MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF ST. FRANCIS MEDICAL CENTER

BYLAWS PART II – APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

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ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Part:

(1) “APPOINTEE” means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center.

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

(3) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), or the American Board of Podiatric Surgery, upon a practitioner, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant’s area of clinical practice.

(4) “CEO/CAO” means the President of the Medical Center, or designee.

(5) “CLINICAL PRIVILEGES” means the authorization granted by the Board to render specific patient care services.

(6) “DAYS” means calendar days.


(8) “EXECUTIVE COMMITTEE” means the Executive Committee of the Medical Staff.

(9) “MEDICAL CENTER” means ST. FRANCIS MEDICAL CENTER.

(10) “MEDICAL STAFF” means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.

(11) “MEDICAL STAFF LEADER” means any Medical Staff officer, medical director, department chair, section chair, and committee chair.

(12) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Medical Center mail, or hand delivery.
(13) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Medical Center or affiliate, including outpatient facilities.

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

(15) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).

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

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Medical Center management, by a Medical Staff appointee, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
ARTICLE 2
QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

(a) have a current license to practice in this state;
(b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;
(c) be located (office and residence) within the geographic service area of the Medical Center, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Medical Center;
(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center;
(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
(g) have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
(h) have never 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, or violence;
(i) agree to fulfill all responsibilities regarding emergency call;
have or agree to make coverage arrangements with other appointees to the Medical Staff for those times when the individual shall be unavailable;

(k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association. It is recognized that emergency medicine physicians may be Board Certified in various specialties and may still be acceptable for Emergency Medicine privileges;

(l) be board certified in their primary area of practice at the Medical Center or must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments); and

(m) meet or exceed criteria established by the department to which he seeks privileges

2.A.2. Waiver of Criteria:

(a) Any individual who does not satisfy one or more of the criteria outlined above 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.

(b) A request for a waiver shall 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 individual in question, input from the relevant Department Chairperson, 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 shall be forwarded to
the Executive Committee. Any recommendation to grant a waiver must include the basis for such.

(c) The Executive Committee shall 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 basis for such.

(d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a “denial” of appointment or clinical privileges.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(f) An application for appointment that does not satisfy an eligibility criterion shall not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

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

(a) relevant training, experience, 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 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;

(e) ability to safely and competently perform the clinical privileges requested; and
(f) recognition of the importance of, and willingness to support, the Medical Center’s commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

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

(a) is licensed to practice a profession in this or any other state;
(b) is a member of any particular professional organization;
(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
(d) resides in the geographic service area of the Medical Center; or
(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, or national origin.

2.A.6. Ethical and Religious Directives:

All appointees shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Medical Center. No activity prohibited by said directives shall be engaged in at the Medical Center by any Appointee.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every appointee specifically agrees to:

(a) provide continuous and timely care to all patients for whom the individual has responsibility;
(b) 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) accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;

(d) comply with clinical practice protocols and guidelines 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;

(e) also comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

(f) inform the Department Chairperson and Credentials Committee of any change in the practitioner’s status or any change in the information provided on the individual’s application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner’s Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual’s ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction;

(g) constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;

(h) immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual’s ability to safely and competently care for patients. The health care
professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership and the matter shall be handled in accordance with the Physician Health Care Program;

(i) appear for personal interviews or telephone interviews in regard to an application for initial appointment or reappointment, if requested;

(j) use the Medical Center sufficiently to allow continuing assessment of current competence;

(k) refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(l) refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(m) refrain from deceiving patients as to the identity of any individual providing treatment or services;

(n) seek consultation whenever necessary;

(o) participate in monitoring and evaluation activities;

(p) complete in a timely manner all medical and other required records, containing all information required by the Medical Center;

(q) perform all services and conduct himself/herself at all times in a cooperative and professional manner;

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

(s) satisfy continuing medical education requirements.

2.B.2. Misstatements or Omissions in Applications:

Any misstatement in, or omission from, an application is grounds for the Medical Center to stop processing the application. The individual shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee shall review the individual’s response and provide a recommendation to the Executive Committee. The Executive Committee shall recommend to the Board whether the application should be processed further.
If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

2.B.3. Burden of Providing Information:

(a) Applicants for appointment and reappointment 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 the applicant’s qualifications or credentials.

(b) Applicants for appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be deemed complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall be deemed incomplete if new, additional, or clarifying information is needed at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) Applicants for appointment or reappointment are responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual’s professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of these Bylaws.

(b) In addition to other information, the applications shall seek the following:
(1) information as to whether the applicant’s medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant’s license to practice any relevant profession in any state, DEA registration, or any state’s controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant’s professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Executive Committee, or the Board may request;

(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 shall sign the application and certify that he or she is able to perform the 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 following conditions:

(i) whether or not appointment or clinical privileges are granted;

(ii) throughout the term of any appointment or reappointment period and thereafter;

(iii) 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; and
(iv) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Medical Center.

(a) **Immunity:**
To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center, any appointee of the Medical Staff, 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, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Medical Center, its authorized agents, or third parties in the course of credentialing and peer review activities.

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

(c) **Authorization to Release Information to Third Parties:**
The individual also authorizes Medical Center representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or
her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) **Hearing and Appeal Procedures:**

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

(e) **Legal Actions:**

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Medical Center and any appointee to the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney’s fees.
ARTICLE 3
PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the Board, upon recommendation by the Executive Committee.

(b) Any individual requesting an application for initial appointment shall be sent a letter that outlines the threshold eligibility criteria for appointment and clinical privileges, and the application form.

(c) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken 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 the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their application shall not be processed. There is no right to a hearing on a determination of ineligibility.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

(d) The names of applicants shall be emailed so that appointees to the Medical Staff may submit, in writing, information bearing on the applicant’s qualifications for appointment or clinical privileges.
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 shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant’s past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted 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 Department Chairperson, the Credentials Committee, and a Credentials Committee representative, the Executive Committee and/or the President of the Medical Staff.

3.A.4. Department Chairperson Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The Department Chairperson shall be available to the Credentials Committee, Executive Committee, and the Board to answer any questions that may be raised with respect to the chairperson’s report and findings.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant Department Chairperson and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the Department Chairperson, any Medical Staff appointee, 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 privileges, the Credentials Committee shall review the applicant’s Confirmation of Ability to Perform Privileges Requested form to determine if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment. If there is a question, the Credentials Committee may require the applicant to undergo a fitness examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(d) The Credentials Committee may recommend appointment with specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the CEO, or designee, explaining the reasons for the delay.

3.A.6. Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:

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

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee prior to its final recommendation; or
(3) 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 Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the CEO, or designee.

(c) If the recommendation of the Executive Committee would entitle the applicant to request a hearing, the Executive Committee shall forward its recommendation to the CEO, or designee, who shall promptly send special notice to the applicant. The CEO, or designee, shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:
(a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
   (1) appoint the applicant and grant clinical privileges as recommended; or
   (2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Medical Center for additional research or information; or
   (3) reject or modify the recommendation.

(b) If the Board’s preliminary determination is to reject a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Executive Committee. If the Board’s preliminary determination remains unfavorable to the applicant, the CEO, or designee, shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(c) The final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.
3.A.8. Time Periods for Processing:

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

3.B. PROVISIONAL STATUS

3.B.1. Duration of Provisional Period:

(a) Appointment to the Medical Staff (regardless of the staff category) and all initial clinical privileges, whether granted at the time of initial appointment, reappointment or during the term of an appointment, shall be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee. During the provisional period, clinical privileges shall be subject to focused professional practice evaluation as described below.

(b) During the provisional period, the individual’s exercise of the relevant clinical privileges shall be evaluated by the chairperson of the department in which the individual has clinical privileges. The evaluation may include chart review, monitoring of the individual’s practice patterns, proctoring, external review and information obtained from other physicians.

3.B.2. Duties During Provisional Period:

(a) During the provisional period, an appointee must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Department Chairperson or other designated observers.

(b) If the Credentials Committee and the Executive Committee determine that a new appointee to the Medical Staff fails, during the provisional period, to:

(1) participate in the required number of cases;
(2) cooperate with the monitoring and observation conditions; or
(3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities.
The member’s Medical Staff appointment and clinical privileges shall be automatically relinquished at the end of the provisional period.

(c) If the Credentials Committee and the Executive Committee determine that an appointee to the Medical Staff who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The individual may not reapply for the privileges in question for two years.

(d) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the appointee shall be entitled to a hearing and appeal.
ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not automatically confer any clinical privileges or right to practice at the Medical Center.

(b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(c) The grant of clinical privileges includes responsibility for emergency service call established to fulfill the Medical Center’s responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(d) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(e) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with applicable contracts.

(f) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) education, relevant training, experience, 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 the same;

(2) utilization patterns;

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

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

(5) availability of qualified staff appointees 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, when available; and
(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(h) The report of the chairperson of the clinical department in which privileges are sought shall be forwarded to the chairperson of the Credentials Committee and processed as a part of the initial application for staff appointment.

(i) During the term of appointment, an appointee may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Voluntary Relinquishment of Privileges:

(a) A Medical Staff appointee may request voluntary relinquishment of clinical privileges by submitting a written request to the Department Chairperson specifying the clinical privilege(s) to be relinquished and the reasons for the request. The Department Chairperson shall make a recommendation to the Executive Committee.
(b) The Board shall make a final decision on the request, based upon, among other factors, the appointee’s insurance coverage, and how the request would affect the Medical Center’s ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. No appointee shall be required to maintain clinical privileges for the purpose of call coverage that are not commensurate with current skills. The Board’s decision shall be reported in writing by the CEO, or designee, to the appointee, the Executive Committee, and the applicable Department Chairperson. If the Board permits the relinquishment of privileges, it shall specify the effective date of the relinquishment.

(c) Failure of an appointee to request relinquishment of clinical privileges as set forth above shall result in the appointee being maintained on the call schedule without any change to his or her call responsibilities.

(d) Appointees must maintain competence to exercise the core privileges in their specialty. Appointees who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage or to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.


(a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure (“new procedure”) shall 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.

(b) The Credentials and Executive Committees shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other
similar hospitals and the experiences of those institutions, and whether the Medical Center has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(c) If it is recommended that the new procedure be offered, the Department Chairperson shall conduct research and consult with experts, including those on the Medical Staff and those outside the Medical Center, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Department Chairperson may also develop criteria and/or indications for when the new procedure is appropriate. The Department Chairperson shall forward recommendations to the Credentials Committee and Executive Committee, which shall review the matter and forward their recommendations to the Board for final action.


(a) Requests for clinical privileges that have been exercised at the Medical Center only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual’s eligibility to request the clinical privileges in question.

(b) The Executive Committee may appoint a Task Force to conduct research and consult with experts, including those on the Medical Staff (e.g., Department Chairpersons, 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).

(c) If the Task Force recommends that individuals from different specialties be permitted to request the privileges at issue, it shall also develop recommendations regarding:

(1) the minimum criteria to request the privilege, including education, training, and experience;

(2) the clinical indications for the procedure;
(3) the monitoring and supervision required during the provisional period;
(4) how the procedure would be reviewed as part of the Medical Center’s ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and
(5) the impact, if any, on emergency call responsibilities.

The Task Force shall forward its recommendations to the Credentials Committee and Executive Committee, which shall review the matter and forward their recommendations to the Board for final action.

4.A.5. Clinical Privileges After Age 75:
(a) The Credentials Committee shall specifically consider the fitness to practice safely and competently and perform the essential functions of appointment and privileges of each appointee who has attained the age of 75 years and who has clinical privileges at the Medical Center. These individuals shall be reappointed on an annual basis. Recommendations by the Credentials Committee for continued clinical privileges for appointees over 75 shall be based upon an evaluation of the individual’s current knowledge and skills.

(b) Upon attaining the age of 75, physicians will remain eligible to vote, hold offices, and serve on committees, have clinical privileges to admit or care for patients at the Medical Center. They shall pay staff dues and shall assume all obligations designated by the department and staff status. Physicians may choose to apply for Emeritus Staff status. If appointee requests Emeritus Status, the appointee shall be ineligible to vote, hold offices, and serve on committees, shall no longer have clinical privileges to admit or care for patients at the Medical Center. Emeritus Staff shall pay no staff dues and shall assume full Emeritus Staff status.

4.A.6. Clinical Privileges for Dentists:
(a) The scope and extent of surgical procedures that a dentist may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges.
(b) Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Executive Committee.

(d) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient’s record. Dentists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws.

4.A.7. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and recommended in the same manner as other clinical privileges, in accordance with applicable state law.

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A podiatrist with clinical privileges to do so may perform a history and physical examination in accordance with the applicable provisions of the Rules and Regulations. The history and physical examination shall have taken place and been recorded in the medical record before podiatric surgery shall be performed. Consultation by a physician shall be in accordance with the applicable provisions of the Rules and Regulations.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient’s record. Podiatrists may write orders which
are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Center and Medical Staff Bylaws.

4.A.8. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson, the Credentials Committee, and the Executive Committee.

(b) Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Part, except for those requirements relating to geographic residency, coverage arrangements and emergency call responsibilities.

(c) Qualified applicants may be granted telemedicine privileges. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

(d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Part in the same manner as for any other applicant, except that the Medical Center may utilize the credentialing information provided by the applicant’s primary hospital/group, provided that hospital/group is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

(e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Medical Center with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant’s primary practice affiliation and evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Medical Center, the individual’s telemedicine privileges will expire at the end of the current term. Once all
information is received and verified, an application to renew telemedicine
privileges will be processed as set forth above.

(f) Individuals granted telemedicine privileges shall be subject to the Medical
Center’s performance improvement, ongoing and focused professional practice
evaluations and peer review activities.

4.B. TEMPORARY CLINICAL PRIVILEGES

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

Temporary clinical privileges shall only be granted to applicants under the following two
circumstances:

- to fulfill an important patient care need; and
- when an applicant with a complete, “clean” application (one that raises no
  concerns and all of the information specified below has been verified) is awaiting
  review and approval of the Medical Staff Executive Committee and the governing
  body.

In the first circumstance, temporary clinical privileges can be granted on a case by case
basis when there is an important patient care need that mandates an immediate
authorization to practice, for a limited period of time, or restricted to a specific patient for
whom privileges are being granted, while the full credentials information is verified and
approved.

In these circumstances, temporary clinical privileges may be granted by the CEO,
or designee, upon recommendation of the applicable clinical Department Chairperson
and the President of the Medical Staff or Chair of the Credentials Committee provided
there is verification of:

- current licensure; and
- current competence.

When the important patient care need no longer exists, the patient shall be
assigned by the President of the Medical Staff, to an appointee with appropriate clinical
privileges. The wishes of the patient shall be considered in the selection of a substitute
physician.
In the second circumstance temporary clinical privileges may be granted when the new applicant for Medical Staff membership or privileges is waiting for a review and recommendation by the Medical Staff Executive Committee and approval by the governing body. Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the CEO, or designee, upon recommendation of the applicable clinical Department Chairperson and the President of the Medical Staff or the Chair of the Credentials Committee provided:

- There is verification of:
  - current licensure;
  - relevant training or experience;
  - current competence;
  - ability to perform the privileges requested; and
  - other criteria required by the Policy on Appointment, Reappointment and Clinical Privileges.

- The results of the National Practitioner Data Bank query have been obtained and evaluated.

- The applicant has:
  - a complete application;
  - no current or previously successful challenge to licensure or registration;
  - not been subject to involuntary termination of medical staff membership;

- not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

Temporary privileges are not to be routinely granted for other administrative purposes such as the following situations:

- the Licensed Independent Practitioner (LIP) fails to provide all information necessary to the processing of his/her reappointment in a timely manner; and

- failure of the staff to verify performance data and information in a timely manner.

In the above situations, the LIP would be required to cease providing care in the facility until the reappointment process is completed.
If, in the above reappointment situations, the failure to allow the practitioner to continue to provide care would result in a problem meeting an important patient care need, then temporary privileges could be granted.

In granting temporary clinical privileges, the Chief Executive Officer, or designee, shall first obtain such individual’s signed acknowledgement to be bound by all of the bylaws, policies, and rules and regulations of the Medical Staff and the hospital then in force in all matters relating to temporary clinical privileges.

In exercising such privileges, the applicant shall act under the supervision of the Chairperson or appropriate designee of the department in which the applicant has requested primary privileges.

Temporary clinical privileges shall be immediately terminated by the Chief Executive Officer, or designee, or a designee upon notice of any failure by the individual to comply with such special conditions.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the Department Chairperson. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

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

(a) The CEO, or designee, may, at any time after consulting with the President of the Medical Staff, the chairperson of the Credentials Committee, or the Department Chairperson, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual’s inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, or designee, the Department Chairperson, or the President of the Medical Staff may immediately terminate all temporary privileges. The Department Chairperson or the President of the Medical Staff shall assign to another appointee to the Medical Staff responsibility for the care of such individual’s patients until they are discharged.
Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

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, an appointee to the Medical Staff 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 shall be assigned by the Department Chairperson or the President of the Medical Staff to an appointee 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, or designee, or the President of the Medical Staff 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 Resource 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 appointee 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 shall 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 shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Medical Center.
ARTICLE 5
PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

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) completed all medical records;
(b) completed all continuing medical education requirements;
(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested; and
(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested by the Department Chairperson (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual’s private office practice, and/or a quality profile from a managed care organization), before the application shall be considered complete and processed further.

5.A.2. Factors for Evaluation:

In considering an individual’s application for reappointment, the factors listed in Section 2.A.3 of this Part shall be considered. Additionally, the following factors shall 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 duties, including committee assignments and emergency call;
(c) the results of the Medical Center’s performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
(d) any focused professional practice evaluations;
(e) verified complaints received from patients and/or staff; and
(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:
(a) An application for reappointment shall be furnished to appointees at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.
(b) Failure to return a completed application within this time frame may result in the assessment of a reappointment processing fee. The Medical Staff Office will exert reasonable means to ensure application is received. In addition, failure to submit a complete application at least three months prior to the expiration of the appointee’s current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
(c) Reappointment shall be for a period of not more than two years.
(d) Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual’s appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.
(e) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to
meet on-call coverage requirements, or denying the community access to needed medical services, the CEO, or designee, shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO, or designee, shall consult with the chairperson of the applicable department, the chairperson of the Credentials Committee, or the President of the Medical Staff. The temporary clinical privileges shall be only for a period not to exceed 120 days.

(f) In the event the application for reappointment is the subject of an investigation or 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.

(g) The application shall be reviewed by the Medical Staff Office 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.

(h) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Office shall forward the application to the relevant Department Chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The
committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual’s compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Part, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Part.

(b) In addition, 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 may be imposed. 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.

5.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.
ARTICLE 6
PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

6.A. COLLEGIAL INTERVENTION

(1) These Bylaws encourage the use of progressive steps by Medical Staff leaders and Medical Center management, beginning with collegial and educational efforts, to address questions relating to an individual’s clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

(3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff appointees and pursuing counseling, education, and related steps, such as the following:
   (a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
   (b) proctoring, monitoring, consultation, and letters of guidance; and
   (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(4) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual’s confidential file. If documentation of collegial efforts is included in an individual’s file, the individual shall have an opportunity to review it and respond in writing. The response shall be maintained in that individual’s file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Medical Center management.
(6) The relevant Medical Staff leader(s), in conjunction with the Chief Medical Officer, President of the Medical Staff, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; Physician Health Care Program; peer review policy). Medical Staff leaders may also direct these matters to the Executive Committee for further action.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

   (1) the clinical competence or clinical practice of any appointee to the Medical Staff, including the care, treatment or management of a patient or patients;

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

   (3) conduct by any appointee to the Medical Staff 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 appointee to work harmoniously with others, the matter may be referred to the Chief Medical Officer, President of the Medical Staff, the chairperson of the department, the chairperson of a standing committee, the CEO, or designee, or the chairperson of the Board.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Credentials Committee.

(c) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to the Credentials Committee, the Credentials Committee shall review the matter
and determine whether to conduct an investigation or to recommend to the Executive Committee that the matter be handled pursuant to another policy, such as the code of conduct policy or the Physician Health Care Program, or to proceed in another manner. In making this determination, the Credentials Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Credentials Committee to do so.

(b) The Credentials Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Credentials Committee’s judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.

c) The Board may also determine to commence an investigation and may delegate the investigation to the Credentials Committee, the Executive Committee, a subcommittee of the Board, or an ad hoc committee.

d) The chairperson of the Credentials Committee shall keep the President of the Medical Staff and the CEO, or designee, fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Credentials Committee shall either investigate the matter itself or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist or podiatrist).

(b) The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed. An
outside consultant or agency may be used whenever a determination is made by the Medical Center and investigating committee that

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

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release 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.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual
to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.

(g) In making its recommendations, the investigating committee shall 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:

1. relevant literature and clinical practice guidelines, as appropriate;
2. all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
3. any information or explanations provided by the individual under review.

6.B.4. Credentials Committee Recommendation:

If an ad hoc investigating committee was appointed, it shall submit its recommendations to the Credentials Committee. The Credentials Committee shall then submit its recommendation to the Executive Committee.

6.B.5. Executive Committee Recommendation:

(a) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee 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 or consultation;
5. recommend additional training or education;
(6) recommend reduction of clinical privileges;
(7) recommend suspension 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) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CEO, or designee, who shall promptly inform the individual by special notice. The CEO, or designee, shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the CEO, or designee, shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

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

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION
OF CLINICAL PRIVILEGES

6.C.1. Grounds for 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 President of the Medical Staff, the Chairperson of a Clinical Department, the CEO, or designee, the Chief Medical Officer, the Board Chair, or the Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual’s clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.
(b) A precautionary suspension or restriction can be imposed 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 Executive Committee that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction—shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO, or designee, the Chief Medical Officer, and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO, or designee, or Executive Committee.

6.C.2. Executive Committee Procedure:

(a) The Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and others, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual’s response, if any, the Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.
6.C.3. Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual’s hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All appointees to the Medical Staff have a duty to cooperate with the President of the Medical Staff, the Department Chairperson, the Executive Committee, and the CEO, or designee, in enforcing precautionary suspensions or restrictions.

6.D. OTHER ACTIONS

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records will be referred to the Medical Executive Committee for further recommendations after notification by the medical records department of such delinquency.

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 failure to satisfy any of the threshold eligibility criteria set forth in this Part must be promptly reported to the CEO, or designee.

(b) An individual’s appointment and clinical privileges shall be automatically relinquished if any of the following occur:

(1) **Licensure:** Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual’s license.

(2) **Controlled Substance Authorization:** Revocation, expiration, suspension or the placement of conditions or restrictions on an individual’s DEA 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:** Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) **Criminal Activity:** 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; or (iv) violence against another.

(c) An individual’s appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this Part, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this Part.

(d) Automatic relinquishment shall take effect immediately upon notice to the Medical Center and continue until the matter is resolved, if applicable. If an individual engages in any patient contact in the hospital after the occurrence of an event that results in automatic relinquishment, without notifying the hospital of that event, then the relinquishment shall be deemed permanent.

(e) Failure to resolve the underlying matter leading to an individual’s clinical privileges being automatically relinquished in accordance with paragraphs (b)(1), (b)(2) or (b)(3) above, within 90 days of the date of relinquishment shall result in automatic resignation from the Medical Staff.

(f) Requests for reinstatement shall be reviewed by the relevant Department Chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, and the CEO, or designee. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff appointee may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the
reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

6.D.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual’s qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the CEO, or designee, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

6.D.4. Failure to Attend Special Conference:

(a) Whenever there is a concern regarding clinical practice or professional conduct involving any individual, the Department Chairperson or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual’s clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.E. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO, or designee. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Appointees of the Medical Staff must report to the CEO, or
designee, 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. Under such circumstances, the CEO, or designee, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

(2) The Board, based on recommendations from the Credentials and Executive Committees, shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Credentials Committee shall consult with the President of the Medical Staff and the relevant Department Chairperson. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual’s completion of all medical records.

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

(4) Individuals requesting reinstatement shall 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 shall then be reviewed by the relevant Department Chairperson, the Chairperson of the Credentials Committee, the President of the Medical Staff, and the CEO, or designee. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff appointee may immediately resume clinical practice at the Medical Center. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
(5) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual’s physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(6) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Board. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

(7) If an individual’s current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(8) 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 shall be final, with no recourse to a hearing and appeal.
ARTICLE 7
HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment to the Medical Staff;
(2) denial of reappointment to the Medical Staff;
(3) revocation of appointment to the Medical Staff;
(4) denial of requested clinical privileges;
(5) revocation of clinical privileges;
(6) suspension of clinical privileges (other than precautionary suspension);
(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
(8) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

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

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

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

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

(a) issuance of a letter of guidance, counsel, warning, or reprimand;
(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
(c) termination of temporary privileges;
(d) automatic relinquishment of appointment or privileges;
(e) imposition of a requirement for additional training or continuing education;
(f) precautionary suspension;
(g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
(h) determination that an application is incomplete;
(i) determination that an application shall not be processed due to a misstatement or omission; or
(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The CEO, or designee, shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:
(a) a statement of the recommendation and the general reasons for it;
(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
(c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the CEO, or designee, and shall include the name, address, and telephone number of the individual’s counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.
7.A.5. Notice of Hearing and Statement of Reasons:
   (a) The CEO, or designee, shall schedule the hearing and provide, by special notice, the following:
       (1) the time, place, and date of the hearing;
       (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
       (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
       (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual’s qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
   (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:
   (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
   (b) The witness list shall include a brief summary of the anticipated testimony.
   (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:
   (a) Hearing Panel:
The CEO, or designee, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

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

(2) The Hearing Panel may include any combination of:
   (i) any appointee of the Medical Staff, provided the appointee has not actively participated in the matter at any previous level, and/or
   (ii) physicians or laypersons not connected with the Medical Center (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Medical Center);

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

(4) Employment by, or other contractual arrangement with, the Medical Center or an affiliate shall not preclude an individual from serving on the Panel;

(5) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing;

(6) The Panel shall not include any individual who is professionally associated with, or related to, the individual requesting the hearing; and

(7) The Panel shall 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.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chair, the CEO, or designee, may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) If no Presiding Officer has been appointed, the chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

(3) 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;

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

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

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

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the CEO, or designee, after consulting with the President of the Medical Staff, 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” shall be deemed to refer to the Hearing Officer.

(d) Objections:

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

7.A.8. 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.B. PRE-HEARING PROCEDURES
7.B.1. General Procedures:

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

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/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 shall 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 Executive Committee;

(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 Executive Committee. The provision of this information is not intended to waive any privilege under the state peer review protection statute.
(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges shall be excluded.

(f) Neither the individual, nor any other person acting on behalf of the individual, may contact Medical Center employees whose names appear on the Executive Committee’s witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Medical Center has been notified and has contacted the employees about their willingness to be interviewed. The Medical Center will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness’s testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall 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.B.4. Stipulations:
The parties and counsel, if applicable, shall 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.B.5. Provision of Information to the Hearing Panel:
The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

7.C. THE HEARING
7.C.1. Failure to Appear:
Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.C.2. Record of Hearing:
A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Medical Center. Copies of the transcript shall be available at the individual’s expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:
(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
   (1) to call and examine witnesses, to the extent they are available and willing to testify;
(2) to introduce exhibits;
(3) to cross-examine any witness on any matter relevant to the issues;
(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
(5) to submit a written statement at the close of the hearing; and
(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

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

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

7.C.A.4. Admissibility of Evidence:
The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.5. Post-Hearing Statement:
Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.C.6. Persons to be Present:
The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO, or designee, or the President of the Medical Staff.

7.C.7. Postponements and Extensions:
Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CEO, or designee, on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:
A majority of the Hearing Panel shall 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 shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:
The Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.2. Basis of Hearing Panel Recommendation:
Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:
Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a
recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.


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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel’s recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO, or designee, either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel’s report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with the Bylaws of the Medical Center or Medical Staff 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.E.3. Time, Place and Notice:

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

7.E.4. Nature of Appeal:

(a) The chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

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

(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel’s recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board’s ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee for its information.
7.E.6. Further Review:

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

7.E.7. Right to One Hearing and One Appeal Only:

No appointee of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current appointee to the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.
ARTICLE 8
CLINICAL ASSOCIATES AND CLINICAL ASSISTANTS

8.A. CLINICAL ASSOCIATES

8.A.1. Qualifications:

(a) Categories of health care professionals other than physicians, dentists, and podiatrists, who are approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies, and who are authorized by New Jersey Law to provide specific, direct patient care services without a prescription or order from a physician, are eligible to practice as Clinical Associates in the hospital. Clinical Associates currently include psychologists and Optometrists.

(b) Each such individual shall file an application on a form supplied by the hospital and provide evidence of their credentials. While these individuals are not Medical Staff members, their application shall be processed in a similar manner. The Credentials and Executive Committees shall recommend to the Board the clinical privileges that the applicant shall be permitted to exercise at the hospital.

(c) Each such individual must provide evidence of current, valid professional liability insurance coverage in such terms and in amounts satisfactory to the hospital.

(d) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible for Allied Health Professional Staff status.

8.A.2. Conditions of Practice:

(a) Clinical Associates shall practice at the discretion of the Board, and thus may be terminated by the Board. When a Clinical Associate is employed, employment may be terminated at will by the Board according to applicable employment policies.

(b) Whenever a concern or question has been raised regarding the clinical practice or clinical competence of any Clinical Associate, the Clinical Associate shall be subject to the provisions of Article 6 of the Bylaws, Part II, Appointment,
Reappointment and Clinical Privileges related to collegial intervention or investigations, as applicable.

(c) A Clinical Associate shall be individually assigned to the Medical Staff Department and clinical unit appropriate to his/her professional training and is subject to an initial period of focused professional practice evaluation as determined for his/her category.

(d) Clinical Associates are not eligible for membership on the Medical Staff, therefore, shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board. They shall be located within the geographic service area of the hospital, close enough to fulfill their responsibilities and to provide timely care for their patients in the hospital.

8.A.3. Responsibilities:

Each Clinical Associate shall:

(a) abide by hospital policies, manuals and descriptions established by the Chief Executive Officer, or designee, and other appropriate designees and Hospital and Medical Staff Bylaws and Rules and Regulations;

(b) participate, when requested, in quality assessment activities and in discharging such other functions as may be required from time to time;

(c) when requested, attend clinical and education meetings of the staff and of the department with which he/she is affiliated;

(d) refrain from any conduct or acts that are or could be reasonable interpreted as being beyond, or an attempt to exceed, the clinical privileges authorized within the Hospital; and

(e) immediately upon notice of any proposed or actual exclusion from any federally funded health care program, individuals must disclose to the Hospital CEO, or designee, by telephone call and in writing, any notice to the member or his or her representative of proposed or actual exclusion and/or any pending investigation of the member from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.
8.B. CLINICAL ASSISTANTS

8.B.1. Qualifications:

(a) Categories of health care professionals other than physicians, dentists, and podiatrists, who are approved by the Board, who are licensed or certified by their respective licensing or certifying agencies, and who provide services as employees of, are under the supervision of and/or have a collaborating relationship with physicians who are presently appointed to the Medical Staff, are eligible to practice as Advanced Clinical Assistants or Dependent Clinical Assistants. Advanced Clinical Assistants include Advanced Practice Nurses, Physician’s Assistants, and such others as may be approved by the Board. Dependent Clinical Assistants include registered nurse first assistants, physician-employed registered nurses and other licensed professionals not employed by the Hospital, as approved by the Board.

(b) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible for Medical Staff or Allied Health Professional Staff status.

8.B.2. Selection Procedure:

(a) To the extent the Board determines to permit such Clinical Assistants to act at the hospital, the Credentials Committee shall recommend to the Executive Committee and the Board the clinical privileges or scope of each such individual’s activities at the hospital, as applicable.

(b) No such individual shall provide services at the hospital as a Clinical Assistant unless and until the Credentials Committee has received, on a form provided by the hospital, sufficient information about the qualifications of that individual to permit the Credentials Committee to recommend the clinical privileges or scope of activities, as applicable, the individual will be permitted to undertake at the hospital. The individual shall file an application according to the requirements outlined in the Hospital’s Allied Health Professionals Policy. The application shall be prepared by the individual’s employer, physician supervisor and or
Collaborating physician as appropriate, and signed by both the employer/supervisor/collaborating physician and the individual.

(c) The Credentials Committee, after receiving the recommendation of the chairperson of the applicable department, shall recommend to the Executive Committee and the Board a written delineation of the clinical privileges or scope of activities, as applicable, each Clinical Assistant is permitted to undertake at the hospital. The physician seeking to employ or have a collaborating relationship with the Clinical Assistant shall have the opportunity to appear before the Credentials Committee and discuss the proposed clinical privileges or scope of activities, as applicable, before any final action is taken on it by the Board. The Clinical Assistant may act at the hospital pursuant to the approved privileges or authorization to practice only so long as he remains an employee of, is supervised by or has a collaborating relationship with a physician currently appointed to the Medical Staff.

8.B.3. Conditions of Practice:

(a) Clinical Assistants shall practice at the hospital at the discretion of the Board and thus may be terminated at will by the Board according to applicable employment policies.

(b) Whenever a concern or question has been raised regarding the clinical practice or clinical competence of any Clinical Assistant, the Clinical Assistant shall be subject to the provisions of Article 6 of the Bylaws, Part II, Appointment, Reappointment and Clinical Privileges relating to collegial intervention or investigations, as applicable.

(c) Clinical Assistants are not eligible for membership on the Medical Staff, therefore, shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the clinical privileges or scope of activities, as applicable, specifically authorized by the Board.

(d) Any activities permitted by the Board to be performed at the hospital by a Clinical Assistant who is a nurse practitioner shall be performed utilizing written joint
protocols of care established, dated and signed by the nurse practitioner and his/her collaborating physician.

(e) Any activities permitted by the Board to be done at the hospital by a Clinical Assistant other than a nurse practitioner shall be done only under the direct and immediate supervision of that individual’s employer/supervisor. However, “direct and immediate supervision” shall not require the actual physical presence of the employer/supervisor.

(f) Should any physician or hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the Clinical Assistant either to act or to issue instructions outside the physical presence of the employer/supervisor/collaborator in a particular instance, such physician or hospital employee has the right to require that the Clinical Assistant’s employer or supervisor validate, either at the time or later, the instructions of the Clinical Assistant. Any act or instruction of the Clinical Assistant shall be delayed until such time as the physician or hospital employee can be certain that the act is clearly within the scope of the Clinical Assistant’s activities as permitted by the Board.

(g) At all times the employing physician will remain responsible for all acts of the Clinical Assistant while at the hospital.

(h) The number of Clinical Assistants acting as employees of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board.

(i) It shall be the responsibility of the physician employing the Clinical Assistant to provide professional liability insurance for the Clinical Assistant in amounts required by the Board that covers any exercise of clinical privileges or activities, as applicable, of the Clinical Assistant at the hospital, and to furnish evidence of such to the hospital. If not employed, the Clinical Assistant must personally provide evidence of current, valid professional liability insurance coverage in such terms and in amounts satisfactory to the hospital. The Clinical Assistant shall act at the hospital only while such coverage is in effect.
(j) The Clinical Assistant shall remain employed by the supervising physician or the Medical Center during their privileges or authorization to practice term. The physician employer, supervisor, and/or collaborating physician may change without effect to the Clinical Assistant’s privileges or authorization to practice. If a credentialed Clinical Assistant changes their Collaborating Physician or Supervising Physician the Clinical Assistant is responsible to notify the Credentials Committee, in writing, prior to the scheduled change.

8.B.4. Responsibilities:

Each Clinical Assistant Shall:

(a) abide by hospital policies, manuals and descriptions established by the Chief Executive Officer, or designee, and other appropriate designees, and Hospital and Medical Staff Bylaws and Rules and Regulations;

(b) participate, when requested, in quality assessment activities and in discharging such other functions as may be required from time to time;

(c) when requested, attend clinical and education meetings of the staff and of the department with which he/she is affiliated;

(d) refrain from any conduct or acts that are or could be reasonable interpreted as being beyond, or an attempt to exceed, the clinical privileges or scope of practice, as applicable, authorized within the Hospital; and

(e) immediately upon notice of any proposed or actual exclusion from any federally funded health care program, individuals must disclose to the Hospital CEO, or designee, by telephone call and in writing, any notice to the member or his or her representative of proposed or actual exclusion and/or any pending investigation of the member from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

8.C. PROCEDURAL RIGHTS FOR CLINICAL ASSOCIATES AND ADVANCED CLINICAL ASSISTANTS

8.C.1. Notice of Recommendation and Hearing Rights:
(a) In the event a recommendation is made by the Executive Committee that an individual not be granted clinical privileges or that the privileges previously granted be restricted, terminated or not renewed, the individual shall receive notice of the recommendation, including a general statement of the reasons for the recommendation, and advising the individual that he or she may request a hearing.

(b) If the individual want to request a hearing, the request must be in writing, directed to the CEO, or designee, or designee, within 30 days after receipt of written notice of the adverse recommendation.

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

8.C.2. Hearing Committee:

(a) If a request for a hearing is timely made, the CEO, or designee, in consultation with the President of the Medical Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Clinical Associates, Advanced Clinical Assistants, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the individual requesting the hearing, or any business competitors of the affected individual.

(b) The CEO, or designee, in consultation with the President of the Medical Staff, shall appoint one of the Hearing Committee members to serve as Chair or may appoint a Presiding Officer (“Presiding Officer”), who may be legal counsel to the Hospital. The role of the Hearing Committee Chair or the Presiding Officer shall be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Hearing Committee Chair or the Presiding Officer shall maintain decorum throughout the hearing.
(c) As an alternative to a Hearing Committee, the CEO, or designee, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

8.C.3. Hearing Process:

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

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

(c) At the hearing, a representative of the Executive Committee shall first present the reasons for the recommendation. The individual requesting the hearing shall be invited to present information to refute the reasons for the recommendation.

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

(e) The individual and the Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel shall not call, examine, or cross-examine witnesses or present the case.

(f) The individual shall have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Executive Committee was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.
The individual and the Executive Committee shall have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer shall establish a reasonable schedule for the submission of such memoranda.

8.C.4. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee shall prepare a written report and recommendation. The Hearing Committee shall forward the report and recommendation, along with all supporting information, to the CEO, or designee. The CEO, or designee, shall send a copy of the written report and recommendation by special notice to the individual and the Executive Committee for information.

(b) Within ten days after notice of such recommendation, the individual and/or the Executive Committee may make a written request for an appeal directed to the CEO, or designee. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.

(d) If a written request for appeal is not timely submitted, the appeal is deemed to be waived and the recommendation and supporting information shall be forwarded to the Board for Final action. If a timely request for appeal is submitted, the CEO, or designee, shall forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board shall arrange for an appeal.

8.C.5. Appellate Review:

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

(b) The individual and the Executive Committee shall each have the right to present a written statement on appeal.

(c) At the sole discretion of the Appellate Review Committee, the individual and a representative of the Executive Committee may also appear personally to discuss their position.

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

(e) The individual shall receive special notice of the Board’s action. A copy of the Board’s final action shall also be sent to the Executive Committee for information.

8.D. PROCEDURAL RIGHTS FOR DEPENDENT CLINICAL ASSISTANTS

(1) A Dependent Clinical Assistant is not entitled to the same procedural rights as provided in the Hearing and Appeal procedures outlined in Part C of this Article, Article 7 of the Policy on Appointment, Reappointment and Clinical Privileges for Medical Staff members and applicants, or the Corporate Bylaws.

(2) Dependent Clinical Assistants shall practice at the discretion of the Board. In the event of an unfavorable recommendation, the Dependent Clinical Assistant is entitled to the following procedural rights:

(a) In the event of an unfavorable recommendation by the Credentials Committee, the Dependent Clinical Assistant shall have the right to appear personally before the Credentials Committee to discuss the recommendation or action before it is transmitted to the Board. The Dependent Clinical Assistant must request such an appearance in writing.
(b) In the event that the Board decided not to grant the Dependent Clinical Assistant authorization to practice, the Dependent Clinical Assistant shall have the right to appear personally before a Dependent Clinical Assistant Procedural Rights Committee made up of three representatives appointed by the Board.

(c) The Dependent Clinical Assistant must request such a meeting with the Dependent Clinical Assistant Procedural Rights Committee in writing. Upon receipt of the request, the Dependent Clinical Assistant shall be informed of the general nature of the evidence supporting the recommendation or action at least ten (10) days prior to the meeting. At the meeting no prescribed procedure is required. The Dependent Clinical Assistant shall be invited to discuss, explain, or refute the recommendation or action. At the conclusion of the Dependent Clinical Assistant Procedural Rights Committee meeting, the committee shall prepare a written recommendation with reasons to the Board within 14 days of the meeting and provide a copy to the Dependent Clinical Assistant.

(d) The Board may take additional steps and make such inquiry as may be necessary to inform the Board of the issues on appeal. The Board shall inform the Dependent Clinical Assistant of its final decision in writing.

8.E. AUTOMATIC RELINQUISHMENT
Restriction, limitation or termination of privileges of a supervising and/or collaborating member of the Medical Staff will result in automatic limitation or relinquishment of the privileges or authorization to practice of the Allied Health Professional that he/she supervises. Such automatic limitation or relinquishment does not entitle the Allied Health Professional to any procedural rights outlined above.
ARTICLE 9
CONFLICTS OF INTEREST

(a) When performing a function outlined in the Bylaws, the Medical Staff Organization and Functions Manual, the Allied Health Professionals Policy, or the Rules and Regulations, if any Medical Staff appointee has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any appointee with knowledge of the existence of a potential conflict of interest or bias on the part of any other appointee may call the conflict of interest to the attention of President of the Medical Staff (or to the Vice President/President Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable Department or Committee Chair. The President of the Medical Staff or the applicable Department or Committee chairperson shall make a final determination as to whether the provisions in this Article should be triggered.

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

(d) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.
ARTICLE 10
CONFIDENTIALITY AND PEER REVIEW PROTECTION

10.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to the Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized appointee of the Medical Staff or authorized Medical Center employee and are for the purpose of conducting legitimate credentialing and peer review activities;

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

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

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

10.B. PEER REVIEW PROTECTION

(1) All credentialing and peer review activities pursuant to the Bylaws and related Medical Staff documents shall be performed by “Peer Review Committees” in accordance with applicable state law. Peer review committees include, but are not limited to:

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

(b) hearing panels;

(c) the Board and its committees;

(d) any individual acting for or on behalf of any such entity, including but not limited to department chairs, section chairs, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

(e) all departments and sections.
All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law. (2) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C §11101 et seq.