MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF NEW HANOVER REGIONAL MEDICAL CENTER

MEDICAL STAFF AND ADVANCED PRACTICE PROFESSIONAL CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of the Administrative Team, a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Medical Center employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When a Medical Staff Member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial Appointment, Reappointment, and/or Clinical Privileges and as a condition of maintaining ongoing Appointment and/or Clinical Privileges, individuals must satisfy the applicable eligibility criteria:

(a) All Practitioners:

(1) have a current, unrestricted license to practice in North Carolina that is not subject to any restrictions, conditions or probationary terms;

(2) not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency;

(3) where applicable to their practice, have a current, unrestricted DEA registration and state-controlled substance license and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended;

(4) have current, valid professional liability insurance coverage in North Carolina in a form and in amounts satisfactory to the Medical Center;

(5) have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(6) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(7) have not been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship or a similarly equivalent program for other categories of Practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(8) have not had Appointment or Clinical Privileges denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(9) have not resigned Appointment or relinquished Clinical Privileges during an Investigation or in exchange for not conducting such an Investigation;

(10) not currently be under any criminal investigation or indictment and have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, violence, or the practitioner-patient relationship;

(11) have or agree to make appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed Practitioner with appropriate specialty-specific Clinical Privileges as determined by the Credentials Committee) with other Practitioners for those times when the individual will be unavailable;

(12) demonstrate recent clinical activity in their primary area of practice during the last year;

(13) meet any current or future eligibility requirements that are applicable to the Clinical Privileges being sought;

(14) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety; and

(15) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

(b) Additional Criteria for Medical Staff Members:

(1) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any inpatients for whom they have responsibility and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. Compliance with this eligibility requirement means that the Practitioner must document that he or she is willing and able to:

(i) respond within 15 minutes, via phone, to an initial contact from the Medical Center; and

(ii) appear in person to attend to a patient within 30 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

(2) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the Credentials Committee) by another Practitioner with appropriate Clinical Privileges;

(3) if applying for Clinical Privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(4) have successfully completed:

(i) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks Clinical Privileges;

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

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

(5) be certified in their primary area of practice at the Medical Center by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, the American Board of Foot and Ankle Surgery, or the American Board of Podiatric Medicine, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff Appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and*

(6) maintain board certification in their primary area of practice at the Medical Center on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so.

* The requirements pertaining to board certification are applicable to those individuals who apply for initial staff Appointment after the date this Policy is adopted and are not applicable to Medical Staff Members who were appointed prior to that date. Those Medical Staff Members will be grandfathered and will be governed by any board certification and residency training requirements that may have been in effect at the time of their initial Appointments.

In addition, in exceptional circumstances, the five-year time frame for initial applicants and the time frame for maintenance/recertification by existing members may be extended for one additional period, not to exceed two years, in order to permit an individual an additional opportunity to obtain or maintain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(i) the individual has been on the Medical Center's Medical Staff for at least two full years;

(ii) there have been no significant documented peer review concerns related to the individual's competence or behavior at the Medical Center during the individual's tenure;

(iii) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

(iv) the appropriate Department Chair at the Medical Center provides a favorable report concerning the individual's qualifications.

(c) Additional Criteria for Advanced Practice Professionals and Licensed Independent Practitioners:

(1) for Advanced Practice Professionals,

(i) have a written collaborative/supervision agreement, as applicable, with a Supervising Physician, that meets any applicable requirements under state law and Medical Center policy; and

(ii) agree to the Standards of Practice outlined in Article 8 of this Policy; and

(2) have completed his or her professional education and is either certified by the appropriate nationally recognized certification organization or, if he or she is not certified, must acquire the appropriate nationally recognized professional certification at the first-time certification is available. All

certifications must be maintained in order to remain eligible for Appointment and Clinical Privileges.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is a demonstrated Medical Center or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Department Chair, and the best interests of the Medical Center and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

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

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of Appointment or Clinical Privileges. Rather, that individual is ineligible to request Appointment or Clinical Privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) An application for Appointment and/or Clinical Privileges that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(g) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent Reappointment cycles.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the assessment of the initial grant or renewal of Clinical Privileges at time of Appointment and Reappointment, as reflected in the following factors:

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

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

(c) good reputation and character;

(d) ability to safely and competently perform the Clinical Privileges requested;

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

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

2.A.4. No Entitlement to Appointment, Reappointment, or Clinical Privileges:

No individual is entitled to receive an application or to be granted Appointment, Reappointment, or particular Clinical Privileges merely because he or she:

(a) is employed by the Medical Center or its subsidiaries or has a contract with the Medical Center;

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

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

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

(e) has had in the past, or currently has, Appointment or Clinical Privileges at any hospital or health care facility;

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

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

2.A.5. Nondiscrimination:

Neither the Medical Center nor the Medical Staff will discriminate in granting Appointment, Reappointment, and/or Clinical Privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, age, ethnic/national identity, religion, disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted Appointment, Reappointment, and/or Clinical Privileges, and as a condition of maintaining ongoing Appointment and/or Clinical Privileges, every Practitioner specifically agrees to the following, as applicable:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Medical Center and Medical Staff in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in activities related to the evaluation of professional practice and performance improvement (e.g., serving as an Assigned Reviewer under the Evaluation of Professional Practice ("EPP") Policy), and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of his or her Clinical Privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);

(e) to comply with Care Standards or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(f) to comply with Care Standards or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leaders, or to clearly document the clinical reasons for variance;

(g) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(h) to inform Medical Staff Services, in writing or via e-mail, as soon as possible, but in all cases within 10 Days, of any change in the Practitioner's status or any change in the information provided on the individual's application form. This information will be provided with or without request and will include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA or state-controlled substance authorization,
- adverse changes in professional liability insurance coverage,
- a judgment or settlement related to a professional liability lawsuit against the Practitioner,
- changes in the Practitioner's status (Appointment or Clinical Privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid an Investigation or initiation of peer review activities,
- changes in the Practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,
- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,
- exclusion, preclusion, or withdrawal from participation in Medicare/Medicaid or any sanctions imposed,
- any changes in the Practitioner's ability to safely and competently exercise Clinical Privileges or perform the duties and responsibilities of Appointment because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue,
- any referral to a state board health-related program (excluding self-reports), and
- any charge of, or arrest for, driving under the influence ("DUI");

(i) to immediately submit to an appropriate evaluation in accordance with the Practitioner Health Policy, which may include, but is not limited to, diagnostic testing such as a blood and/or urine test, when there is the potential for imminent danger to patients or staff or significant concerns exist regarding the individual's ability to safely and competently care for patients (all such requests will be managed in accordance with the Practitioner Health Policy);

(j) to meet with Medical Staff Leaders and/or members of the Administrative Team upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical Staff Leaders and/or Administrative Team as may be requested;

(k) to appear for personal or phone interviews in regard to an application for initial Appointment or Reappointment, if requested;

(l) to maintain and monitor a current e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff information to the Practitioner;

(m) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);

(n) to participate on a Medical Center-approved secure communication platform (e.g., PerfectServe);

(o) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;

(p) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(q) to not deceive patients as to the identity of any individual providing treatment or services;

(r) to seek consultation in accordance with the Medical Staff Rules and Regulations;

(s) to complete in a timely and legible manner all medical and other required records, containing all information required by the Medical Center, and to utilize the electronic medical record as required;

(t) to cooperate with all care management activities;

(u) to participate in an Organized Health Care Arrangement with the Medical Center and abide by the terms of the Medical Center's Notice of Privacy Practices with respect to health care delivered in the Medical Center;

(v) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(w) to promptly pay any applicable dues, assessments, and/or fines; and

(x) that, if there is any misstatement in, or omission from, the application, the Medical Center may stop processing the application (or, if Appointment has been granted prior to the discovery of a misstatement or omission, Appointment and Clinical Privileges may be deemed to be automatically relinquished). In either situation, there will be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that Appointment and Clinical Privileges should be automatically relinquished pursuant to this provision, the individual may not reapply for a period of at least two years.

2.B.2. Burden of Providing Information:

(a) Individuals seeking Appointment, Reappointment, and/or Clinical Privileges have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for Appointment, Reappointment, and current clinical competence for any requested Clinical Privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking Appointment, Reappointment, and/or Clinical Privileges have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application will become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 45 Days after the individual has been notified of the additional information required, the application will be deemed to

be withdrawn and the individual may not submit another application for Appointment or Clinical Privileges for a period of two years.

(d) The individual seeking Appointment, Reappointment and/or Clinical Privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for Appointment and Reappointment will contain a request for specific Clinical Privileges and will 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 will seek the following:

(1) information as to whether the applicant's 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, health care facility, or other organization, 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 MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the Clinical Privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant will sign the application and certify that he or she is able to perform the Clinical Privileges requested and the responsibilities of Appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for Appointment, Reappointment, or Clinical Privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Medical Center or the Board, its Medical Staff, any Medical Staff Member, Advanced Practice Professional, or Board member, their authorized representatives, and third parties who provide information for any matter relating to Appointment, Reappointment, Clinical Privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, its Medical Staff, 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 and/or Clinical Privileges, 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 these third parties to release this information to the Medical Center, its Medical Staff, Medical Staff Leaders, and their authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Medical Center.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes the Medical Center, its Medical Staff, and their authorized representatives to release information to (i) 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, Clinical Privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Medical Center that are assessing my professional qualifications, competence, or health pursuant to a

review that I have been notified is occurring under applicable Medical Center or Medical Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any Peer Review Information in response to such inquiries does not waive any associated privilege, and any and all such disclosures will be made with the understanding that the receiving entity will only use such Peer Review Information for Peer Review purposes.

(d) Authorization to Share Information among Facilities within the System:

The individual specifically authorizes each hospital, health care facility, or other organization that provides health care services and which is under common ownership, control, or management with the Medical Center (hereinafter "facilities within the System") to share credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting Appointment, Reappointment, or Clinical Privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Medical Center, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff Members, Advanced Practice Professionals, Licensed Independent Practitioners, authorized representatives, agents, and employees who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not Appointment, Reappointment, or Clinical Privileges are granted;

(2) throughout the term of any Appointment or Reappointment period and thereafter;

(3) should Appointment, Reappointment, or Clinical Privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Medical Center's professional review activities;

(4) as applicable, to any third-party inquiries received about his or her tenure at the Medical Center after the individual leaves his or her practice at the Medical Center; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for Appointment will be on approved forms or submitted through an approved Medical Center portal/website.

(b) An individual seeking initial Appointment will be sent information that (i) outlines the threshold eligibility criteria for Appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for any Clinical Privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final six months of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications will not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services.

(b) As a preliminary step, the application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications will not be processed. Individuals who fail to submit a completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility or that an application is incomplete does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

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

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application and obtained from peer references (from the same discipline where practicable) and from other available sources, including the

applicant's past or current Department Chairs 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.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested Clinical Privileges. This interview may be conducted by a combination of any of the following: the relevant Department Chair or Division Chief, the Credentials Committee, a Credentials Committee representative, the MEC, the Medical Staff President, and/or members of the Administrative Team. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

3.A.4. Department Chair Procedure:

(a) Medical Staff Services will transmit the complete application and all supporting materials to the relevant Department Chair in which the applicant seeks Clinical Privileges. The Department Chair will prepare a written report regarding whether the applicant has satisfied all of the qualifications for Appointment and the Clinical Privileges requested on a form provided by Medical Staff Services.

(b) The Department Chair will be available to the Advanced Practice Professionals Committee (if applicable), the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Advanced Practice Professionals Committee ("APP Committee") Procedure:

If the applicant is an Advanced Practice Professional, the APP Committee will review and consider, as applicable, the report prepared by the relevant Department Chair and make a recommendation to the Credentials Committee.

3.A.6. Credentials Committee Procedure:

(a) The Credentials Committee will review and consider the report prepared by the relevant Department Chair and will make a recommendation. The recommendation of the APP Committee will also be considered, if applicable.

(b) The Credentials Committee may use the expertise of the Department Chair or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for Appointment and Clinical Privileges, the Credentials Committee will review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to perform the Clinical Privileges requested and the responsibilities of

Appointment. If so, the Credentials Committee may require the applicant to provide information regarding his or her health status and/or undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination will be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application will cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions on Appointment and/or Clinical Privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that Appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, as pertinent, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.7. MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC 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 MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation will be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, as pertinent, the MEC will forward its recommendation to the CEO, who will promptly send Special Notice to the applicant. The CEO will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.8. Board Action:

(a) Expedited Review: The Board may delegate to a committee, consisting of at least two Board members, action on Appointment, Reappointment, and Clinical Privileges if there has been a favorable recommendation from the Credentials Committee and the MEC. Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for ratification at its next meeting.

(b) Full Board Review: When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted Appointment and Clinical Privileges, the Board may:

(1) appoint the applicant and grant Clinical Privileges as recommended; or

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

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO will promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke Appointment and/or Clinical Privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.9. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 60 Days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.A.10. Duration of Appointment:

All initial Appointments and any other initial grants of Clinical Privileges pursuant to this Policy will be for a duration of not more than two years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted Clinical Privileges, whether at the time of initial Appointment, Reappointment, or during the term of Appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or Reappointment will not confer any Clinical Privileges or right to admit or treat patients at the Medical Center. Each Practitioner who has been granted Appointment is entitled to exercise only those Clinical Privileges specifically granted by the Board.

(b) For requests for Clinical Privileges to be processed, all threshold criteria applicable to the Clinical Privileges being requested must be satisfied.

(c) Requests for Clinical Privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(d) Requests for Clinical Privileges that have been grouped into Core Privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(e) The Clinical Privileges recommended to the Board will be based on consideration of the following factors:

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

(2) appropriateness of utilization patterns;

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

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

(5) availability of other qualified staff members with appropriate Clinical Privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the Clinical Privileges requested;

(7) the Medical Center's available resources and personnel;

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

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of Appointment or Clinical Privileges at another hospital;

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

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

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

(f) Core Privileges, Special Privileges, Clinical Privilege delineations, and/or the criteria for the same will be developed by the relevant Department Chair, with the approval of the department, and will be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all Clinical Privileges requested.

(h) The report of the relevant Department Chair in which Clinical Privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff Appointment.

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of Clinical Privileges during the term of Appointment (increases and relinquishments), resignation from the Medical Staff or Permission to Practice as an Advanced Practice Professional, and waivers related to eligibility criteria for Clinical Privileges or the scope of those privileges.

(b) Submitting a Request. Requests for modifications, waivers, and resignations related to Clinical Privileges must be submitted in writing or electronically to Medical Staff Services.

(c) Increased Privileges.

(1) Requests for increased Clinical Privileges must state the specific additional Clinical Privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial Clinical Privileges.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for Clinical Privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question. All such requests will be processed in accordance with Section 2.A.2 of this Policy. In addition to the factors defined in Section 2.A.2, the Medical Staff Leaders may also consider the additional factors set forth in Section 4.A.2(f) in considering all such requests.

(2) If the individual is requesting a waiver of the requirement that each individual apply for the full core of Clinical Privileges in his or her specialty, the process set forth in this paragraph will apply.

(i) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services within the core that the Practitioner does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) Review Process: A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee will specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant Department Chair. The Credentials Committee's recommendation will be forwarded to the MEC, which will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny

the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(iii) On-Call Obligations: By applying for a waiver related to limiting the scope of Core Privileges, the Medical Staff Member nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other Medical Staff Members in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff Leaders after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the other Medical Staff Members in arranging for another individual with appropriate Clinical Privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual Clinical Privilege, whether or not part of the core, must provide a good cause basis for the modification of Clinical Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign Appointment and relinquish all Clinical Privileges must specify the desired date of resignation, which must be at least 30 Days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:

(i) completion of all medical records;

(ii) as applicable, the appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) as applicable, the completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the Medical Staff President, the CEO will act on the resignation request with a report on the matter forwarded to the MEC. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to Core Privileges:

(1) the Medical Center's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed on the individual;

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

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Medical Center;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant Clinical Privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to Clinical Privileges, it will specify the date that the modification or waiver will be effective. Failure of a Practitioner to request Clinical Privilege modifications or waivers in accordance with this Section shall, as applicable, result in the Practitioner retaining Appointment and Clinical Privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to Clinical Privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of Clinical Privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for Clinical Privileges to perform either a procedure not currently being performed at the Medical Center or a new technique to perform an existing procedure (hereafter, "new procedure") will not be processed until (1) a determination has been made that the procedure shall be offered by the Medical Center, and (2) criteria to be eligible to request those Clinical Privileges have been established as set forth in this Section.

(b) As an initial step in the process, the Practitioner seeking to perform the new procedure will prepare and submit a report to the Medical Staff President addressing the following:

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

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

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

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

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

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

The Administrative Team will review this report and consult with the Medical Staff President, the Department Chair, and the Credentials Committee (any of which may conduct additional research as may be necessary) and make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the Administrative Team is favorable, the Credentials Committee will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing Clinical Privilege. If it is determined that it does constitute a "new procedure," the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the Clinical Privileges at the Medical Center. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

(3) the manner of addressing the most common complications that may arise in the performance of the new procedure;

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

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

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

(e) The Board will make a reasonable effort to render the final decision within 60 Days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for Clinical Privileges that previously at the Medical Center 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) As an initial step in the process, the Practitioner seeking the Clinical Privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the Clinical Privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care. The Administrative Team will confirm the request is permissible under any existing exclusive contracts or Board directives regarding a closed service that are in place at the Medical Center before the request is forwarded to the Credentials Committee.

(c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairs, Division Chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the Clinical Privileges at issue. If it does, the committee may develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the Clinical Privileges in question;

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

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

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

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

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

(e) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action. The Board will make a reasonable effort to render the final decision within 60 Days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to exercise the Clinical Privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists:

(a) The scope and extent of surgical procedures that a Dentist may perform in the Medical Center will be delineated and recommended in the same manner as other Clinical Privileges.

(b) Surgical procedures performed by Dentists will be under the overall supervision of the relevant Department Chair. A medical history and physical examination of the patient will be made and recorded by a qualified Practitioner who has been granted Clinical Privileges to complete medical histories and physical examinations before dental surgery will be performed, and a designated Physician will be responsible for the medical care of the patient throughout the period of hospitalization.

4.A.6. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a Podiatrist may perform in the Medical Center will be delineated and recommended in the same manner as other Clinical Privileges.

(b) Surgical procedures performed by Podiatrists will be under the overall supervision of the relevant Department Chair. A medical history and physical examination of the patient will be made and recorded by a qualified Practitioner who has been granted Clinical Privileges to complete medical histories and physical examinations before podiatric surgery will be performed, and a designated Physician member of the Medical Staff will be responsible for the medical care of the patient throughout the period of hospitalization.

4.A.7. Physicians in Training:

(a) Physicians in residency training will not hold Appointments to the Medical Staff and will not be granted Clinical Privileges. The program director, clinical faculty, and/or attending staff member will be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Medical Center. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) A physician in training at the fellowship level may request Clinical Privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for such Clinical Privileges will be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, will be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may only be granted Clinical Privileges in those areas for which they can demonstrate current clinical competence.

4.A.8. Telemedicine Privileges for Distant-Site Practitioners:

(a) A qualified individual providing services from a distant-site location may be granted Telemedicine Privileges regardless of whether the individual is appointed to the Medical Staff or as an the Advanced Practice Professional.

(b) Requests for initial or renewed Telemedicine Privileges by distant-site Practitioners will be processed through one of the following options, as determined by the CEO in consultation with the Medical Staff President:

(1) A request for Telemedicine Privileges may be processed through the same process for applications for Appointment, as set forth in this Policy. In such case, the distant-site Practitioner must satisfy all qualifications and requirements set forth in this Policy, except those relating to response times, coverage arrangements, and emergency call responsibilities.

(2) If the distant-site Practitioner is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for Telemedicine Privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Medical Center must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the distant-site Practitioner is licensed and carries liability insurance in North Carolina;

(ii) a current list of Clinical Privileges granted to the distant-site Practitioner;

(iii) information indicating that the distant-site Practitioner has actively exercised the relevant Clinical Privileges during the previous 12 months and has done so in a competent manner;

(iv) confirmation that the distant-site Practitioner satisfies all of the distant hospital or telemedicine entity's qualifications for the Clinical Privileges granted;

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

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

This information will be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Medical Center may determine that a distant-site Practitioner is ineligible for Appointment or Clinical Privileges if the individual fails to satisfy the threshold eligibility criteria set forth in this Policy.

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

(d) Distant-site Practitioners who have been granted Telemedicine Privileges will be subject to the Medical Center's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the distant-site Practitioner by patients, other Practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine Privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement. The loss of Temporary Privileges based on the termination or non-renewal of such an agreement does not entitle an affected Practitioner to the procedural rights outlined in Article 7 of this Policy.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary Privileges for an applicant for initial Appointment may be granted by the CEO when there is an important patient care, treatment, or service need under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the Clinical Privileges requested, and current professional liability coverage; compliance with Clinical Privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Appointment or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Medical Staff President or the Credentials Committee or its Chair, and after considering the evaluation of the Department Chair; and

(5) Temporary Privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The CEO may grant Temporary Privileges to an individual serving as a locum tenens for a member of the Medical Staff or an Advanced Practice Professional who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous year), ability to exercise the Clinical Privileges requested, and current professional liability coverage; compliance with Clinical Privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Appointment or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility;

(4) the applicant has received a favorable recommendation from the Medical Staff President and/or Credentials Committee Chair, after considering the evaluation of the Department Chair;

(5) the applicant will be subject to any focused professional practice requirements established by the Medical Center; and

(6) the individual may exercise Locum Tenens Privileges for a maximum of 180 Days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 10 Days prior to each time that he or she will be exercising Locum Tenens Privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for Locum Tenens Privileges.

(c) Visiting. The CEO, upon recommendation of the Medical Staff President or the Credentials Committee Chair, may also grant Temporary Privileges in other limited situations when there is an important patient care, treatment, or service need, under the following circumstances:

(1) the Temporary Privileges are needed (i) for the care of a specific patient; (ii) when a proctoring or consulting Practitioner is needed, but is otherwise unavailable; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area;

(2) the following factors are considered and/or verified prior to the granting of Temporary Privileges: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Medical Center, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of Temporary Privileges in these situations will not exceed 60 Days; however, in exceptional situations, this period of time may be extended in the discretion of the CEO and the Medical Staff President.

Any individual seeking visiting Temporary Privileges who is currently appointed in good standing at another facility within the System with a grant of Clinical Privileges relevant to the request for visiting Temporary Privileges will be immediately authorized to exercise visiting Temporary Privileges upon verification of good standing by Medical Staff Services and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for the granting of Temporary Privileges will generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of Temporary Privileges.

(d) Automatic Expiration. All grants of Temporary Privileges will automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such Temporary Privileges by the relevant Department Chair, the Chair of the Credentials Committee, the Medical Staff President, and the CEO.

(e) Compliance with Bylaws and Policies. Prior to any Temporary Privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and the Medical Center.

(f) FPPE. Individuals who are granted Temporary Privileges will be subject to the Medical Center policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary Clinical Privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The CEO may withdraw Temporary Privileges at any time, after consulting with the Medical Staff President, the Chair of the Credentials Committee, the relevant Department Chair, or the VPMA. Clinical Privileges will then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted Temporary Privileges, the CEO, the relevant Department Chair, the Medical Staff President, or the VPMA may immediately withdraw all Temporary Privileges. The Department Chair or the Medical Staff President will assign to another Practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.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 Practitioner may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of Clinical Privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the relevant Department Chair or the Medical Staff President to a member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the VPMA, or the Medical Staff President may use a modified credentialing process to grant Disaster Privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

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

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

(b) A volunteer's license may be verified in any of the following ways: (i) current Medical Center picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Medical Center employee or Medical Staff Member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

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

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

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

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Medical Center may enter into contracts with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Medical Center. The Board may accomplish this by (i) entering into an exclusive contract that confers the exclusive right to perform specified services to one or more members or groups of members, or (ii) passing a Board resolution that would limit the members who may exercise Clinical Privileges in any clinical specialty to employees of the Medical Center or its affiliates. All individuals providing clinical services pursuant to such contracts will obtain and maintain Clinical Privileges at the Medical Center, in accordance with the terms of this Policy.

(2) MEC Review. Prior to the Medical Center signing an exclusive contract or passing any Board resolution as described above in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Medical Staff President) will review the quality of care and service implications of the proposed exclusive contract or Board resolution and provide a report of its findings and recommendations to the Board within 30 Days of the Board's request.

As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Medical Center administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff Members who may be a party to the arrangement, are not relevant and will neither be disclosed to the MEC nor discussed as part of the MEC's review.

(3) Meeting with Board or Board Committee. After receiving the MEC's report, the Board will determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff Member from exercising Clinical Privileges that had previously been granted, the affected member is entitled to the following notice and review procedures (Note: If more than one physician in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

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

the Medical Center or the Board resolution becoming effective. Any such meeting must be requested by the affected member and held within 30 Days of the notice, unless this time frame is extended by mutual agreement.

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

(c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member will be notified that he or she is ineligible to continue to exercise the Clinical Privileges covered by the exclusive contract or Board resolution as described in more detail in Section (4) below.

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

(4) Effect of Exclusive Contract or Board Resolution on Clinical Privileges. If the Board enters into an exclusive contract or by resolution limits the members who may exercise Clinical Privileges in any clinical specialty to employees of the Medical Center or its affiliates, then the following apply:

(a) Effect on Existing Privileges and Appointment.

(i) individuals who held Clinical Privileges prior to execution of an exclusive contract or a Board resolution are no longer eligible to exercise the Clinical Privileges covered by the contract or resolution as of the effective date of the exclusive contract or Board resolution and for as long as the contract or resolution is in effect, unless they are members of the group that holds the exclusive contract, or the contract or resolution contains an exception that allows them to continue exercising the Clinical Privileges covered by the exclusive contract or Board resolution;

(ii) an individual who leaves a group that has an exclusive contract with the Medical Center is no longer eligible to exercise Clinical Privileges covered by the contract upon the effective date of his or her departure from the group;

(iii) individuals who are members of a group that has an exclusive contract with the Medical Center are no longer eligible to exercise Clinical Privileges if the Medical Center enters into a new exclusive contract with a different group as of the effective date of the contract and so long as the contract is in effect, unless the individuals

subsequently join the group that holds the new exclusive contract or the contract contains an exception that allows them to continue exercising Clinical Privileges covered by the exclusive contract; and

(iv) if all of an individual's Clinical Privileges are covered by an exclusive contract or a Board resolution and the individual is not authorized by the contract or the terms of the Board resolution to exercise any of those Clinical Privileges, the individual will be deemed to have voluntarily resigned his or her Appointment.

(b) Applicants for Privileges. No other individual except those authorized by the exclusive contract or the terms of a Board resolution may exercise Clinical Privileges that are covered by the exclusive contract or board resolution while the contract or Board resolution is in effect. This means that only individuals who are authorized by the exclusive contract or Board resolution are eligible to apply for Clinical Privileges that are covered by an exclusive contract or Board resolution.

(5) Changes to Existing Exclusive Contracts or Resolutions. If the Medical Center is considering a change to an existing exclusive contract or resolution (e.g., replacing the group who currently holds an exclusive contract with another group), the Administrative Team shall consult with the MEC as outlined in paragraph (2) to discuss the quality of care and service implications of such a change prior to any final determination is made on how to proceed.

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

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

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial Appointment will apply to continued Appointment, Reappointment, and Clinical Privileges.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for Reappointment and renewal of Clinical Privileges, an individual must have, during the previous Appointment term:

(a) satisfied all Medical Staff responsibilities, including payment of dues or fines;

(b) continued to meet all qualifications and criteria for Appointment and the Clinical Privileges requested, including those set forth in Section 2.A.1 of this Policy;

(c) if applying for renewal of Clinical Privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the Clinical Privileges requested. Any individual seeking Reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further; and

(d) paid the Reappointment processing fee, if any.

5.A.2. Factors for Evaluation:

In considering an individual's application for Reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the Reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Medical Center;

(b) participation in Medical Staff or Advanced Practice Professional duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with activities related to the evaluation of professional practice, case management, participation in performance improvement, utilization activities, and such other reasonable duties and responsibilities as assigned;

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

(d) any focused professional practice evaluations;

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

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for Reappointment will be furnished to Practitioners at least four months prior to the expiration of their current Appointment term. A completed Reappointment application must be returned to Medical Staff Services within 45 Days.

(b) Failure to submit a complete application within 45 Days will result in the assessment of a Reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the Practitioner's current term may result in the automatic expiration of Appointment and Clinical Privileges at the end of the then current term of Appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and Medical Staff Leaders. If an individual's Clinical Privileges lapse due to a processing delay, subsequent Board action may be to grant Reappointment and renewal of Clinical Privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.8(a).

(c) Reappointment will be for a period of not more than two years.

(d) The application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for Reappointment and for the Clinical Privileges requested.

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

5.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services will forward the application to the relevant Department Chair and the application for Reappointment will be processed in a manner consistent with applications for initial Appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new Clinical Privileges are requested.

5.A.5. Conditional Reappointments:

(a) Recommendations for Reappointment and renewed Clinical Privileges may be contingent on a Practitioner's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for Reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the applicant for Reappointment is the subject of an unresolved professional practice evaluation concern, an Investigation, or a hearing at the time Reappointment is being considered, a conditional Reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

(a) If the Credentials Committee or MEC is considering a recommendation to deny Reappointment or to reduce Clinical Privileges, the chair will notify the Practitioner of the possible recommendation and invite the member to meet prior to any final recommendation being made.

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

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

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The Practitioner will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting will be permitted or made.

(e) If the Board determines to reject a favorable recommendation from the MEC, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO will promptly send a Special Notice to the applicant that the applicant is entitled to request a hearing under this Policy.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 60 business Days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted Clinical Privileges, whether at the time of initial Appointment, Reappointment, or during the term of Appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 6

QUESTIONS INVOLVING PRACTITIONERS

6.A. GENERAL

(1) Activities related to the evaluation of professional practice will be conducted in accordance with the relevant Medical Staff policy (e.g., the EPP Policy, Professionalism Policy, or Practitioner Health Policy). These policies encourage the use of Initial Mentoring Efforts and Progressive Steps by Medical Staff leaders and the Administrative Team (when requested) to address questions relating to a Practitioner's clinical practice, professional conduct, and/or health.

(2) If these policies fail to resolve an issue and/or when an issue is of such severity that in the discretion of Medical Staff Leaders it requires further review, the matter may be referred to the MEC for its review in accordance with Section 6.C of this Policy.

(3) In addition, this Policy provides mechanisms related to voluntary refrainments, precautionary suspensions and restrictions, automatic relinquishments, and leaves of absence.

6.B. REQUEST TO REFRAIN FROM PRACTICING/PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.B.1. Grounds for Requests to Voluntarily Refrain/Precautionary Suspension or Restriction:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any Medical Staff Officer, acting in conjunction with the CEO or the VPMA, will have the authority to proceed as follows:

(1) request that the Practitioner agree to voluntarily refrain from exercising Clinical Privileges pending further review of the circumstances by the Leadership Council in accordance with Section 6.B.2 of this Policy (agreements to voluntarily refrain may also be utilized in other professional practice evaluation contexts such as Voluntary Enhancement Plans, the details of which are addressed in the relevant Medical Staff policy); or

(2) if the Practitioner is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's Clinical Privileges as a precaution, which actions will be reviewed by the MEC in accordance with Section 6.B.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a

pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension, restriction, or agreement.

(d) These actions will become effective immediately, will promptly be reported in writing to the CEO, the VPMA, and the Medical Staff President, and will remain in effect unless the action is modified by the MEC.

(e) The Practitioner will be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence will also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), and will be provided to the Practitioner within three Days of the action.

6.B.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council will review the matter resulting in a Practitioner's agreement to voluntarily refrain from exercising Clinical Privileges within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the Practitioner will be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual will be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting will be permitted or made; however, minutes of the meeting will be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council will determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate an Investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council will also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

6.B.3. MEC Review Process for Precautionary Suspensions or Restrictions:

(a) The MEC will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the Practitioner will be given an opportunity to meet with the MEC. The individual may propose ways other than a precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual will be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting will be permitted or made; however, minutes of the meeting will be prepared.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC will determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or an Investigation, referring the matter for review pursuant to another policy, or recommending some other action that is deemed appropriate under the circumstances. The MEC will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated throughout any further review process (and hearing and appeal, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.B.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the Department Chair or the Medical Staff President may assign, as appropriate, to another Practitioner with appropriate Clinical Privileges responsibility for care of the individual's hospitalized patients, or to otherwise aid in implementing the precautionary suspension, restriction, or agreement to refrain from practicing. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician but may not always be accommodated.

(b) All Practitioners have a duty to cooperate with the Medical Staff President, the Department Chair, the MEC, the VPMA, and the CEO in enforcing precautionary suspensions or restrictions or agreements to voluntarily refrain from practicing.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

(a) Where Initial Mentoring Efforts, Progressive Steps, and/or other efforts under one or more of the policies referenced in this Article have not resolved an issue and/or

when there is an issue of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients;

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

(3) the known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Medical Center or the Medical Staff; and/or

(4) conduct by any Practitioner that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical Staff, including the inability of the Practitioner to work harmoniously with others,

the matter may be referred to the Medical Staff President, the relevant Department Chair, the chair of a standing committee, the VPMA, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Practitioner, the matter will be referred to the Medical Staff President, the relevant Department Chair, the chair of a standing committee, the VPMA, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred will conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, will forward it in writing to the MEC.

(d) No action taken pursuant to this Section will constitute an Investigation.

6.C.2. Initiation of Investigation:

(a) When a question involving a Practitioner's clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner that the MEC believes is appropriate. Prior to making its determination, the MEC may discuss the matter with the individual involved. An Investigation will begin only after a formal determination by the MEC to do so. The MEC's determination will be recorded in the minutes of the meeting where the determination is made.

(b) The MEC will inform the individual that an Investigation has begun. The notification will include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

(3) a statement that the individual will be given the opportunity to meet with the committee conducting the Investigation before the Investigation concludes; and

(4) a copy of Section 6.C.3 of this Policy, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Medical Center or Medical Staff.

6.C.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC will either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 9. Any ad hoc committee may include individuals not on the Medical Staff or Advanced Practice Professionals. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (i.e., another Physician if the Investigation involves a Physician).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee will also have available to it the full resources of the Medical Staff and the Medical Center, including the authority to arrange for an external review, if needed. An external review may be used whenever the Medical Center and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the CEO or VPMA should be consulted if the Medical Center is paying for the review. In addition, the individual under Investigation will be notified of that decision and the nature of the external review. However, the individual under Investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual will be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated will execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination will be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings will apply. No recording (audio or video) or transcript of the meeting will be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified

by the investigating committee during its review. A summary of the interview will be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee will make a reasonable effort to complete the Investigation and issue its report within 30 Days of the commencement of the Investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee will make a reasonable effort to complete the Investigation and issue its report within 30 Days after the completion of the external review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee will prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.C.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued Appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of Clinical Privileges;

(7) recommend suspension or Restriction of Clinical Privileges for a term;

(8) recommend revocation of Appointment and/or Clinical Privileges; or

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

(b) If the recommendation by the MEC would entitle the individual to request a hearing in accordance with Section 7.A.1, the recommendation will be forwarded to the CEO, who will promptly inform the individual by Special Notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) A determination by the MEC that does not entitle the individual to request a hearing will take effect immediately. All such determinations will be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification to the recommendation of the MEC that would result in an action that would entitle the individual to request a hearing, the CEO will inform the individual by Special Notice. No final action will occur until the individual has completed or waived a hearing and appeal.

(d) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal will be monitored by Medical Staff Leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.D. AUTOMATIC RELINQUISHMENT/ACTIONS

6.D.1. General:

(a) An Automatic Relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of the Medical Center to file a report with the National Practitioner Data Bank or any state licensing agency and will take effect without hearing or appeal.

(b) Except as otherwise provided below, an Automatic Relinquishment of Appointment and Clinical Privileges will be effective immediately upon actual or Special Notice to the individual. Such Special Notice will be provided after confirmation of the event(s) that led to the Automatic Relinquishment by the Medical Staff President, the VPMA, and/or CEO.

6.D.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must promptly report to Medical Staff Services.

(b) An individual's Appointment and Clinical Privileges will be automatically relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which will be assessed at time of Reappointment). This includes, but is not limited to, the following occurrences:

(1) Licensure (in any state): Revocation, expiration, suspension, the placement of restrictions on an individual's license or certification, or an individual's license or certification being placed on probationary status.

(2) Controlled Substance Authorization: Revocation, suspension or the placement of restrictions on an individual's DEA registration or state-controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Medical Center or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Exclusion, preclusion or debarment or proposed exclusion, preclusion, or debarment by government action or

from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; (vi) violence against another; or (vii) the practitioner-patient relationship. (DUIs will be reviewed in accordance with the Practitioner Health Policy.)

(c) In addition to the above, an Advanced Practice Professional's Appointment and Clinical Privileges will also be automatically relinquished upon the occurrence of the following:

(1) a determination is made that there is no longer a need for the services of a particular discipline or category of Advanced Practice Professional;

(2) an Advanced Practice Professional fails, for any reason, to maintain an appropriate relationship with a Supervising Physician as defined in this Policy; or

(3) any Advanced Practice Professional employed by the Medical Center has his or her employment terminated.

(d) Automatic relinquishment will take effect immediately upon Special Notice to the individual and will continue, unless a waiver of the threshold eligibility criteria is granted pursuant to Section 2.A.2., or until the matter is resolved and the individual is granted reinstatement, as may be applicable.

(e) If the underlying matter leading to automatic relinquishment is resolved within 60 Days (i.e., the individual can establish that s/he continues to meet all threshold eligibility criteria), the individual may request reinstatement in accordance with Section 6.D.6. In addition, if an arrest, charge or indictment as defined above has not been fully resolved within the 60-day time period, an individual may request reinstatement but bears the burden of demonstrating, in the full discretion of the Leadership Council, that the underlying matter does not raise concerns about the individual's professional qualifications and/or ability to completely and safely exercise Clinical Privileges. Failure to resolve the matter within 60 Days of the date of relinquishment will result in an automatic resignation of Appointment and Clinical Privileges.

(f) If an individual no longer meets threshold eligibility criteria as a result of the matter that led to the automatic relinquishment, s/he must request a waiver of threshold eligibility criteria in accordance with Section 2.A.2.

6.D.3. Failure to Complete Medical Records:

Failure to complete medical records may result in the automatic relinquishment of Clinical Privileges in accordance with the process set forth in the Medical Staff Rules and Regulations.

6.D.4. Failure to Provide Requested Information:

(a) Failure to provide information pertaining to an individual's qualifications for continued Appointment or Clinical Privileges, in response to a written request from the Credentials Committee, the MEC, the Leadership Council, the Committee for Professional Enhancement, the VPMA, the CEO, or any other committee authorized to request such information, will result in the automatic relinquishment of all Clinical Privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 Days of the date of relinquishment, it will result in automatic resignation of Appointment and Clinical Privileges.

(b) Automatic relinquishment or resignation as described in this Section will not occur if the Practitioner's failure to provide written input is due to the legitimate unavailability of the Practitioner. These circumstances are limited to a planned vacation out of town, attendance at a conference, illness, family emergency or other cause beyond the Practitioner's control. In such case, the requesting committee or individual will establish a reasonable deadline depending on the circumstances.

6.D.5. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any Practitioner, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders, one or more members of the Administrative Team, and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel will be present at this meeting, and no recording (audio or video) or transcript will be permitted or made.

(c) The notice to the individual regarding this meeting will be given in writing at least three Days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting will result in the automatic relinquishment of all Clinical Privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 Days of the date of relinquishment, it will result in automatic resignation of Appointment and Clinical Privileges.

(e) Automatic relinquishment or resignation as described in this Section will not occur if the Practitioner's failure to attend a meeting is due to the legitimate unavailability of the Practitioner. These circumstances are limited to a planned vacation out of town, attendance at a conference, illness, family emergency or other cause beyond the Practitioner's control. In such case, the requesting committee or individual will establish a reasonable deadline depending on the circumstances.

6.D.6. Request for Reinstatement:

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

(b) Requests for reinstatement following the relinquishment of Clinical Privileges due to medical record delinquencies will be accomplished in accordance with applicable medical record policies and/or Rules and Regulations.

(c) Requests for reinstatement following the relinquishment of Clinical Privileges due to (i) failure to provide requested information and/or (ii) failure to attend a special meeting will be reviewed by the Leadership Council Chair. If the Leadership Council Chair recommends favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the full Leadership Council in accordance with (d) below.

(d) All other requests for reinstatement following a relinquishment of Clinical Privileges will be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Medical Center. If, however, the Leadership Council has any questions or concerns, those questions will be noted, and the reinstatement request will be forwarded to the Credentials Committee, MEC, and Board for review and recommendation.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

(a) General. A Practitioner may request a leave of absence by submitting a written request to Medical Staff Services. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

(b) The Medical Staff President will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the Medical Staff President may consult with the VPMA and the relevant Department Chair. The

granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Leaves for Health Issues. Except for maternity leaves, Practitioners must report to the Medical Staff President any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances (whether by report of the Practitioner or otherwise), the CEO and/or Medical Staff President, in consultation with the VPMA, may trigger an automatic medical leave of absence at any point after becoming aware of the Practitioner's absence from patient care. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been triggered.

6.E.2. Duties of a Practitioner on Leave:

During the leave of absence, the individual will not exercise any Clinical Privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.E.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Center. Requests for reinstatement will then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff Member may immediately resume clinical practice at the Medical Center. If, however, the Leadership Council has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the Physician or other health care professional treating the Practitioner, indicating that the Practitioner is capable of resuming a hospital practice and safely exercising the Clinical Privileges requested.

(c) Absence for longer than one year will result in automatic relinquishment of Appointment and Clinical Privileges unless an extension is granted by the Medical Staff President. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

(d) If an individual's current Appointment is due to expire during the leave, the individual must apply for Reappointment, or Appointment and Clinical Privileges will lapse at the end of the Appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner will be deemed a voluntary resignation of Appointment and Clinical Privileges.

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

6.F. ACTION AT ANOTHER HOSPITAL OR FACILITY WITHIN THE SYSTEM

(1) Each hospital, health care facility, or other organization that provides health care services and which is under common ownership, control, or management with the Medical Center (hereinafter "facilities within the System") will share information regarding the implementation or occurrence of any of the following actions with all other facilities within the System at which an individual maintains Appointment, Clinical Privileges, or any other permission to care for patients:

(a) automatic relinquishment or resignation of Appointment or Clinical Privileges for any reason set forth in this Policy or other Medical Staff policies, ***except for*** those relinquishments or resignations that result from:

(i) incomplete medical records;

(ii) the failure to provide documentation showing evidence of any required immunizations, vaccinations, and/or screening tests;

(iii) the failure to provide requested information about a Practitioner's professional qualifications in a timely manner;

(iv) suspension or termination of a Practitioner's employment by the Medical Center or by an employer that is directly or indirectly, through one or more intermediaries, controlled by the facilities within the System;

(v) termination of a Practitioner's contractual relationship with a contract provider (e.g., exclusive provider), unless the termination related to the Practitioner's clinical competence or professional conduct;

(b) voluntary agreement to modify Clinical Privileges or to refrain from exercising some or all Clinical Privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;

(c) any denial, suspension, revocation, or termination of Appointment and/or Clinical Privileges;

(d) participation in a Voluntary Enhancement Plan under the Evaluation of Professional Practice Policy or Medical Staff Professionalism Policy;

(e) a grant of conditional Appointment or Clinical Privileges (either at initial Appointment or Reappointment), or conditional continued Appointment or Clinical Privileges; and/or

(f) any other event which, in the sole discretion of the facility within the System making the notification, raises a significant concern about the Practitioner's clinical competence, professional conduct, health/ability to safely practice, or utilization practices.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) (a), (b), or (c) above have occurred at any facility within the System, that action will either:

(a) automatically and immediately take effect at the facility within the System receiving the notice; or

(b) be cause for the facility within the System receiving the notice to determine that the individual no longer satisfies the eligibility criteria set forth in this Policy and has therefore automatically relinquished his or her Appointment and Clinical Privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural rights (including advance notice, additional peer review, formal Investigation, hearing, or appeal) other than what occurred at the facility within the System taking the original action. All other information that is shared pursuant to Paragraph (1) above will be reviewed by Medical Staff Leaders at the receiving facility within the System to determine whether additional steps may be necessary.

(3) The MEC may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving facility within the System. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the Practitioner has been notified in writing of such. Waivers are within the discretion of the MEC and are final. They will be granted only as follows:

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

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the facility within the System

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

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal Investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES FOR PRACTITIONERS

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial Appointment;

(2) denial of Reappointment;

(3) revocation of Appointment;

(4) denial of requested Clinical Privileges, whether at time of initial Appointment, Reappointment, or during the course of Appointment;

(5) revocation of Clinical Privileges;

(6) suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension, which entitles an individual to the procedures outlined in Section 6.B.3 of this Policy, which are deemed fair under the circumstances);

(7) a Restriction of Clinical Privileges lasting for more than 30 Days; or

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

(b) No other recommendations will entitle the individual to a hearing.

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

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

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

(a) determination that an applicant for Appointment fails to meet the threshold eligibility qualifications or criteria outlined in Section 2.A.1 of this Policy;

(b) ineligibility to request Appointment of Clinical Privileges, or to continue Clinical Privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) determination that an applicant for Clinical Privileges fails to meet the eligibility criteria to hold the Clinical Privilege;

(d) determination that an application is incomplete or untimely;

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

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of Appointment and Clinical Privileges as a result of failure to submit an application for Reappointment within the allowable time period;

(h) issuance of an Informational Letter, and Educational Letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for a Practitioner;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Voluntary Enhancement Plan;

(l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an Investigation into any matter or the Appointment of an ad hoc investigating committee;

(n) grant of conditional Appointment or Reappointment or of an Appointment or Reappointment period that is less than two years;

(o) refusal of the Medical Center to consider a request for Appointment, Reappointment, or Clinical Privileges after a final adverse decision regarding such request;

(p) precautionary suspension;

(q) Restriction or suspension of Clinical Privileges for less than 30 Days;

(r) automatic relinquishment of Appointment or Clinical Privileges or automatic resignation;

(s) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(t) removal from the on-call roster or any other reading panel;

(u) withdrawal of Temporary Privileges;

(v) requirement to appear for a special meeting;

(w) termination of any contract with or employment by the Medical Center; and

(x) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

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

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

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

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 Days following receipt of the notice to request a hearing. The request will be in writing to the CEO and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The CEO will schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

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

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

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing will begin 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.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Medical Staff President, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, at least two of whom must be a Physician, and may include any combination of:

(i) any Practitioner, provided the individual has not actively participated in the matter at any previous level; and/or

(ii) Practitioners or laypersons not connected with the Medical Center (i.e., Physicians not on the Medical Staff or laypersons not affiliated with the Medical Center).

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

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

(4) The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the Appointment of the Hearing Panel will comply with the guidelines set forth in the conflict of interest provisions found in Article 9 of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Medical Staff President, will appoint a Presiding Officer who will be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Medical Center in any legal matters. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) 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;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but will not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Medical Staff President, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, will be made in writing, within 10 Days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Medical Staff President and must include the basis for the objection. The Medical Staff President will be given a reasonable opportunity to comment. The CEO will rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Medical Center, but the individual requesting the hearing may elect to share in contributing to the compensation (should he or she wish to do so).

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Medical Center employees or Practitioners whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Medical Center has been notified and has contacted the individuals about their willingness to be interviewed. The Medical Center will advise the individual who has requested the hearing once it has contacted such employees or Practitioners and confirmed their willingness to meet. An employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Practitioner who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

7.C.2. Time Frames:

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

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

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

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

7.C.3. Witness List:

(a) At least 10 Days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

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

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

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential

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

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

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

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

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

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

The provision of this information will not waive any privilege under the North Carolina peer review protection statutes.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.

(d) At least 10 Days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party will provide the other party with its proposed exhibits. All objections to documents or witnesses will be submitted in writing at least five Days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Appointment or the relevant Clinical Privileges will be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer will require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which will be held no later than 14 Days prior to the hearing. At the pre-hearing conference, the Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination and will resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

The parties and their counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness 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 proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

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

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

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

upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.D.2. Record of Hearing:

No recording (audio or video) of the hearing will be permitted or made. A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Medical Center. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

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

7.D.5. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding, the Medical Staff President, and the CEO. In addition, administrative personnel may be present as requested by the CEO or the Medical Staff President.

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

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

7.E.2. Deliberations and Recommendation of the Hearing Panel:

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

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the CEO. The CEO will send by Special Notice a copy of the report to the individual who requested the hearing. The CEO will also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 Days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 Days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

7.F.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 on behalf of the Chair) will schedule and arrange for an appeal. The individual will be given Special Notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

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

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

(a) Within 30 Days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Medical Center and the quality of care provided.

(c) The Board will render its final decision in writing, including specific reasons, and will send Special Notice to the individual. A copy will also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board will be effective immediately and will not be subject to further review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No Practitioner will be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial Appointment or Reappointment or revokes the Appointment and/or Clinical Privileges of a current Practitioner, that individual will be ineligible to apply for staff Appointment or for those Clinical Privileges at the Medical Center unless the Board provides otherwise.

ARTICLE 8

CONDITIONS OF PRACTICE
FOR ADVANCED PRACTICE PROFESSIONALS
AND ALLIED HEALTH PROFESSIONALS

8.A. RIGHTS AND PREROGATIVES

(1) Advanced Practice Professionals shall not be Appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff Appointment. The rights and prerogatives of Advanced Practice Professionals are as set forth in this Section.

(2) Advanced Practice Professionals may attend meetings of the Medical Staff and of relevant departments and divisions, without vote.

(3) The Leadership Council will appoint one Advanced Practice Professionals to the MEC, one to the Credentials Committee, and one to the Committee for Professional Enhancement, all with vote.

(4) Advanced Practice Professionals may be appointed to serve on other Medical Staff committees, in the discretion of the Leadership Council, also with vote.

8.B. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ADVANCED PRACTICE PROFESSIONALS IN THE INPATIENT SETTING

(1) As a condition of being granted Appointment, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of utilizing the services of Advanced Practice Professionals in the Medical Center, all Medical Staff Members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice apply to the functioning of Advanced Practice Professionals in the inpatient hospital setting:

(a) Exercise of Clinical Privileges. Advanced Practice Professionals may exercise those Clinical Privileges as have been granted pursuant to their approved delineation of Clinical Privileges, which delineations specify the requisite levels of supervision that apply to their Clinical Privileges (general, direct, or personal, which terms are defined in the Glossary), of which only "personal" supervision requires the actual physical presence of the Supervising Physician.

(b) Admitting Privileges. Advanced Practice Professionals are not granted inpatient Admitting Privileges and therefore may not admit patients independent of the Supervising Physician. However, an Advanced Practice Professional is permitted to write inpatient admission orders on behalf of a Supervising Physician who has inpatient Admitting Privileges and may examine the patient, gather data, order tests, develop an assessment and plan, and generate other documentation to help facilitate the admission. In such situations, the Supervising Physician (or his or her covering physician) must see the patient within 24 hours of the admission.

(c) Consultations. Advanced Practice Professionals may not independently provide patient consultations in lieu of the Practitioners' Supervising Physicians. An Advanced Practice Professional may examine patients, gather data, order tests, and generate documentation; however, the Supervising Physician must personally see the patient if requested by the physician seeking the consultation.

(d) Emergency On-Call Coverage. Advanced Practice Professionals may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. It will be within the discretion of the Emergency Department personnel requesting assistance whether it is appropriate to contact an Advanced Practice Professional prior to contacting the Supervising Physician. However, when contacted by the Emergency Department, the Supervising Physician (or his/her covering Physician) must personally respond to all calls in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an Advanced Practice Professional to see the patient, gather data, order tests, and generate documentation for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department Physician.

(e) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Medical Center personnel requesting assistance whether it is appropriate to contact an Advanced Practice Professional or the Supervising Physician. Advanced Practice Professionals may not independently respond to calls from the floor or special care units regarding hospitalized inpatients that were specifically directed to the Supervising Physician. The Supervising Physician must personally respond to all calls that have been specifically directed to him or her in a timely manner.

(f) Daily Inpatient Rounds for Attending Physicians. An Advanced Practice Professional is permitted to perform daily inpatient rounds; however, all patients must also be visited during their observation or hospitalization by the Supervising Physician (or a designated physician) either in person or via

technology-enabled direct communication and evaluation (i.e., telemedicine).

Exceptions to the above Standards of Practice may be granted by the MEC to a Practitioner in a particular clinical situation, upon demonstration of good cause shown. When the MEC grants such an exception, the committee will follow the same process as set forth in Section 2.A.2 of this Policy.

8.C. OVERSIGHT BY SUPERVISING PHYSICIAN

(1) Any activities permitted to be performed at the Medical Center by an Advanced Practice Professional or Allied Health Professional will be performed only in collaboration with or under the supervision or direction of a Supervising Physician.

(2) Advanced Practice Professionals and Allied Health Professionals may function in the Medical Center only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision or collaboration agreement with the Supervising Physician. In addition, should the Medical Staff Appointment or Clinical Privileges of the Supervising Physician be revoked or terminated, the Clinical Privileges of the Advanced Practice Professional or the Scope of Practice of the Allied Health Professional will be automatically relinquished (unless the individual will be supervised by another Practitioner appointed to the Medical Staff).

(3) An Advanced Practice Professional or Allied Health Professional and the Supervising Physician must provide the Medical Center with a copy of any written supervision or collaboration agreement that may be required by the state as well as notice of any revisions or modifications that are made to any such agreements between them. This notice must be provided to Medical Staff Services within three Days of any such change.

(4) At the discretion of the Medical Staff Leaders, the Physician who is the primary Supervising Physician for the Advanced Practice Professional may be kept apprised of the review process when such concerns exist. This could include copying the Supervising Physician on all correspondence that the Advanced Practice Professional receives from the Medical Staff Leaders and/or invitation to participate in any meetings or interventions. The Supervising Physician will maintain all such information in a confidential manner.

8.D. QUESTIONS REGARDING AUTHORITY OF AN ADVANCED PRACTICE PROFESSIONAL OR ALLIED HEALTH PROFESSIONAL

(1) Should any Medical Staff Member or Medical Center employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an Advanced Practice Professional or Allied Health Professional, either to act or to issue instructions outside the physical presence of the Supervising

Physician in a particular instance, the Medical Staff Member or Medical Center employee will have the right to require that the Advanced Practice Professional's or Allied Health Professional's Supervising Physician validate, either at the time or later, the instructions of the Advanced Practice Professional or Allied Health Professional. Any act or instruction of the Advanced Practice Professional or Allied Health Professional will be delayed until such time as the staff member or Medical Center employee can be certain that the act is clearly within the scope of the Advanced Practice Professional's or Allied Health Professional's activities as permitted by the Board.

(2) Any question regarding the clinical practice or professional conduct of an Advanced Practice Professional or Allied Health Professional will be immediately reported to the Medical Staff President, the relevant Department Chair, or the VPMA who will address the matter in accordance with Article 6 of this Policy. The individual to whom the concern has been reported may also discuss the matter with the Supervising Physician.

8.E. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(1) Physicians who wish to utilize the services of an Advanced Practice Professional or Allied Health Professional in their clinical practice at the Medical Center must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with Human Resources policies and procedures before the Advanced Practice Professional or Allied Health Professional participates in any clinical or direct patient care of any kind in the Medical Center.

(2) The Supervising Physician will remain responsible for all care provided by the Advanced Practice Professional or Allied Health Professional in the Medical Center.

(3) Supervising Physicians who wish to utilize the services of an Advanced Practice Professional or Allied Health Professional in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.B above.

(4) The number of Advanced Practice Professionals or Allied Health Professionals acting under the Supervision of one Supervising Physician, as well as the care they may provide, will be consistent with any applicable state statutes and regulations and any other policies adopted by the Medical Center. The Supervising Physician will make all appropriate filings with the relevant state board regarding the Supervision and responsibilities of the Advanced Practice Professional or Allied Health Professional, to the extent that such filings are required, and will provide a copy of the same to Medical Staff Services.

ARTICLE 9

CONFLICT OF INTEREST GUIDELINES FOR ACTIVITIES RELATED TO CREDENTIALING, PRIVILEGING, AND THE EVALUATION OF PROFESSIONAL PRACTICE

9.A.1. General Principles:

(a) All those involved in activities related to credentialing, privileging, and the evaluation of professional practice (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest will be referred to as an "Interested Member."

(d) No Practitioner has a right to compel the disqualification of another individual based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(e) The fact that any individual chooses to refrain from participation, or is excused from participation, in any Medical Staff Function will not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.

(f) **Appendix D** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Medical Center. The remainder of this Article is intended to supplement **Appendix D** and expand upon the guidelines that are summarized in the chart.

9.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or VPMA.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or VPMA.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or VPMA of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review will be deemed waived.

9.A.3. Implementation of Conflict of Interest Guidelines in **Appendix D**:

This Section describes how to implement the Conflict of Interest Guidelines found in **Appendix D** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, Committee for Professional Enhancement member, MEC member);

- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and

- Paragraph (c) describes how to apply the guidelines in **Appendix D** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations that Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) Employment or Contractual Arrangement with the Medical Center. Because Medical Staff Functions are performed on behalf of the Medical Center, the interests of those who are employed by, or under contract with, the Medical Center are aligned with the Medical Center's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Medical Center or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the evaluation of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a practitioner whose application or provision of care is under review should not participate in the review process regarding the practitioner. However, if the patient-physician relationship has terminated and the review process does not involve the health condition for which the practitioner sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations that Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix D**:

(1) Significant Financial Relationship (e.g., when the Interested Member and other practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) Direct Competitor (e.g., practitioners in the same specialty, but in different groups);

(3) Close Friendships;

(4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) Active Involvement in Certain Prior Interventions with the Individual under Review (e.g., where the Interested Member was involved in the development of a prior Voluntary Enhancement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or collegial intervention efforts (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer or VPMA, or filed a report through the Medical Center's electronic reporting system)).

(c) Application of the Guidelines in **Appendix D** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Activities Related to Credentialing and the Evaluation of Professional Practice

An Interested Member may participate as an individual reviewer so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

(i) participation in the review of applications for initial and renewed Appointment and Clinical Privileges (which is subsequently reviewed by the Credentials Committee and/or MEC); and

(ii) participation as a case reviewer in activities related to the evaluation of professional practice (which is subsequently reviewed by the Leadership Council, Committee for Professional Enhancement, Investigating Committee, and/or MEC).

(2) Credentials Committee, Leadership Council, and Committee for Professional Enhancement Members

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and Committee for Professional Enhancement because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the Appointment or Clinical Privileges of a Practitioner, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue,

would skew the recommendation or determination of the committee, or would otherwise be unfair to the practitioner under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial Appointment, Reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the Appointment or Clinical Privileges of a Practitioner. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix D**.

(4) Investigating Committees

Once an Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial Appointment, Reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect Appointment or Clinical Privileges of a Practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix D**.

ARTICLE 10

CONFIDENTIALITY AND PEER REVIEW PROTECTION

10.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy will be strictly confidential. Individuals participating in, or subject to, activities related to credentialing and the evaluation of professional practice will make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized Practitioner or authorized Medical Center employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Medical Center policy; or

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any Practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO or the Medical Staff President (or the Vice Medical Staff President/President-Elect if the Medical Staff President is the person committing the claimed breach).

10.B. PEER REVIEW PROTECTION

(1) All activities related to credentialing and the evaluation of professional practice pursuant to this Policy and related Medical Staff documents will be performed by "peer review committees" in accordance with state law. These committees include, but are not limited to:

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

(b) all departments, divisions, and service lines;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to Department Chairs, Division Chiefs, Service Line Directors,

committee chairs and members, Medical Staff officers, the VPMA, all Medical Center personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state law.

(2) All peer review committees will 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 11

AMENDMENTS

This Policy may be amended pursuant to Article 8 of the Medical Staff Bylaws.

ARTICLE 12

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Medical Center policies pertaining to the subject matter thereof.

Medical Staff: December 14, 2020

Board or Trustees: December 15, 2020

APPENDIX A

Those individuals currently practicing as Advanced Practice Professionals at the Medical Center are as follows:

- Advanced Practice Registered Nurse
    - Certified Registered Nurse Anesthetist
    - Certified Nurse Midwife
    - Nurse Practitioner
- Clinical Pharmacist Practitioner
- Licensed Professional Counselor
- Perfusionists
- Physician Assistant
- Psychologist

APPENDIX B

A listing of those individuals currently practicing as Allied Health Professionals at the Medical Center will be maintained by Human Resources.

APPENDIX C

Those individuals currently practicing as Licensed Independent Practitioners at the Medical Center are as follows:

Moonlighting Residents and Fellows

APPENDIX D

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee member					Hearing Panel	Board
			Credentials	Leadership Council	CPE	MEC	Investigating Committee		
Employment/contract relationship with Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y – (Green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – (Yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and Committee for Professional Enhancement have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or Committee for Professional Enhancement always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

N – (Red "N") means the Interested Member should not serve in the indicated role.

R – (Red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Section 9.A.3 of the Credentials Policy.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.