two-thirds vote of the Executive Committee or by a two-thirds vote of the Medical Staff. The grounds for removal shall include:
  - (1) failure to comply with the Medical Staff Documents or willful disregard of the Hospital's Bylaws and standing policies;
  - (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 that office.
- (b) A proposal to remove an elected officer or an at-large member of the Executive Member may be received at any regular meeting of the Executive Committee or the Medical Staff if it is supported by a petition signed by at least twenty percent of the medical staff. The proposal must state with particularity the grounds for removal. The Chief of Staff, or the Chief of Staff Elect in such cases where the removal of the Chief of Staff is sought, shall place the note on the agenda for the next regular meeting of the Executive Committee or Medical Staff as applicable. The Chief of Staff or the Chief of Staff Elect, as applicable, may in his/her discretion, call a special meeting for purposes of considering and voting on the removal action.
- (c) At least 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 action shall be considered. The individual shall be afforded an opportunity to speak to the Executive Committee or the Medical Staff, as applicable, prior to a vote on removal.
- (d) Automatic removal will occur (without need for a vote) in the event any of the following affects the officer in question:
  - 1. Loss or suspension of the officer's medical license in North Carolina;
  - 2. Ineligibility of membership in the active staff category;

3. Recommendation by the MEC or Board for the imposition of corrective action or the acceptance of such recommendation by the Board.

### **3.H. 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 there is a vacancy in the office of Chief of Staff-Elect, the 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 Executive Committee.

## ARTICLE 4

### CLINICAL ORGANIZATION OF THE MEDICAL STAFF

#### 4.A. Organization

The medical staff of CaroMont Regional Medical Center is a non-departmentalized organization that carries out its responsibilities through the work of its committees and by individuals assigned specific tasks. The medical staff may be assisted in meeting these responsibilities by optional clinical divisions if formed as specified in section 4.B below.

#### 4.B Optional Clinical Interest Group

- 1) The MEC must authorize any group of practitioners interested in forming a Clinical Interest Group. Such a Clinical Interest Group shall be completely optional and may exist to perform any of the following:
  1. Assist medical staff peer review committees in the performance of peer evaluations and chart reviews if requested.
  2. Offer continuing medical education and promote forums for the discussion of patient care issues.
  3. Sponsor “grand rounds”, peer review protected morbidity & mortality (M&M) conferences, or clinico-pathologic conferences (CPCs).
  4. Provide a vehicle for discussion of policies & procedures or equipment needs in a specialty or service line area. However, such Groups will have no authority to enact, revise, or implement policies.
  5. Create an opportunity for networking and collegial interaction among practitioners with common interests.
  6. Develop recommendations for submission to the MEC or other medical staff or hospital committees.
  7. Participate in the development of criteria for clinical privileges when requested for input by the Credentials Committee or MEC.
  8. Participate in the development of clinical protocols when asked to by the MEC or an appropriate medical staff committee.
  9. Discuss a specific issue at the request of a medical staff committee.
  10. Provide a forum for discussion for clinicians in a particular specialty or interdisciplinary group of specialties.
  
- 2). Clinical Interest Groups are not required to hold regular meetings, keep minutes or track attendance, and have no regularly assigned responsibilities. A written report is required only when a Clinical Interest Group wishes to make a formal recommendation to the MEC, another medical staff committee, or to the Hospital’s administrative team. Clinical Interest Groups are free to structure their activities in whatever manner its constituents see fit. Neither the Hospital nor Medical Staff will have any obligations to provide resources to a Clinical Interest Group.

## ARTICLE 5

### **MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT, PEER REVIEW, AND CREDENTIALING FUNCTIONS**

There shall be an executive committee of the medical staff (referred to in these Bylaws as the Medical Executive Committee or MEC) and standing committees of the medical staff accountable to the MEC as may be established in these Bylaws or created by the Chief of Staff or MEC from time to time to accomplish medical staff functions. Additional ad hoc committees may be created by action of the MEC or Chief of Staff in order to address specific time-limited issues or problems.

The medical staff shall also carry out its responsibilities through participation in committees of the Hospital and/or through individual members who act as liaisons to Hospital departments or the medical staff.

#### **5.A. APPOINTMENT**

1. All committee chairs and members shall be appointed by the Chief of Staff-Elect and Chief of Staff. Committee chairs shall be appointed based on the criteria set forth in Chapter I, Section 3.B. of these Bylaws.
2. Committee chairs and members shall be appointed for staggered, two-year terms. They may be reappointed for additional terms.
3. The Chief of Staff and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

#### **5.B. EXECUTIVE COMMITTEE**

##### **5.B.1. Composition**

- (a) The Executive Committee shall be comprised of the following:
  - Chief of Staff
  - Chief of Staff Elect
  - Past Chief of Staff
  - Chair of the Grievance Committee
  - Chair of the Peer Review Committee
  - Two Members Elected At Large by the Medical Staff

The nominations for At Large MEC members and their election shall be carried out in the same manner as described above for medical staff officers in Article 3.

- (b) The Chief of Staff will chair the Executive Committee.

### **5.B.2. Duties**

- (a) The Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and over performance improvement activities regarding the professional services provided by individuals with clinical privileges. The specific actions delegated to the Executive Committee include the following:
- (1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings; provided, however, that the officers of the Medical Staff are empowered to act in urgent situations between Executive Committee meetings, but shall present their actions at the next regular meeting of the Executive Committee for approval or disapproval;
  - (2) adopting and amending the Medical Staff Documents (except the Bylaws) and forwarding such actions to the Board of Directors for approval or disapproval;
  - (3) recommending directly to the Board on at least the following:
    - (i) the Medical Staff's structure;
    - (ii) the mechanism used to review credentials and to delineate individual clinical privileges;
    - (iii) recommendations of individuals for Medical Staff appointment;
    - (iv) recommendations for delineated clinical privileges for each eligible individual;
    - (v) participation of the Medical Staff in Hospital performance improvement activities;
    - (vi) the mechanism by which Medical Staff appointment may be restricted or terminated.
  - (4) consulting with Hospital administration on quality-related aspects of contracts for patient care services with entities outside the Hospital;
  - (5) receiving and acting on reports and recommendations from Medical Staff committees, , and other groups as appropriate;
  - (6) reviewing, at least every three years, the Medical Staff Documents and recommending such changes as may be necessary or desirable; and

- (7) performing such other functions as are required or authorized in the Medical Staff Documents.
- (b) The specific actions delegated to the Executive Committee may be amended by a two thirds vote of the Medical Staff. A proposal to add, modify, or delete a specific delegated action may be received at any regular meeting of the Medical Staff. The proposal must state with particularity the basis for the action. The Chief of Staff shall place the matter on the agenda for the next regular meeting of the Medical Staff. The Chief of Staff may, in his/her discretion, call a special meeting for purposes of considering and a voting on the proposal, provided that at least two weeks' notice of the special meeting shall be provided.

### **5.B.3. Meetings**

The Executive Committee shall meet as often as necessary to fulfill its responsibilities and shall maintain a record of its proceedings and actions pursuant to current Hospital record retention policies.

### **5.C. PERFORMANCE IMPROVEMENT ACTIVITIES**

- (a) The performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require Medical Staff leadership or participation. These functions shall be performed by such committees Service Lines, Clinical Interest Groups and individuals as may be designated by the Executive Committee which will have oversight of all clinical performance improvement. 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:
  - (i) medical assessment and treatment of patients;
  - (ii) use of medications;
  - (iii) use of blood and blood components;
  - (iv) use of operative and other procedures;
  - (v) efficiency of clinical practice patterns; and
  - (vi) significant departures from established patterns of clinical practice.

- (b) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Organizational Manual.

#### **5.D. PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS**

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, but are not limited to:

- (a) education of patients and families;
- (b) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and
- (c) accurate, timely, and legible completion of patients' medical records.

#### **5.E. CREATION OF STANDING COMMITTEES**

In accordance with the amendment provisions in the Organizational Manual, the Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the Executive Committee.

#### **5.F. SPECIAL TASK FORCES**

Special task forces shall be created and their members and chairs shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.

## **ARTICLE 6**

### **MEETINGS**

#### **6.A. MEDICAL STAFF YEAR**

The Medical Staff year is January 1 to December 31.

#### **6.B. MEDICAL STAFF MEETINGS**

##### **6.B.1. Regular Meetings:**

The Medical Staff shall meet semi-annually (first and third quarters). One of these meetings will be designated as the annual business meeting. The exact dates of these meetings will be designated by the Chief of Staff.

##### **6.B.2. Special Meetings:**

Special meetings of the Medical Staff may be called by the Chief of Staff, the Executive Committee, the Board, or by a petition signed by not less than 20% of the Medical Staff members eligible to vote

#### **6.C: COMMITTEE MEETINGS**

##### **6.C.1. Regular Meetings**

Except as otherwise provided in these Bylaws or in the Organizational Manual, each committee shall meet As often as necessary to fulfill its responsibilities.

##### **6.C.2. Special Meetings**

A special meeting of any committee may be called by or at the request of the Chair, the Chief of Staff, or by a petition signed by not less than 20% of the Medical Staff members eligible to vote of the applicable committee, but not by fewer than two members.

#### **6.D. PROVISIONS COMMON TO ALL MEETINGS**

##### **6.D.1. Notice of Meetings**

- (a) Medical Staff members shall be provided written notice of all regular meetings of the Medical Staff and regular meetings of committees Notice may also be provided by posting in a designated location at least 30 days prior to the meetings. All notices shall state the date, time, and place of the meetings.

- (b) Unless a contrary provision of these Bylaws specifies otherwise, when special meetings of the Medical Staff, or committees are called, the required notice period shall be reduced to three working days (i.e., must be given at least three working days prior to the special meeting). In addition, posting in a designated location shall not be the sole mechanism used for providing notice of special meetings.
- (c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to improper notice for the meeting, unless that individual is attending solely for purposes of objecting to the notice utilized for the meeting.

#### **6.D.2. Quorum and Voting**

- (a) For any regular or special meeting of the Medical Staff, or committee, those voting members present (but in no event less than three members) shall constitute a quorum, except for meetings of the Executive Committee and the Credentials Committee, where the presence of at least 50% of the total Committee shall constitute a quorum.
- (b) Recommendations and actions of the Medical Staff, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals who are entitled to vote unless a contrary provision of these Bylaws specifies a super majority requirement in order to approve a recommendation. For Medical Staff meetings,.
- (c) The voting members of the Medical Staff or a committee may also be presented with a question by mail, facsimile, e-mail, or hand-delivery, and their votes returned to the presiding officer or the Medical Staff Office by 5:00 pm on the date indicated. All votes must be signed as appropriate and dated. A quorum for purposes of these votes shall be at least 50% of the votes received from the eligible voting members of the Medical Staff or committee. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned have so indicated, unless a contrary provision of these Bylaws specifies a super-majority requirement in order to approve the question.

#### **6.D.3. Agenda**

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, or committee.

#### **6.D.4. Rules of Order**

Wherever they do not conflict with these Bylaws, the then-current version of Robert's Rules of Order shall govern all meetings and elections.

#### **6.D.5. Minutes, Reports, and Recommendations**

- (a) Minutes of all meetings of the Medical Staff and its committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.
- (b) A summary of all recommendations and actions of the Medical Staff and committees shall be transmitted to the Executive Committee and the CEO. The Board shall be kept apprised of the recommendations of the Medical Staff and its committees.
- (c) A file of the minutes of all meetings shall be maintained by the Hospital pursuant to then-current Hospital record retention policies. Members of the Medical Staff may have access to the "business" sections of Medical Staff minutes, but not to any peer review sections. Any access to records must be monitored by the Medical Staff Office or appropriate physician leader.

#### **6.D.6. Confidentiality**

Members of the Medical Staff who have access to credentialing and/or peer review and/or behavioral or health information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. A breach of confidentiality may result in the imposition of disciplinary action.

#### **6.D.7. Attendance Requirements**

- (a) Each Active Staff member is encouraged to attend and participate in all Medical Staff meetings and applicable committee meetings each year.

## ARTICLE 7

### **CONFLICT OF INTEREST**

- (a) When performing a function outlined in the Medical Staff Documents, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest, or a bias, in any matter involving another member of the Medical Staff that comes before the individual, the individual with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.
- (b) The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the Chief of Staff or applicable committee chair by any other member with knowledge of it.

## ARTICLE 8

### **BOARD CONFIRMATION AND INDEMNIFICATION**

All Medical Staff officers, committee chairs, committee members, and individual Medical Staff members who act for and 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, provided that the Board has confirmed the appointment and/or election of the individual to the position in question.

## ARTICLE 9

### AMENDMENTS TO THE BYLAWS

#### Methods of Adoption and Amendment to Medical Staff Bylaws

- a. Proposed amendments to the Medical Staff Bylaws may be offered for consideration by any medical staff Committee, member of the active medical staff, or by the MEC.
- b. The MEC may utilize, at its discretion, a bylaws committee to review proposed bylaws changes and suggest modifications to the language of a proposed change as well as recommend adoption or rejection of any proposed change;
- c. The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose if such proposals are compliant with Joint Commission standards and regulatory requirements. Following an affirmative vote by the MEC, all members of the medical staff eligible to vote shall receive a description of the proposed amendment(s) by email or mail. At least thirty days following this dissemination of the proposed amendment, all eligible members of the medical staff will be expected to vote on the proposed amendment(s). This vote may be conducted via printed or electronic ballot in a manner determined by the MEC. To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the medical staff in the active category who cast votes and the Board must subsequently ratify the amendment.
- d. If the MEC does not vote affirmatively to present a proposed amendment for vote by the medical staff, individuals supporting the amendment can nevertheless request such a vote by presenting the Chief of Staff with a supportive petition signed by twenty percent (20%) of the active members of the Medical Staff. Upon receiving such a petition, the Chief of Staff will proceed to arrange a vote by the entire active medical staff following the procedures above for an amendment proposal voted on affirmatively by the MEC.

## **ARTICLE 10**

### **MEDICAL STAFF DOCUMENTS**

#### **10.A. MEDICAL STAFF BYLAWS**

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

#### **10.B. 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 the mission of Caromont Health. All members of the medical staff and all privileged practitioners are required to comply with medical staff policies.

#### **10.C. ORGANIZATIONAL MANUAL**

The Medical Staff shall adopt an Organizational Manual to more specifically enumerate and elucidate the organization of the Medical Staff and the work of the Medical Staff committees.

#### **10.D. PROCEDURES FOR ADOPTING AND AMENDING THE MEDICAL STAFF POLICIES**

##### **10.D.1. Amendments to all other Documents and/or Medical Staff Policies**

- (a) Medical Staff Policies may be adopted, amended, repealed, or added by vote of the Executive Committee. The General Medical Staff will be notified of the aforementioned Medical Staff Policy(s) prior to consideration by the Board.
- (b) Adoption of and changes to the Medical Staff Policies shall become effective only when approved by the Board.
- (c) The present Medical Staff Policies, not including the Bylaws, are hereby readopted and placed into effect insofar as they are consistent with these Bylaws,

until such time as they are amended in accordance with this Article. To the extent they are inconsistent, they are of no force and effect.

- (d) Anything to the contrary contained in these Bylaws or Medical Staff Policies notwithstanding, neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Policies.
- (e) Notwithstanding any other requirement in this Article to the contrary, the Medical Staff may propose amendments to the Medical Staff Policies directly to the Board using the following procedures:
  - 1. A proposal to amend the Medical Staff Policies may be made at any regular or special meeting of the Medical Staff.
  - 2. A simple majority of those present at the meeting must vote to forward the proposal to an ad hoc committee for review. Such ad hoc committee shall report on the proposed amendments favorably or unfavorably at the next regularly meeting of the Medical Staff or at a special meeting called for such purpose.
  - 3. The proposed amendments may be voted upon at any meeting of the Medical Staff if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the members of the Medical Staff who are entitled to vote and who are present at the meeting.

(f) In cases of a need for an urgent amendment to Medical Staff Policies necessary to comply with applicable laws, regulations or accrediting standards, the Medical Executive Committee may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification to the general Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee.

#### **10.D.2 Medical Staff and Medical Executive Committee Conflict Resolution**

In the event that the Medical Staff and the Medical Executive Committee would have a conflict on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, which cannot be resolved through the traditional channels during a open forum at a Medical Executive Committee meeting or General Medical Staff meeting, the following protocol would be activated. A group of three appointed representatives from each body would address the hospital governing body in the "Open" portion of the Board meeting. If the conflict required immediate resolution, and could not wait until the next scheduled Board meeting, the CEO and/or Board Chair would have the option of calling an emergency Board Executive Meeting for the two sides to present their concerns.

**ARTICLE 11**  
**APPOINTMENT TO THE MEDICAL STAFF**

**11.A. GENERAL CONDITIONS OF APPOINTMENT OF MEMBERSHIP AND/OR PRIVILEGES**

**11.A.1. Qualifications**

(a) All applicants must meet the qualifications specified in Chapter I, Section 2.A. of these Bylaws. In addition, applicants must meet the additional qualifications specified for the category of staff privileges for which the individual is applying.

(b) Waiver of Criteria for Initial Appointment and/or Reappointment:

(i) Any individual who does not satisfy a standard or additional qualification may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to the qualification in question.

(ii) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in any particular case shall not set a precedent for any other individual or group of individuals.

(iii) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(iv) A determination that an individual is not entitled to a waiver is not a “denial” of appointment or clinical privileges.

**11.A.2. Basic Responsibilities and Requirements for Applicants and Members of the Medical Staff and Practitioners Granted Privileges**

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment and/or permission to exercise clinical privileges, every applicant and Medical Staff member and privileged practitioner specifically agrees to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by the Medical Staff Documents in effect during the period of the individual's grant of clinical privileges and/or appointment to the Medical Staff;
- (c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as shall be assigned by the Chief of Staff or in accordance with policies passed by the MEC and as, where applicable, are consistent with the responsibilities and prerogatives of the category of membership held;
- (d) to provide new or updated information to the Medical Staff Office, as it occurs, that is pertinent to any question on the application form. This includes immediately informing the Chief of Staff of any malpractice suits filed against the practitioner, any criminal actions initiated against the practitioner or any civil actions involving health care fraud, any actions taken against the license of the practitioner in any state, and actions taken by any institution to suspend, limit, restrict, or revoke clinical privileges or medical staff membership.
- (e) to acknowledge that the individual has had an opportunity to read a copy of the Medical Staff Documents and agrees to comply with them.
- (f) to appear for personal interviews, if requested, in regard to an application for initial appointment or reappointment;
- (g) to use the Hospital sufficiently to allow the Medical Staff leaders and committees to perform a continuing assessment of current competence;
- (h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (i) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (j) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (k) to seek consultation when clinically appropriate.(l) to participate in monitoring and evaluation activities;
- (l) to complete in a timely manner all medical and other required records for the care of patients, containing all information required;

- (m) to perform all services and conduct himself or herself at all times in a cooperative and professional , in accordance to the Code of Conduct.
- (n) to pay any applicable dues, fines, and assessments;
- (o) to satisfy continuing medical education requirements as required by the North Carolina Medical Board and/or by the Medical Staff; and
- (p) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to any hearing or appeal.

### **11.A.3. Burden of Providing Information**

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Medical Staff leaders and/or the Hospital Board for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts.
- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) An applications shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time.
- (d) It is the responsibility of the individual seeking appointment or reappointment to provide a complete application, including adequate responses from references. An incomplete application will not be processed. Any application that continues to be incomplete 30 days after notice from the Hospital that the application is incomplete shall be deemed to be withdrawn, unless it is clearly demonstrated by the applicant that he/she is actively and in good faith pursuing completion of the application.

## **11.B. FACTORS FOR EVALUATION**

Only those individuals who can document that they are appropriately qualified will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, demonstrated current competence, and clinical judgment;
- (b) adherence to the ethics of their profession;
- (c) good reputation and character;
- (d) ability to perform, safely and competently, the clinical privileges requested; and
- (e) ability to work harmoniously with others sufficiently so as not to disrupt the delivery of quality healthcare or the orderly operation of the Hospital.

## **11.C. APPLICATION**

### **11.C.1. Information**

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

settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request; and

- (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.
  - (5) current information involving any criminal actions initiated against the practitioner or any civil actions involving health care fraud, any actions taken against the license of the practitioner in any state, and actions taken by any institution to suspend, limit, restrict or revoke clinical privileges or medical staff membership.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

#### **11.C.2. Grant of Immunity and Authorization to Obtain/Release Information**

By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) **Immunity:**

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, the Medical Staff, their authorized representatives, and third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or third parties.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information (except for health status information that may require a specific release) to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation status at the requesting organization/facility.

(d) Hearing and Appeal Procedures:

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

(e) Legal Actions:

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

## **11.D PROCEDURE FOR INITIAL APPOINTMENT**

### **11.D.1. Request for Application**

- (a) Applications for appointment shall be in writing and shall be on forms approved by the Board, upon recommendation by the Executive Committee and Credentials Committee.
- (b) Any individual requesting an application for initial appointment shall be sent (1) a letter that outlines the eligibility criteria for appointment and clinical

privileges, and (2) a Request for Application form which requests proof that the individual meets the eligibility criteria for appointment and clinical privileges. A completed Request for Application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt, if the individual desires further consideration (unless it is clearly demonstrated by the individual that he/she is actively and in good faith pursuing completion of the Request for Application form). The Request for Application form will be reviewed and if the eligibility criteria are satisfied, an application will be forwarded. Individuals who fail to meet the eligibility criteria shall not be given an application and shall be notified that they are ineligible to apply. There is no right to a hearing on a determination of ineligibility.

- (c) Applications may be provided to residents who are in the final six months of their training, but will not be processed until satisfaction of all applicable eligibility criteria is documented.

#### **11.D.2. Initial Review of Application**

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt of same if the individual desires further consideration (unless it is clearly demonstrated by the individual that he/she is actively and in good faith pursuing completion of the application form). The application must be accompanied by the nonrefundable application fee.
- (b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed.
- (c) The Medical Staff Office verifies information about the applicant's licensure, specific training, experience and current competence provided by the applicant with information from the primary source(s) whenever feasible. The Medical Staff Office shall also be responsible for confirming that all references and other information or materials deemed pertinent have been received.

- (d) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges. Any such information shall be provided to the Medical Staff Office, which will be included in the credentials file to be reviewed.

### **11.D.3. Steps to Be Followed for All Initial Applicants**

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. Identification will be sought from initial applicants to ascertain that in fact the individual requesting privileges and arriving to provide care and services is one and the same as the individual identified in the credentialing application. The guidelines used for identification will be the same as noted in Disaster Management Staff Privileges, Section 12.D. of these Bylaws.
- (b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any of the following: a Credentials Committee representative, the full Credentials Committee, and/or the Chief of Staff or their designee.

### **11.D.4 Use of Subject Matter Experts**

- (a) The Medical Staff Office, upon direction of the Credentials Committee or its Chair, may transmit the complete application and all supporting materials to an appropriate subject matter expert for review and evaluation.. The subject matter expert will assess the application to see if the applicant meets requirements for appointment and the clinical privileges requested.
- (b) The subject matter expert may recommend that (1) an application raises no questions and should be considered for appointment, or (2) an application raises questions and the subject matter expert has reservations regarding appointment.
- (c) The subject matter expert shall be available to answer any questions that may be raised by the Credentials Committee or MEC with respect to that expert's report and findings.

#### **11.D.5. Credentials Committee Procedure**

- (a) The Credentials Committee shall review and consider the application and any reports prepared by a subject matter expert and shall make a recommendation regarding the appropriate action to take with respect to the application. The Credentials Committee may carry out its obligations through the use of one or more subcommittees, such as a subcommittee to address the credentials of Allied Health Practitioners.
  - (i) The Credentials Committee may use the expertise of any subject matter expert, any other member of the Medical Staff, or an outside consultant, if additional information is required regarding the applicant's qualifications.
  - (ii) If there is any question about the applicant's ability to perform the privileges requested and/or the responsibilities of appointment, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within sixty (60) days after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.
  - (iii) In making its recommendation regarding the application, the Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years.
- (b) The Credentials Committee shall prepare written findings and a recommendation regarding the application for the Executive Committee.
- (c) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and the CEO, explaining the reasons for the delay.

#### **11.D.6. Executive Committee Procedure**

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:
  - (1) adopt the findings and recommendation of the Credentials Committee as its own; or

- (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
  - (3) make a different recommendation regarding the disposition of the application, which shall be accompanied by a written report containing supporting information for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Executive Committee is to appoint, the recommendation shall be forwarded to the Board.
  - (c) If the recommendation of the Executive Committee is to deny, revise or revoke an initially requested privilege or an existing privilege petitioned for renewal or change, the Committee shall forward its recommendation to the CEO. Within thirty (30) days of receipt of the recommendation, the CEO shall notify the physician in writing of the recommendation. If the recommendation would entitle the applicant to request a hearing, the applicant shall have fifteen (15) days to respond in writing as to whether the applicant will request a hearing or waive the hearing and appeal. If the applicant requests a hearing, the CEO shall then hold the application until after the applicant has completed the hearing and appeal process specified in Article 15 of these Bylaws.

#### **11.D.7. Board Action**

- (a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
  - (1) appoint the applicant and grant clinical privileges as recommended; or
  - (2) refer the matter back to the Credentials Committee or Executive Committee, or to another source inside or outside the Hospital, for additional research or information; or
  - (3) reject or modify the recommendation.
- (b) If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chief of Staff and the Chief of Staff-Elect. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.
- (c) Upon receipt of a recommendation that the applicant's request for privileges be denied, revised or revoked, the Board may:

- (1) approve the request, or
  - (2) refer the matter back to the Credentials Committee or Executive Committee, or to another source inside or outside the Hospital, for additional research or information; or
  - (3) reject or modify the recommendation.
- (d) The decision to grant, deny, revise or revoke privilege(s) is disseminated and made available to all appropriate internal personnel in the hospital. This information will be disseminated to appropriate authorities such as the North Carolina Medical Board and National Practitioner Data Bank as required by law.

#### **11.D.8. Time Periods for Processing**

All applications for initial appointment shall be processed in a timely manner. Absent a concern with the application, each application that proceeds through the full credentialing procedure is expected to be processed within 120 days from the date it is deemed complete. These time periods are intended to be guidelines designed to assist the individuals/bodies in accomplishing their tasks. They shall not be deemed to create any right for the applicant to have an application processed within these precise time periods.

### **11.E: CONFIRMATION OF COMPETENCY TO HOLD ASSIGNED PRIVILEGES**

#### **11.E.1. Focused Professional Practice Evaluation**

The Medical Staff will confirm the competence of all practitioners newly granted privileges at CaroMont Regional Medical Center. This will occur following the practitioner's initial appointment of privileges and subsequently at any time a new privilege is requested for addition to the practitioner's then current privileges. This activity will occur in conformance with a policy on Focused Professional Practice Evaluation (FPPE) adopted by the MEC. This policy will determine the manner and duration of the evaluation of the practitioner's exercise of privileges and the available monitoring modalities that may be used. As a result of this initial FPPE, the Credentials Committee may recommend to the MEC and Board modifications in the privileges granted upon initial appointment.

#### **11.E.2 Use of Ongoing Professional Practice Evaluation**

The Medical Staff participates in ongoing professional practice evaluation (OPPE) to identify practitioner performance concerns and trends that impact the safety and quality of patient care. Information from the OPPE process will be used by medical staff and Hospital leaders to determine if existing privileges should be maintained, revised or revoked prior to or at the time of reappointment. OPPE is part of the medical staff's peer review process to evaluate, measure, and improve a practitioner's current clinical competency. In addition, each practitioner may be subject to a focused professional practice evaluation (FPPE) at any time issues affecting the provision of safe, high quality

patient care are identified through OPPE. As a result of this FPPE, the Credentials Committee may recommend to the MEC and Board modifications in the privileges of the practitioner evaluated.

## **ARTICLE 12**

### **CLINICAL PRIVILEGES**

#### **12.A. CLINICAL PRIVILEGES**

##### **12.A.1. General**

- (a) Appointment or reappointment shall not confer any specific clinical privileges at the Hospital.
- (b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board. Clinical privileges may be granted without medical staff membership.
- (c) The granting of clinical privileges includes responsibility for emergency service call as established by the MEC to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act, other applicable laws, regulations or standards, and to meet the needs of the community.
- (d) Clinical privileges may be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations.
- (e) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.
- (f) Any requests for clinical privileges that are covered by an existing exclusive contract at the Hospital will not be processed except as consistent with that contract.
- (g) In accepting and/or exercising any clinical privileges granted by the Board, a practitioner is agreeing to abide by all applicable medical staff policies regardless of whether the practitioner is a medical staff member.
- (h) The clinical privileges recommended to the Board shall be based upon consideration of the following:
  - (1) the applicant's education, training, experience, demonstrated current competence and judgment, references, and ability to perform the privileges requested competently and safely;

- (2) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;
  - (3) adequate professional liability insurance coverage for the clinical privileges requested;
  - (4) the Hospital's available resources and personnel;
  - (5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
  - (6) any collaboration or supervising agreement where the applicant is a dependent practitioner seeking clinical privileges;
  - (7) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital or health care facility; and
  - (8) other relevant information, including any written report and findings by a subject matter expert whose input is requested by an appropriate medical staff leader or committee.
- (h) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
  - (i) The report of a subject matter expert regarding the privileges being sought may requested and forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.
  - (j) During the term of appointment, a practitioner may request a revision to existing privileges or additional privileges by applying in writing. The request shall state the specific revisions or additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

#### **12.A.2. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons**

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be subject to review through the Hospital's internal quality review and performance improvement processes. The Medical Staff Bylaws and Policies

shall specify the exact requirements for completion of a medical history and physical examination of the patient.

- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials and Executive Committees.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent and in compliance with the Hospital and Medical Staff Bylaws and Policies.

### **12.A.3. Clinical Privileges for New Procedures**

- (a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure (collectively, "new procedure")) will not be processed until (1) a determination has been made by the Board that the procedure will be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established by the Board.
- (b) The Credentials Committee and the Executive Committee shall make a preliminary recommendation to the Board as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the new procedure.
- (c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. In order to facilitate the development of these credentialing criteria, any member of the Medical Staff with an interest in the new procedure should provide any relevant research or other information. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

#### **12.A.4. Clinical Privileges That Cross Specialty Lines**

- (a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g. individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies), to assist in determining an appropriate response to the individual's request.
- (c) The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.
- (d) The following information shall be obtained from the applicant for the specific privileges in question:
  - (i) NPDB Report
  - (ii) North Carolina medical license
  - (iii) Malpractice insurance that covers requested privileges
  - (iv) Letter from residency program director verifying training and competence in performing the procedures requested
  - (v) Documentation of all cases performed, with outcomes (cases may be obtained from the current practice, past affiliations and training program for the past 24 months) and clinical evaluations if deemed necessary by the Credentials Chair.

#### **12.A.5. Clinical Privileges After Age 72**

- (a) Individuals who desire to exercise clinical privileges after the age of 72 must apply for reappointment on a yearly basis.
- (b) As part of the annual reappointment process, these members will be required to have a physical and mental health assessment performed by a physician who is acceptable to the Credentials Committee. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively and effectively in a hospital setting. The examining physician shall provide this report directly to the Committee and

shall be available to discuss any questions or concerns that the Committee may have.

- (c) Additionally as part of the annual reappointment process, these members will be required to have a FPPE specific to their practice and privileges to evaluate the competencies required to deliver safe and effective care.

#### **12.A.6. Physicians in Training**

Physicians in training at CaroMont Regional Medical Center 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 residency program and approved by the Credentials Committee and the Board. Program Directors are responsible for verifying the qualifications and credentials of each resident permitted to function. Care of patients by physicians in training shall be under the supervision of a member of the Active Staff.

#### **12.B: TEMPORARY CLINICAL PRIVILEGES**

##### **12.B.1. Eligibility to Request Temporary Clinical Privileges**

- (a) Temporary privileges may only be granted by the CEO (i) on a case by case basis when an important patient care need mandates an immediate authorization to practice while the full credentials information 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 waiting for a review and recommendation by the Medical Executive Committee and approval by the Board. The applicant must: a) have a complete application; b) no current or previously successful challenge of licensure or registration; c) not been subject to involuntarily termination of medical staff membership at another organization; and, d) not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.
- (b) Permission to practice with temporary privileges may be granted by the CEO only after he/she has consulted with the Chair of the Credentials Committee and the Chief of Staff.
- (c) 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, professional liability insurance coverage, and Medicare and Medicaid participation status, and shall query the National Practitioner Data Bank, before a final decision is made to grant temporary privileges.

- (d) Prior to temporary privileges being effective, the individual must agree in writing to be bound by the Medical Staff Documents, Medical Staff and Hospital policies, procedures and protocols.
- (e) Temporary privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.
- (f) Temporary privileges shall expire at the end of the time period for which they are granted.

### **12.B.2. Supervision Requirements**

Requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges by the Chief of Staff or CEO

### **12.B.3. Termination of Temporary Clinical Privileges**

- (a) The granting of temporary privileges is a courtesy and may be terminated for any reason. The CEO, in conjunction with the Chief of Staff or the Chair of the Credentials Committee, , may terminate temporary admitting privileges at any time and for any reason. Any remaining temporary clinical privileges shall be terminated when the individual's inpatients are discharged.
- (b) When an individual's temporary privileges have been terminated, the Chief of Staff shall assign to other members of the Medical Staff responsibility for the care of such terminated individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (c) Neither the denial nor termination of such 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.

### **12.C. EMERGENCY SITUATIONS**

- (1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of category status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.

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

## **12.D: DISASTER MANAGEMENT STAFF PRIVILEGES**

### **12.D.1. Eligibility to Request Clinical Privileges in an Officially Declared Emergency**

- (a) Clinical privileges may only be granted to a provider to be a member of the Disaster Management Staff by the CEO or Chief of Staff, or their respective designee, for the care of patients during an official state of emergency, as declared by local, State or federal officials.
- (b) The Medical Staff Office or designee will obtain a valid government issued form of identification such as a driver's license or passport and at least one of the following forms of identification prior to granting clinical privileges to a member of the Disaster Management Staff:
  - (i) Valid professional license or certification to practice in the State of North Carolina or any state or United States territory that clearly identifies professional designation;
  - (ii) Primary source verification of the license;
  - (iii) A current photo hospital identification card from any hospital that can be verified to exist in the United States or its territories;
  - (iv) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
  - (v) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, State or municipal entity;
  - (vii) Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding practitioner's identity and qualifications for practice.
- (c) Primary source verification of licensure and identification begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the Hospital. In the extraordinary circumstances that primary source verification cannot be completed in 72 hours, it is expected that it be done as soon as possible with documentation of why not completed within 72 hours to include reasons not performed, evidence of the physician's demonstrated ability to continue to provide adequate, treatment and services; and evidence of the hospital's attempt to perform primary source

verification as soon as possible. A query to the National Practitioner Data Bank and an Office of Inspector General Query will be made. A record of this information will be maintained in the Medical Staff Office.

- (d) Based on its oversight of each volunteer physician, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.
- (e) Practitioners granted emergency clinical privileges shall be provided with identification which readily identifies their status.
- (f) Emergency clinical privileges will:
  - (i) Reflect the practitioner's training and specialty;
  - (ii) Be granted for the duration of the disaster only; and
  - (iii) Automatically terminate at the end of needed services

#### **12.D.2. Supervision Requirements**

Requirements of supervision and reporting may be imposed on any individual granted emergency clinical privileges.

#### **12.D.3. Termination of Emergency Clinical Privileges**

- (a) The CEO or designee will decide, based on information obtained regarding the professional practice of the volunteer, within 72 hours whether to continue the disaster privileges initially granted.
- (b) The granting of emergency clinical privileges is a courtesy. Appointments to the Disaster Management Staff and the corresponding clinical privileges of those members may be immediately terminated by the CEO, the Chief of Staff or their respective designees, at any time and for any reason.
- (c) In the event that a member of the Disaster Management Staff has been caring for a patient and his/her appointment and/or privileges are terminated, the Chief of Staff shall assign to another member of the Medical Staff or the Disaster Management Staff responsibility for the care of such terminated individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (d) Neither the denial nor termination of emergency clinical privileges shall entitle the individual to any of the procedural rights provided in these Bylaws.

## **12. E. History and Physicals**

The history and physical examination (H&P), when required, shall be performed and recorded by a physician, dentist, podiatrist, or privileged practitioner who has an active NC license and has been granted privileges by the hospital. The H&P is the responsibility of the attending physician or designee. Oral surgeons, dentists, and podiatrists are responsible for the history and physical examination 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 Cath Lab, and other areas that perform invasive procedures.

A medical history and appropriate physical examination 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.

H&P UPDATE: For an H&P that was completed within 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 24 hours after admission, but prior to an operative or high-risk procedure requiring moderate sedation or anesthesia services. The update note must include language such as "Patient examined and no changes" or changes identified should be documented.

## ARTICLE 13

### PROCEDURE FOR REAPPOINTMENT OF MEMBERSHIP AND/OR PRIVILEGES

#### 13.A. PROCEDURES FOR REAPPOINTMENT OF MEMBERSHIP AND/OR PRIVILEGES

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

##### 13.A.1. Eligibility for Reappointment

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

- (a) completed all medical records;
- (b) completed all continuing applicable medical education requirements as required by the North Carolina Medical Board and/or by the Medical Staff;
- (c) satisfied all applicable medical staff responsibilities, including payment of any applicable dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) had sufficient patient contacts to enable the Credentials Committee and MEC to assess current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and
- (f) paid the reappointment processing fee, if applicable.

##### 13.A.2. Factors for Evaluation

The following factors will be evaluated as part of the reappointment process:

- (a) current clinical competence, judgment and technical skill in the treatment of patients;

- (b) compliance with the Medical Staff Documents and the Bylaws, medical staff and hospital policies, protocols and procedures of the Hospital;
- (c) participation in Medical Staff duties, including committee assignments and emergency call;
- (d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;
- (e) use of the Hospital's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty;
- (f) whether the applicant's medical staff appointment or clinical privileges at another facility have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, or otherwise limited, or are currently being investigated or challenged;
- (g) whether the applicant's license to practice in any state or DEA registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;
- (h) whether the applicant's professional liability coverage and/or professional liability litigation experience has changed, including specifically information concerning past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;
- (i) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;
- (j) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;
- (k) appropriate resolution of any verified complaints received from patients, Hospital personnel, and/or Medical Staff members; and
- (l) other reasonable indicators of continuing qualifications.

### **13.A.3. Reappointment Process**

- (a) An application for reappointment shall be furnished to members and practitioners holding clinical privileges at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.
- (b) Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed.
- (c) Reappointment, if granted, shall be for a period of not more than two years.
- (d) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the expiration of the current term, the CEO, on behalf of the Board, shall have the authority to grant the individual interim appointment and clinical privileges until such time as the Board can act on the application.
- (e) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.
- (f) The Medical Staff Office shall gather and verify all relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.
- (g) The Medical Staff Office shall forward the application to Credentials Committee and the application for reappointment shall be processed in the same manner as applications for initial appointment.

### **13.A.4. All Applications for Reappointment**

- (a) All applications for reappointment and renewal of clinical privileges shall be processed in the same manner as initial applicants.
- (b) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the Chair of the Committee will notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or

refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply, including the right to have counsel present. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

#### **13.A.5. Time Periods for Processing**

All applications for reappointment shall be processed in a timely manner. Absent a concern with the application, each complete application that proceeds through the full Credentials Committee procedure shall be processed within 120 days from the date it is deemed complete. (It is expected that applications proceeding through the interim reappointment route will be processed more quickly than in these time periods.) These time periods are intended to be guidelines designed to assist the individuals/bodies in accomplishing their tasks. They shall not be deemed to create any right for the applicant to have an application processed within these precise time periods.

## **ARTICLE 14**

### **QUESTIONS INVOLVING MEDICAL STAFF MEMBERS AND PRACTITIONERS HOLDING CLINICAL PRIVILEGES**

#### **14.A. COLLEGIAL INTERVENTION**

- (1) When there are questions relating to an individual's clinical practice and/or professional conduct, collegial intervention and educational efforts by Medical Staff leaders and Hospital administration should be initiated. The goal of these efforts is to arrive at voluntary, responsive actions to address the concerns that have been raised. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional peer review activities.
- (4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Medical Staff leaders may also handle clinical practice or professional conduct issues using other policies applicable to the Medical Staff (e.g., Physician Health Policy; Code of Conduct Policy; Sexual Harassment Policy), as well as the process established by the Grievance Committee of the Medical Staff, and/or Section 14.C. of these Bylaws, pertaining to Investigations.

## **14.B. PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES**

### **14.B.1. Grounds for 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 of imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation of the concerns raised.
- (b) Precautionary suspension is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
- (c) A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief of Staff, and shall remain in effect unless it is modified by the CEO or the Executive Committee.

### **14.B.2. Executive Committee Procedure**

- (a) The Executive Committee shall review the matter resulting in a precautionary suspension within 14 days and determine whether there is sufficient information to warrant a recommendation, or proceed under the investigative procedure provided for in Section 14.C. of these Bylaws.
- (b) The suspended individual may request a meeting with the Executive Committee to discuss the circumstances leading to the suspension.

### **14.B.3. Care of Suspended Individual's Patients**

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

## **14.C. INVESTIGATIONS**

### **14.C.1. Initial Review**

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

the matter may be referred in writing to the Chief of Staff, the chair of a standing committee, or the CEO.
- (b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Executive Committee.
- (c) No action taken pursuant to this Section shall constitute an investigation.

### **14.C.2. Initiation of Investigation**

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Committee shall review the matter and determine whether to conduct an investigation. In making this determination, the Executive Committee will discuss the matter with the individual. An investigation shall begin only after a determination by the Executive Committee.
- (b) The Executive Committee shall promptly inform the individual that an investigation has begun.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.

- (d) The Chief of Staff shall keep the CEO fully informed of all action taken in connection with an investigation.

### **14.C.3. Investigative Procedure**

- (a) Once a determination has been made to begin an investigation, the Executive Committee shall (i) investigate the matter itself, (ii) request that the Credentials Committee conduct the investigation, (iii) request that the Peer Review Committee conduct the investigation, (iv) request that the Physician Health and Behavior Health Committee conduct the investigation, if the matter pertains to professional conduct, or (iv) appoint an individual (“Investigator”) or ad hoc committee (“Investigating Committee”) to conduct the investigation. Neither the Investigator nor any member of the Investigating Committee shall be partners, business associates, or relatives of the individual being investigated. Individuals not on the Medical Staff may be appointed as either investigator or as a member of the Investigating Committee. Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee shall include (or the Investigator shall be) a peer of the individual (e.g., physician, dentist).
- (b) The Investigating Committee (or the Investigator, as applicable) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and Investigating Committee that:
  - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
  - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
  - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
- (c) The Investigating Committee (or the Investigator, as applicable) may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The results of such examination shall be made available for consideration by the Investigating Committee (or Investigator).
- (d) The individual shall have an opportunity to meet with the Investigating Committee (or the Investigator, as applicable) before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss,

explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the Investigating Committee (or Investigator) and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

- (e) The Investigating Committee (or Investigator) shall make a reasonable effort to complete the investigation and issue its report within 30 days of being requested to perform the investigation by the Executive Committee, provided that an outside review is not necessary. When an outside review is necessary, the Investigating Committee (or Investigator) shall make a reasonable effort to complete the investigation and issue its report within 60 to 90 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the Investigating Committee (or Investigator) is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the Investigating Committee (or Investigator) shall prepare a report with its findings, conclusions and recommendations. The report shall be presented to the Executive Committee for further review.
- (g) In making their recommendations, the Investigating Committee (or Investigator) and the Executive Committee shall strive to achieve a consensus as to what is in the best interests of patient care and the orderly operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committees may consider:
  - (1) relevant literature and clinical practice guidelines, as appropriate;
  - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); and
  - (3) any information or explanations provided by the individual under review.

#### **14.C.4. Recommendation**

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from the Investigating Committee (or Investigator, as applicable). Specifically, the Executive Committee may:

- (1) determine that no action is justified;
  - (2) issue a letter of guidance or counsel;
  - (3) issue a letter of warning or reprimand;
  - (4) impose conditions for continued appointment;
  - (5) impose a requirement for monitoring or consultation;
  - (6) recommend additional training or education;
  - (7) recommend reduction of clinical privileges;
  - (8) recommend suspension of clinical privileges for a term;
  - (9) recommend revocation of appointment and/or clinical privileges; or
  - (10) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The individual shall have fifteen (15) days to respond in writing to the Special Notice, indicating whether the individual requests a hearing and appeal or waives the right to a hearing. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. The individual shall have fifteen (15) days to respond in writing to the Special Notice, indicating whether the individual requests a hearing and appeal or waives the right to a hearing. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by medical staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

## **14.D. AUTOMATIC SUSPENSION OR TERMINATION**

### **14.D.1. Action by Government Agency or Insurer**

Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below in Section 14.D.2 must be promptly reported to the Chief of Staff and CEO.

### **14.D.2. Events Resulting in Automatic Suspension or Termination**

An individual's clinical privileges shall be automatically suspended, limited, terminated or inactivated as described in items (a)-(i) below. Automatic suspension, limitation or terminations shall take effect immediately and shall be final without a right to hearing or further review. The Medical Staff Office shall notify the individual of the action taken. Notice shall include the requirements for reinstatement. Giving of such notice will not, however, be required in order for the suspension, limitation, termination or inactivation of privileges to become effective.

(a) Licensure. If the license to practice medicine, dentistry or other health occupation is:

- (1) Expired, then the individual's clinical privileges shall be inactivated until the license is renewed. After thirty (30) days, if the license has not been renewed, the individual's appointment and clinical privileges will be terminated;
- (2) Revoked or suspended, then the individual's clinical privileges and membership shall be terminated;
- (3) Restricted, then the individual's clinical privileges shall be suspended pending further review and recommendation by the Credentials Committee and approval by the MEC.

(b) DEA Registration. Whenever an individual's DEA certificate or prescribing authority is:

- (1) Expired, then the individual's clinical privileges and membership shall be suspended until the DEA Registration is renewed. After thirty (30) days, if the DEA Registration has not been renewed, the individual's clinical privileges and membership will be terminated;
- (2) Revoked or suspended, then the individual's clinical privileges and membership shall be terminated;

(3) Restricted, then the individual's clinical privileges shall be suspended pending further review and recommendation by the Credentials Committee and approval by the MEC.

(c) Professional Liability Coverage. The clinical privileges 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 inactivated until evidence of coverage is provided. If evidence of coverage is not provided after thirty (30) days, the individual's clinical privileges will be terminated.

(d) Medical Records. Failure to comply with the requirements set forth in the Medical Staff Medical Records Policy shall result in suspension until all delinquent records are completed and reinstatement accomplished in accordance with the Medical Records Policy.

(e) OIG Medicare Exclusion. If any individual is excluded by the Office of the Inspector General (OIG) from participating as a provider in any federal healthcare program, the provider's clinical privileges shall be automatically terminated.

(f) Mandatory Vaccinations. If any individual fails to comply with a mandatory vaccination policy, the individual's clinical privileges shall be suspended during the period of non-compliance, or in the case of influenza, until the published flu season ends.

(g) Criminal Activity. If an individual is convicted of, or enters a plea of guilty or *nolo contendere* to, any felony, the individual's clinical privileges shall be terminated.

(h) Failure to Pay Medical Staff Dues. After two written warnings of delinquency, spaced at least thirty (30) days apart, an individual's privileges will be automatically suspended until such time as the individual pays the delinquent dues. After sixty (60) days, if the Medical Staff dues have not been paid, the individual will be deemed to have voluntarily resigned from the Medical Staff.

- (i) Failure to Provide Requested Information. Failure of an individual to provide information pertaining to his/her qualifications for appointment or clinical privileges or to attend a special 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. Such suspension shall remain in effect until the matter is resolved.

#### **14.D.3. Reinstatement of Clinical Privileges**

- (a) When the licensure, Drug Enforcement Administration (DEA) certification, or professional liability insurance of a provider has been reinstated within 30 days of suspension for non-renewal, the provider shall notify the Medical Staff Office of the reinstatement and provide copy(s) of the documentation which demonstrates reinstatement. Upon receiving the appropriate documentation, the provider's clinical privileges will automatically reinstate without further review. The Medical Staff Office will notify the Chief of Staff and the Chief Medical Officer.
- (b) When an individual has been suspended for failure to complete medical records pursuant to the Medical Staff Medical Records policy, failure to comply with the Medical Staff Influenza policy, or failure to pay Medical Staff Dues, reinstatement shall be governed by the respective policies.
- (c) When an individual has been suspended for failure to provide to provide requested information, the provider's clinical privileges shall be reinstated upon confirmation from the Committee requesting the information that the matter has been resolved.
- (d) Reinstatement for all suspensions other than those described in 14.D.3(a)-(c) will be reviewed by the Credentials Committee which will forward its recommendations regarding the request to reinstate Hospital appointment and clinical privileges to the Medical Executive Committee. The Medical Executive Committee will consider all information and make a recommendation to the Board of Directors. The Board of Directors may accept the recommendation from the MEC or make its own determination on the reinstatement of Hospital appointment and clinical privileges.

#### **14.E. LEAVES OF ABSENCE**

- (1) 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 year, and the reasons for the leave. Any absence from the Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.
- (2) The Chief of Staff will make a recommendation to the Executive Committee and to

the Board as to whether a request for a leave of absence should be granted. After reviewing the matter, and, if applicable, the Executive Committee's recommendation, the Board shall determine whether to grant the leave.

- (3) No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to the Chief of Staff a written summary of professional activities during the leave of absence. The Chief of Staff shall refer the matter to the Executive Committee for a recommendation. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.
- (4) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (5) The Board shall then consider the recommendations of the Executive Committee and may approve reinstatement to the same or a different staff category and may limit or modify the individual's clinical privileges. In the event the Board determines to take action that would entitle the individual to request a hearing, the individual shall be given Special Notice. The individual shall have 15 days to respond in writing and either request a hearing or waive the right to a hearing.
- (6) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interests of the Hospital.
- (7) 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 a leave, or where a request for extension is not granted, the requesting individual may meet with the Executive Committee to discuss. The decision of the Executive Committee, subject to approval by the Board, is final, with no recourse to a hearing or appeal.

## **ARTICLE 15**

### **HEARING AND APPEAL PROCEDURES**

#### **15.A. INITIATION OF HEARING**

##### **15.A.1. Grounds for Hearing**

- (a) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
  - (1) denial of initial appointment to the Medical Staff if based on a determination of clinical incompetence or unprofessional conduct;
  - (2) denial of reappointment to the Medical Staff if based on a determination of clinical incompetence or unprofessional conduct;
  - (3) revocation of appointment to the Medical Staff if based on a determination of clinical incompetence or unprofessional conduct;
  - (4) denial of requested clinical privileges if based on a determination of clinical incompetence or unprofessional conduct;
  - (5) revocation of clinical privileges if based on a determination of clinical incompetence or unprofessional conduct;
  - (6) suspension of clinical privileges for more than 14 days if based on a determination of clinical incompetence or unprofessional conduct; or
  - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance) if based on a determination of clinical incompetence or unprofessional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) The hearing shall be conducted in accordance with the procedures outlined in the Bylaws and determined by the Presiding Officer or Hearing Officer.
- (d) An individual may also request a hearing before the Board takes final action, if the Board makes any of the foregoing recommendations without a prior Executive Committee recommendation to do so. In this instance, all references in this Article to the "Executive Committee" shall be deemed to refer to the "Board."

### **15.A.2. Actions Not Grounds for Hearing**

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

- (a) issuance of a letter of guidance, warning, or reprimand;
- (b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges unless based on a determination of clinical incompetence or unprofessional conduct;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension that is imposed for fourteen days or less;
- (g) denial of a request for leave of absence, or for an extension of a leave;
- (h) determination that an application is incomplete; or
- (i) determination that an application will not be processed due to a misstatement or omission.
- (j) a change in medical staff category to which a medical staff member is appointed by the Board.

### **15.B. THE HEARING**

#### **15.B.1. Notice of Recommendation**

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

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 15 days of receipt of this notice; and
- (c) a copy of this Article.

### **15.B.2. Request for Hearing**

An individual has 15 days following receipt of the Special Notice to respond in writing and either request a hearing or waive the right to a hearing. The request shall be in writing to the CEO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within the required timeframe shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

### **15.B.3. Notice of Hearing**

- (a) Following receipt of the individual's written request for a hearing, the CEO shall schedule the hearing and provide, by Special Notice, the
  - (a) time, place and date of the hearing,
  - (b) the names of the Hearing Panel members, Presiding Officer and/or Hearing Officer, if known; and
  - (c) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

### **15.B.4. Hearing Panel, Presiding Officer, and Hearing Officer**

The CEO, in consultation with the Chief of Staff, shall appoint either (i) a Hearing Panel and, as applicable a Presiding Officer, or (ii) a Hearing Officer. Once selected, the identity of the individual(s) appointed shall be provided by Special Notice. The individual requesting a hearing is prohibited from discussing the circumstances giving rise to the hearing with any Hearing Panel member, Presiding Officer or Hearing Officer prior to the hearing.

- (a) Hearing Panel:
  - (1) The Hearing Panel shall be composed of not less than three individuals, one of whom shall be designated as chair. The Hearing Panelists shall not have actively participated in the matter at any previous level and may be physicians or laypersons, may be individuals who are or are not connected with the Hospital, or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a

member of the Hearing Panel. Employment by the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include anyone who (i) is in direct economic competition with, (ii) is a medical partner of or is otherwise associated in practice with, or (iii) is involved in an active, known referral relationship with, the individual requesting the hearing.

(3) Presiding Officer:

(i) 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 Presiding Officer shall not act as an advocate for either side at the hearing. If no Presiding Officer has been appointed, the Chair of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

(ii) The Presiding Officer shall:

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

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

(3) maintain decorum throughout the hearing;

(4) determine the order of procedure;

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

(6) conduct argument by counsel on procedural points outside the presence of the Hearing Panel.

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

(iv) If the Presiding Officer is someone other than the Hearing Panel Chair, the Presiding Officer may participate in the private deliberations

of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. If the Presiding Officer is also the Hearing Panel Chair, the Hearing Panel Chair shall be entitled to vote on the Hearing Panel's recommendations.

(b) Hearing Officer:

(1) When either of the following conditions are satisfied, a Hearing Officer may be appointed in lieu of a Hearing Panel:

(i) when there are difficulties in assembling a Hearing Panel; or

(ii) when the basis for the recommendation to be reviewed during the hearing pertains only to professional conduct.

(2) The Hearing Officer may be any individual, although it is preferred that the Hearing Officer be an attorney. If an attorney is selected, he/she may not be an attorney who currently provides counsel to the Hospital or to the Medical Staff leaders. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

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

(c) Objections:

Any objection to any member of the Hearing Panel, including the Presiding Officer, or to the Hearing Officer, shall be made in writing to the CEO within 10 days of receipt of notice, who shall resolve the objection.

## **15.C. PRE-HEARING AND HEARING PROCEDURE**

### **15.C.1. Witness List**

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing and the CEO shall exchange a written list of the names of witnesses expected to offer testimony during the hearing.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

### **15.C.2. Provision of Relevant Information**

- (a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not be disclosed or used for any purpose outside of the hearing or any subsequent appeal under these Bylaws:
  - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
  - (2) reports of experts relied upon by the Executive Committee;
  - (3) redacted copies of relevant 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 individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.
- (c) The individual requesting the hearing shall provide a copy of any expert reports s/he intends to rely on at the hearing prior to the pre-hearing conference.
- (d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

### **15.C.3. Pre-Hearing Conference**

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

### **15.C.4. Failure to Appear**

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

### **15.C.5. Record of Hearing**

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available to the individual at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

### **15.C.6. Rights of Both Sides and the Hearing Panel at the Hearing**

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

### **15.C.7. Admissibility of Evidence**

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

### **15.C.8. Post-Hearing Statement**

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

### **15.C.9. Persons to be Present**

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the Chief of Staff. A physician may bring any physician colleague he wishes, but that individual's role is limited to being an observer.

### **15.C.10. Postponements and Extensions**

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

## **15.D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS**

### **15.D.1. Order of Presentation**

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

### **15.D.2. Basis of Hearing Panel Recommendation**

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

### **15.D.3. Deliberations and Recommendation of the Hearing Panel**

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

### **15.D.4. Disposition of Hearing Panel Report**

The Hearing Panel shall deliver its report to the CEO. The CEO shall send, by Special Notice, a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the Executive Committee.

## **15.E: APPEAL PROCEDURE**

### **15.E.1. Time for Appeal**

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

### **15.E.2. Grounds for Appeal**

The grounds for appeal shall be limited to the following:

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

### **15.E.3. Time, Place and Notice**

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board or the CEO shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

#### **15.E.4. Nature of Appellate Review**

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

#### **15.E.5. Final Decision of the Board**

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send Special Notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee for its information.

#### **15.E.6. Further Review**

Except where the matter is referred for further action and recommendation in accordance with Section 15.E.5, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 30 days except as the parties may otherwise agree.

**15.E.7. Right to One Hearing and One Appeal Only**

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

## ARTICLE 16

### **CONFIDENTIALITY AND PEER REVIEW PROTECTION**

- (a) Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:
- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities, or
  - (2) when the disclosures are authorized, in writing, by the CEO, the Chief of Staff, or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action (Medical Staff members) or employment termination (Hospital employees) and/or appropriate legal action.

- (b) All peer review activities pursuant to these Bylaws and related Medical Staff Documents shall be performed by “medical review committees” in accordance with North Carolina law. Medical review committees include, but are not limited to:
- (1) all committees;
  - (2) the Board of Directors and its committees; and
  - (3) any individual acting for or on behalf of any such entity, including but not limited to committee chairs and members, officers of the Medical Staff, and subject matter experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by medical review committees are confidential and covered by the provisions of N.C. Gen. Stat. §§131E-76, 131E-95, and 131E-97.2, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

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

**ARTICLE 17**

**ADOPTION**

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and associated Medical Staff Documents, pertaining to the subject matter thereof.

Adopted by the Medical Staff:

Date: September 14, 2009

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Johnathan D. Williams, M.D.  
Chief of Staff

Approved by the Board:

Date: September 28, 2009

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Mr. Robert H. Blalock, Jr.  
Chair, Board of Directors