MEDICAL STAFF BYLAWS

THE MEDICAL CENTER OF CENTRAL GEORGIA

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PREAMBLE

The Medical Center of Central Georgia is a nonprofit corporation organized under the laws of the State of Georgia, whose purpose is to provide high quality patient care.

The Medical Staff promotes a superior level of professional performance among its members and is responsible for the oversight of care, treatment, and services provided by its members and other individuals with clinical privileges, provides for the uniform quality of patient care, treatment and services and reports to and is accountable to the Board. The Medical Staff is an integral part of the hospital and is not a separate entity.

These medical staff bylaws create a system of rights and responsibilities between the organized medical staff and the board, and between the organized medical staff and its members. Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the hospital or the Board or the Medical staff and any member of the Medical Staff or any person granted clinical privileges.

These bylaws and the Rules and Regulations are intended for internal hospital use only and solely for the governance of the internal affairs of the hospital. Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. No person is authorized to rely on any provisions of these Bylaws or Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided

STATEMENT OF PURPOSE AND RESPONSIBILITIES

The purpose of the Medical Staff of the Medical Center of Central Georgia shall be to:

(a) serve as the formal organizational structure of those practitioners granted the privilege of practicing in the Medical Center;

(b) serve as the primary means for accountability to the Board for the ethical conduct and professional performance of its members, granting of privileges, making appointments and reappointments to membership on the Medical staff;

(c) provide a means through which members of the Medical Staff may address with Board those aspects of policy that involve professional practice or may affect the care of patients;

(d) provide oversight for the quality of care, treatment, and services provided by the Medical Staff members and others with clinical privileges.

The Medical Staff shall be responsible for:

(a) providing a credentialing program to ensure that practitioners seeking appointment or reappointment to the Medical Staff, and the exercise of clinical privileges, and other individuals seeking clinical privileges, shall be qualified academically, be currently licensed to practice in Georgia, and have demonstrated satisfactory performance within their respective areas of practice;

(b) providing for the continuous monitoring and evaluation of patient care practices of members of the Medical Staff and others with clinical privileges, including consideration of the appropriate utilization of Medical Center resources in the care of patients;

(c) supporting a program of continuing education for members of the Medical Staff and other healthcare professionals in the Medical Center;

(d) recommending to the board all actions taken with regard to appointments, reappointments, clinical privileges of practitioners, and corrective actions imposed pursuant to these Bylaws;

(e) assisting the Board in identifying community health needs and implementing programs to satisfy those needs;

(f) through its governance structure, enforcing the Bylaws, Rules and Regulations, and other written policies of the Medical Staff.

ARTICLE 1
APPOINTMENT TO THE MEDICAL STAFF

1.A. QUALIFICATIONS FOR MEDICAL STAFF APPOINTMENT

1.A.1. General:

Appointment to the Medical Staff is a privilege, which shall be extended only to highly qualified individuals who continuously meet the requirements of these Bylaws. For purposes of these Bylaws "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges, and the granting of clinical privileges does not automatically confer Staff membership or appointment as in the case of Allied Health Professionals. The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the hospital to provide patient care independently within the Hospital. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. All individuals practicing medicine, dentistry, podiatry, and psychology in the Medical Center, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff.

1.A.2. Specific Qualifications:

Only physicians, dentists, podiatrists, and psychologists who satisfy the following conditions shall be eligible for appointment to the Medical Staff:

(a) have graduated from an accredited school of medicine, dentistry, podiatry or hold a Ph.D. in a recognized field of psychology and be licensed by the state psychology board of Georgia to practice psychology. If the physician is a graduate of a foreign medical school, he/she must have successfully completed the Educational Commission for Foreign Medical Graduates (ECFMG) verification of graduation from a foreign medical school.

(b) have a current unrestricted license to practice in the State of Georgia;

(c) where applicable to their practice, have a current unrestricted DEA certificate;

(d) are located (office and residence) close enough to the Medical Center to fulfill their medical staff responsibilities and to provide timely and continuous care to their hospitalized patients, in accordance with those specific requirements as approved by the Board;

(e) possess current, valid professional liability insurance coverage at least in the amount of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the aggregate;

(f) have successfully completed a residency training program accredited by the American College of Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges. Graduates of foreign medical schools must complete three years of post-graduate training in the United States in a program approved by the ACGME or the AOA or three years of post graduate training in Canada in a program approved by the Royal College of Physicians and Surgeons of Canada, in accordance with the rules and regulations of the Composite State Board of Medical Examiners. (These provisions are not applicable to dentists). Podiatrists shall have completed a residency program of at least two years' duration;

(g) physicians must possess board certification in their appropriate specialty or subspecialty of practice, where applicable and/or required by established privilege criteria, recognized by the American Board of Medical Specialists (“ABMS”) or American Osteopathic Association (“AOA”). Podiatrists must possess board certification by the American Board of Podiatric Surgery (“ABPS”). Oral and Maxillofacial Surgeons must possess board certification by the American Board of Oral and Maxillofacial Surgery (“ABOMS”). Dentists must possess board certification in one of the boards recognized by the American Dental Association (“ADA”). Psychologists must possess board certification by the American Board of Professional Psychology (ABPP). If the applicant is within seven (7) years of completion of residency and is not so certified at the time of application, the applicant must provide documentation indicating his/her successful attainment of such board certification within seven (7) years of completion of residency; (This applies to all applicants after July 1, 1995). Under special circumstances deemed appropriate by the Department Chairman, Chief of Staff, Medical Executive Committee, and the Board of Directors, equivalent board certification from another country may be accepted. (See Article 4.A.3. for requirement for board recertification).

Board certification requirements specific to Advanced Dependent Practitioners (ADPs) are addressed in Article 7.C.

(h) can document that they are highly qualified in regard to their:

(i) background, experience, training, and demonstrated competence;

(ii) adherence to the ethics of their profession;

(iii) good reputation and character;

(iv) ability to safely and competently exercise the clinical privileges requested; and

v) ability to work harmoniously with others sufficiently to convince the Medical Center that all patients treated by them at the Medical Center will receive quality care and that the Medical Staff will be able to operate in an orderly manner;

(i) have appropriate coverage in case of illness or unavailability;

(j) are not currently excluded from participation in any federal health program;

(k) have never been convicted of a felony crime;

(l) can document (by driver's license, passport, etc.) they are the individual identified in the credentialing documents.

1.A.3. No Entitlement to Appointment:

No individual shall be entitled to appointment or reappointment to the Medical Staff or to the grant or renewal of particular clinical privileges merely by virtue of the fact that such individual:

(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

(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.

1.A.4. Nondiscrimination Policy:

No individual shall be denied appointment or reappointment on the basis of sex, race, creed, religion, age, color, or national origin.

1.B. MEDICAL STAFF CATEGORIES

The following staff categories shall exist at the Medical Center: Active, Consulting, Honorary and Affiliate.

1.B.1. ACTIVE STAFF

Qualifications:

Appointees to the Active Staff must meet all criteria and qualifications outlined in Section 1.A. of these bylaws.

Prerogatives:

An Active Staff appointee may:

(a) exercise the privileges granted without limitation, except as otherwise provided in these bylaws or by specific privilege restriction;

(b) vote on all matters presented at the meetings of the Medical Staff and of the department and committees to which he/she is appointed;

(c) serve on committees of the Medical Staff; and

(d) hold office and serve as department chairperson, division chief and/or committee chairperson.

Responsibilities:

(a) Appointees to the Active Staff must fulfill all responsibilities and requirements outlined in these bylaws and are expected to:

  (1) assume all the functions and responsibilities of appointment to the Active Staff;

  (2) attend medical staff and applicable department and committee meetings;

  (3) serve on medical staff committees;

  (4) fulfill consultation requirements as defined in Section 13.B.2.(b) of these bylaws;

  (5) faithfully perform the duties of any office or position to which elected or appointed;

  (6) participate in performance improvement and monitoring activities;

  (7) comply with ethical and professional standards applicable to such member;

  (8) obtain regular health screenings sufficient to identify conditions which may place patients or other personnel at risk for infection, injury or improper care; and

  (9) provide appropriate medical care for each patient under the care of such member.

  (10) serve on any hearing panel as requested by the Chief Medical Officer, as long as no conflict of interest exists.

(b) In addition to the above, each member of the Active Staff must contribute a reasonable amount of time, as determined by the Medical Executive Committee with departmental input, to the following activities: (i) delivery of care to indigent patients; (ii) care for unassigned patients; (iii) performance of emergency service care

Each medical staff member shall be required to provide call coverage for the Emergency Department until one of the following is reached:

1. 20 years of service at MCCG, or
2. 10 years of service at MCCG and age 55, or
3. 5 years of service at MCCG and age 60

Members of the medical staff are expected to notify the Medical Staff Office at least two (2) years prior to ending call coverage to the Emergency Department. The purpose of this notification is to allow the medical staff member's department to plan appropriately for call coverage. The medical staff office will query the medical staff member at the time of reappointment for eligibility to stop providing call coverage. The two-year notification rule is waived for physicians who, under the current or previous rules, would be eligible to end ED call on or before December 31, 2009. Nothing in these bylaws shall override the requirements of a medical staff member's obligation to his or her group practice.

1.B.2. CONSULTING STAFF

Qualifications:

The Consulting Staff shall consist of individuals who are of recognized professional ability and expertise and who provide a service that is not otherwise available at the Medical Center. Appointees to this category must meet all criteria and qualifications outlined in Section 1.A. of these bylaws. They must also be a member of the Active or Emeritus Staff at another hospital where they are currently practicing.

Responsibilities and Prerogatives:

Members of the Consulting Staff:

(a) are entitled to treat patients within the limits of their assigned clinical privileges;

(b) may attend open medical staff, department and division meetings (without vote);

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

(d) shall not be eligible to hold office or serve as department or committee chairperson.

(e) shall not be entitled to admit patients to the Medical Center.

1.B.3. HONORARY STAFF

Honorary status is restricted to those individuals the Medical Staff wishes to honor. Honorary Staff appointees are not eligible to admit patients to, or exercise clinical privileges at, the Medical Center. They may be invited to serve on committees and may have the right to vote on any such committees. Honorary staff appointees shall be exempt from the reappointment procedure as outlined in these bylaws.

1.B.4. AFFILIATE STAFF

Qualifications:

(a) The Affiliate Staff shall consist of those physicians, dentists, podiatrists, and psychologists who desire to be associated with, but who do not intend to establish an active practice at, the Medical Center. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education endeavors, and to permit such individuals to access Medical Center services for their patients by direct referral of patients to other appointees on the Medical Staff for admission, evaluation and/or care and treatment.

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed by these bylaws. They must meet all criteria and qualifications outlined in Section 1.A. of these bylaws.

Prerogatives and Responsibilities:

(a) Affiliate Staff appointees shall:

  (1) be entitled (but not required) to attend meetings of the Medical Staff and departments, but without vote;

  (2) have no staff committee responsibilities but may be assigned to special committees (with vote);

  (3) be entitled to attend educational programs of the Medical Staff;

  (4) be entitled to refer patients to Active Staff appointees at the Medical Center, visit those patients when hospitalized and review their medical records, but may not write orders or make medical record entries or actively participate in the provision or management of care to patients at the Medical Center;

  (5) be permitted to use the Medical Center's diagnostic facilities; and

  (6) not be granted clinical privileges, and shall not admit or treat patients at the Medical Center.

(b) The appointment of physicians to Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Executive Committee with thirty (30) days written notice, without rights to a hearing or appeal as set forth in these bylaws.

(c) Any Affiliate staff appointee who desires to transfer to another category and to request clinical privileges, must meet the qualifications, standards and requirements for appointment and clinical privileges as set forth in these bylaws.

1.C. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

1.C.1. Duties of Members:

Appointment to the Medical Staff shall require that each member assume such reasonable duties and responsibilities as defined by these bylaws.

1.C.2. Basic Responsibilities and Requirements for Applicants and Appointees:

As a condition of consideration for initial appointment or reappointment, and as a condition of continued appointment, if granted, every applicant and appointee shall specifically agree to the following:

(a) to provide appropriate continuous care and supervision to all hospitalized patients for whom the individual has responsibility;

(b) to abide by all bylaws, policies and rules and regulations of the Medical Center and the Medical Staff as determined by the Medical Executive Committee to apply to the medical staff, which are in force when the individual is initially appointed to the Medical Staff, and any revisions or amendments adopted thereafter;

(c) to accept committee assignments and such other reasonable medical staff duties and responsibilities, including professional review activities, performance improvement activities, ER call, and patient call rotations, as shall be requested by the Medical Executive Committee or its designee;

(d) to provide, with or without request, new or updated information to the Credentials Committee, as it occurs, that is materially pertinent to any question on the application form;

(e) to attest that he or she has had an opportunity to read a copy of these bylaws and rules and regulations of the Medical Staff as are in force at the time of application, and to agree to be bound by the terms thereof in all matters relating to appointment, reappointment, and clinical privileges, without regard to whether the same are granted;

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

(g) to use the Medical Center facilities sufficiently to allow the Medical Center, through assessment by appropriate medical staff committees and department chairpersons, to evaluate in a continuing manner the current competence of the appointee. This requirement may be modified for individuals in specialties that do not require use of Medical Center facilities or treatment of hospitalized patients;

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

(i) to refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(j) to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(k) to seek consultation and respond to consultation requests as set forth in Section 13.B.2.(b) of these bylaws;

(l) to promptly notify the Chief Medical Officer and the Chief of Staff of any change in participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a QIO citation and/or quality denial letter concerning alleged quality problems in patient care;

(m) to abide by generally recognized ethical principles applicable to the individual's profession;

(n) to participate in the monitoring and evaluation activities of clinical departments;

(o) to complete in a timely manner the medical and other required records for all patients as required by the bylaws and rules and regulations of the Medical Staff, and other applicable policies of the Medical Staff and Medical Center;

(p) to work cooperatively and professionally with members of the Medical Staff, Medical Center management, Medical Associates, Medical Assistants, Physician Extenders, nurses, and other Medical Center personnel;

(q) to appropriately satisfy the continuing medical education requirements for Medical Staff appointees;

(r) to authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(s) to agree that recommendations of the Medical Staff and decisions of the Board with respect to any professional review action are final and binding on the practitioner unless timely appealed in accordance with the appeal procedures set forth in these bylaws;

(t) to abide by the Terms of the Medical Center's Privacy Notice. In connection with their compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy standards, the medical staff and the Medical Center intend to constitute an "organized health care arrangement" with respect to their joint activities. Accordingly, each practitioner agrees that, as a condition to

medical staff membership, the practitioner will abide by the terms of the Medical Center's HIPAA privacy notice, as implemented from time to time with respect to protected health information created or maintained in connection with their joint activities; and

(u) to comply with the reporting requirements set forth in Section 1.C.4 of the Medical Staff Bylaws.

1.C.3. Application Forms

(a) Applications for initial appointment and reappointment shall contain a request for specific clinical privileges desired by the individual and shall require detailed information concerning the individual's professional qualifications. The current applications for initial appointment and reappointment are incorporated by reference and made a part of these bylaws. 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 ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, limited, modified, subjected to probationary or other conditions, reduced, or not renewed at any other hospital or health care facility;

(2) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration certificate, is or ever has been voluntarily or involuntarily suspended, modified, terminated, restricted, relinquished, withdrawn, or is currently being challenged;

(3) information concerning the applicant's professional liability litigation experience, including information concerning prior or 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 Medical Executive Committee, or the Board may subsequently deem appropriate; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.

(b) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment and the granting of clinical privileges. However, the mere

presence of verdicts, settlements, or claims shall not, in and of themselves, be sufficient to deny appointment, reappointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement, or claim, in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular clinical privilege, or general behavior.

1.C.4. Burden of Providing Information:

(a) Applicants for appointment and reappointment shall have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) Applicants for appointment and reappointment shall have the burden of providing evidence that all the statements made and information given on their applications are current, true, correct, and complete.

(c) An application shall be deemed to be complete when it is submitted in writing on a form approved by the Medical Executive Committee and the Board, and with all questions answered with current, true, correct and complete information and all supporting documentation supplied and including any additional information needed to perform the required review of qualifications and competence of the applicant. If during the processing of the application the Board or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered completed until such additional information or verification is received, and/or the interview is conducted with the applicant satisfactorily responding to interview questions.

(d) Failure to provide a complete application, as defined in ¶1.C.4(c), within ninety (90) days of being provided with an application form for appointment, or failure to provide additional information within ninety (90) days after being notified of the additional information required and/or failure to appear for any requested interview and satisfactorily responding to questions during the interview, shall be deemed to be a voluntary withdrawal from the application process. Voluntary withdrawal from the application process is not an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws. The

Chief Medical Officer shall provide notice to the individual regarding his/her withdrawal from the application process due to lack of requested information and/or failure to appear for an interview and satisfactorily respond to interview questions.

(e) Should materially pertinent information provided in the application change during the course of an appointment process or during the subsequent appointment term, the appointee has the burden to promptly provide information about such change to the Credentials Committee sufficient for the Credentials Committee's review and assessment.

1.C.5. Grant of Immunity and Authorization to Obtain/Release Information:

The following statements, which shall be included on the application form for initial appointment and reappointment, and which are incorporated into these bylaws, are express conditions applicable to any appointment to the Medical Staff and to all others seeking or exercising clinical privileges at the Medical Center. By applying for appointment, reappointment, or clinical privileges, all applicants expressly accept these conditions whether or not appointment or clinical privileges are granted. This acceptance continues to apply throughout all terms of appointment, reappointment, and/or the grant of clinical privileges.

(a) The applicant releases from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations, including the Medical Staff and its representatives) for their acts performed in a reasonable manner in conjunction with investigating and evaluating the applicant's qualifications, and waives all legal claims of whatever nature against the Medical Center, and their representatives and designated agents acting in good faith and without malice in connection with the investigation of the applicant's qualifications.

(b) The applicant specifically authorizes the Medical Center, the Medical Staff, and their authorized representatives and designated agents to obtain and act upon information regarding the applicant's competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to the applicant's qualifications or matters addressed in the application.

(c) The applicant authorizes the inspection of records and documents (including medical records of patients attended and peer review information) that may be material to an evaluation of the applicant and his qualifications and his ability to carry out the clinical privileges requested. The applicant authorizes each and

every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for evaluation of the applicant. The applicant also agrees to appear for interviews, if required or requested by the Medical Center, in regard to the application.

(d) The applicant consents to and authorizes the release by the Medical Center to other healthcare entities and interested persons on request of information the Medical Center may have concerning the applicant (including but not limited to peer review information which is provided to another healthcare entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. The applicant releases from all liability the Medical Center and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Medical Center or its representatives or agents.

1.D. INFORMAL PROCEEDINGS

Nothing in the Medical Staff Bylaws shall preclude collegial, educational, and/or informal efforts to address questions or concerns relating to an individual's practice and conduct at the Medical Center. The bylaws specifically encourage voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the individual, the Credentials Committee, the Medical Executive Committee, and the Board. All efforts of the Medical Center and the Medical Staff leaders in this regard are intended to be and are part of the Medical Center's performance improvement and professional review activities.

1.E. CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to these bylaws shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Medical Center and the Medical Staff. In addition, reports of actions taken pursuant to these bylaws shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

1.F. PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, records and actions made or taken pursuant to these bylaws are deemed to be covered by the provisions of Ga. Code 31-7-131 et seq., 31-7-141 et seq., and 31-7-15 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations, or investigations pursuant to these bylaws shall be considered to be acting on behalf of the Medical Center when engaged in such

professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE 2

INITIAL APPOINTMENT TO THE MEDICAL STAFF

2.A. PROCEDURE FOR INITIAL APPOINTMENT

2.A.1. Request for Application:

Individuals seeking appointment and clinical privileges to practice at the Medical Center must submit a written or verbal request for an application to the Medical Staff Office.

2.A.2. Approval of Application Forms

All forms used in the application and appointment process shall be approved by the Medical Executive Committee upon recommendation of the Credentials Committee. These forms shall be obtained from the Chief Medical Officer.

2.A.3. Application Review Process:

(a) An application for appointment to the Medical Staff shall be processed only for those individuals who, according to the Medical Staff Bylaws:

(1) meet the threshold criteria for appointment to the Medical Staff set forth in Section 1.A.2 of this policy;

(2) desire to provide care and treatment to patients for conditions and diseases for which the Medical Center has facilities and personnel;

(3) are not seeking clinical privileges that are currently subject to an exclusive contract;

(4) are not seeking clinical privileges in a specialty in which, pursuant to the Medical Center's Medical Staff Development Plan, applications are not currently being accepted.

2.A.4. Submission of Application:

(a) The application for medical staff appointment or clinical privileges shall be submitted by the applicant to the Medical Staff Office. The application must be accompanied by payment of the processing fee as established by the Medical Executive Committee.

(b) As a preliminary step, the completed application form shall be reviewed by the Chief Medical Officer or designee to determine whether the individual satisfies the processing criteria of ¶ 2.A.3. Individuals who have submitted applications that do not meet these processing criteria shall be notified that they are not eligible for appointment and that their application will not be processed. Such

individuals shall also be notified that they do not have a right to request a hearing.

(c) The Chief Medical Officer or designee shall also review the application to determine that all questions have been answered, all references and other information or materials deemed pertinent has been received and that pertinent information provided on the application has been verified with primary sources or designated equivalent sources. Only completed applications, as defined in Section 1.C.4 (c) above, shall be processed. As part of the process of reviewing the application, the Chief Medical Officer or designee shall determine whether the application should be processed in accordance with Section 2.A.5. If so, the Chief Medical Officer or designee shall transmit the complete application and all supporting materials to the appropriate department chairperson.

(d) As part of the process of performing the evaluation, the Chief Medical Officer or designee shall have the right to meet with the applicant to discuss any aspect of the application, the applicant's qualifications, and the requested clinical privileges.

(e) The Medical Staff Office shall post or circulate the name of the applicant so that each Medical Staff appointee may have an opportunity to submit, in writing to the Credentials Committee, information bearing on the applicant's qualifications for staff appointment or clinical privileges.

2.A.5. Department Chairperson Procedure

(a) The chairperson of each department in which the applicant seeks clinical privileges shall serve as a consultant to the Credentials Committee and, acting on behalf of the Credentials Committee, shall evaluate the applicant's education, training, and experience. Such evaluation shall include inquiries directed to the applicant's past or current department chairperson(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) As part of the process of performing the evaluation, the department chairperson shall have the right to meet with the applicant to discuss any aspect of the application, the applicant's qualifications, and the requested clinical privileges.

(c) The department chairperson shall prepare a written report to the Credentials Committee concerning the applicant's qualifications for appointment and for the requested clinical privileges. This report shall address whether the applicant satisfies the current criteria for the clinical privileges requested. The report shall

be prepared within a reasonable time frame, but not later than thirty (30) days from the time the department chairperson received the completed application.

(d) The department chairperson shall be available to answer any questions that may be raised with respect to the chairperson's report and findings.

2.A.6. Credentials Committee Procedure

(a) All applications for initial appointment and clinical privileges shall be processed as set forth in Sections 2.A.5. through 2.A.9.

(b) The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(c) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss the applicant's application, qualifications, and clinical privileges requested.

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

(e) Any current Medical Staff appointee shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns the appointee may have about the applicant before the Credentials Committee makes a recommendation.

(f) If, after considering the report of the clinical department chairperson concerned, and all other relevant information, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment and clinical privileges to be granted. The Credentials Committee may, in its discretion, recommend that certain limitations, conditions or restrictions be imposed on the initial grant of appointment and/or clinical privileges.

2.A.7. Credentials Committee Report:

(a) Not later than forty-five (45) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof to the Medical Executive

Committee. The completed application and all supporting documentation, including the department chairperson's report, shall accompany the Credential Committee's recommendations and findings.

(b) If the Credentials Committee cannot complete its recommendation within forty-five (45) days of receipt of the completed applications and all required and requested information, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and Chief Medical Officer, explaining the reasons for the delay.

(c) The Chairperson of the Credentials Committee shall be available to meet with the Medical Executive Committee (and the Board) to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

2.A.8. Medical Executive Committee Procedure:

(a) At its next regular meeting, after receipt of the Credentials Committee's report and recommendation, the Medical 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 preparation of responses to specific questions prior to making its final recommendation, in which case, no further action will be taken until the Credentials Committee has responded; or

(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation

(b) If the recommendation of the Medical Executive Committee is favorable, it shall transmit its recommendations through the Chief of Staff or designee to the Board, including the findings and recommendations of the Credentials Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted.

(c) Any recommendation by the Medical Executive Committee that would entitle the affected individual to the hearing and appeals procedures provided in these bylaws shall be forwarded to the Chief Medical Officer, who shall promptly notify the affected individual by Special Notice. The Chief Medical Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in these bylaws.

(d) The Chairpersons of the Executive and Credentials Committees shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

2.A.9. Action of the Board:

(a) Upon receipt of a recommendation from the Medical Executive Committee that the applicant be appointed with the clinical privileges requested, the Board may: appoint the applicant and grant clinical privileges as recommended; or

(1) refer the matter back to the Medical Executive Committee or to another source inside or outside the hospital for additional research or information; or

(2) reject the recommendation

(b) If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairperson of the Credentials Committee and/or the Chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, that determination and the reasons in support thereof shall be sent to the Chief Medical Officer, who shall promptly notify the applicant by Special Notice. The Board shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in these bylaws.

(c) If the Board's decision is favorable, the Board shall send notice of its action to the applicant by mail within 30 days.

(d) The final decision to grant, limit, revise, or deny an applicant's privileges will also be disseminated to all appropriate internal hospital personnel and external agencies, as defined by state and federal laws. An email notification will be sent to all hospital departments to inform of new medical staff members. Clinical privileges are available for review in all clinical areas by authorized personnel via the intranet through the Medical Affairs website.

2.A.10. Medical Staff Orientation

Prior to working at the Medical Center all initial medical staff appointees shall be required to attend a medical staff orientation that has been approved by the Medical Executive Committee. Failure to attend orientation will result in automatic relinquishment or limitation of clinical privileges until such time as this orientation is completed.

ARTICLE 3
CLINICAL PRIVILEGES

3.A. CLINICAL PRIVILEGES

3.A.1. General:

(a) Neither medical staff appointment nor reappointment, as such, shall confer any clinical privileges or right to practice at the Medical Center.

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

(c) The granting of clinical privileges shall carry with it acceptance of the obligations of such privileges, including participation in emergency service and rotational obligations established to fulfill the Medical Center's responsibilities under the Emergency Medical Treatment and Active Labor Act.

(d) Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations to patients currently in the hospital.

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

(1) the applicant's ability to meet all current criteria for the requested clinical privileges;

(2) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to safely and competently exercise the clinical privileges requested;

(3) availability of qualified physicians or other appropriate appointees to provide coverage in case of the individual's illness or unavailability;

(4) ability of the Medical Center to accommodate the applicant's practice based on available resources and personnel;

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

(6) any information concerning professional review actions, voluntary or involuntary termination of medical staff appointment, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility;

(7) any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant;

(8) morbidity and mortality data (where available); and

(9) other relevant information, including a written report of the findings by the chairperson of each of the clinical departments in which such privileges are sought.

(f) An individual requesting clinical privileges shall have the burden of establishing that he or she satisfies the basic qualifications for, and is otherwise competent to exercise, the clinical privileges in question. A period of focused professional practice evaluation is implemented for all initially requested privileges.

(g) The report(s) of the appropriate department chairperson(s) shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

(h) an applicant shall submit a statement that no health problems exist that could affect his or her ability to perform the privileges requested.

(i) In no event shall an applicant for appointment or reappointment to the medical staff be denied appointment on the basis of inclusion or exclusion from any third party payer or managed care organization network panel membership.

3.A.2. Application for Additional Clinical Privileges for Procedures Currently Available at the Medical Center:

(a) Whenever, during the term of appointment, additional clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the Chief Medical Officer. The application shall state in detail the specific additional clinical privileges desired and the individual’s relevant recent training and experience which justify the additional privileges.

(b) The Chief Medical Officer shall transmit the request to the appropriate department chairperson for an evaluation on behalf of the Credentials Committee. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.

(c) The recommendation for additional privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as deemed necessary.

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

Whenever a medical staff appointee requests clinical privileges to perform a procedure not currently being performed at the Medical Center, or to utilize a significantly new technique to perform an existing procedure, the following process shall be followed:

(a) The appointee shall first be informed by the Chief Medical Officer that his or her request will not be processed until

(1) a determination has been made regarding whether the procedure will be offered by the Medical Center and, if so, until

(2) minimum threshold criteria for the requested procedure have been established

(b) Upon request by the Chief Medical Officer, the Credentials Committee shall make a preliminary recommendation as to whether the new procedure is one that should be offered to patients. One factor to be considered in reaching this determination is whether the Medical Center has the capabilities, including support services, to perform the procedure in question.

(c) If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold credentialing criteria. The minimum threshold criteria shall include:

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

(2) the extent of monitoring and supervision that should occur if the privileges are granted, and

(3) the criteria and/or indications for when the new procedure is appropriate.

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

(d) After receiving recommendations from the Executive and Credentials Committees, the Board shall make a determination as to whether the new procedure is one that will be offered to patients. If the Board determines to offer the procedure, the Board shall then approve the minimum threshold qualifications that an individual must possess in order to be eligible to request the clinical privileges in question.

(e) Once the foregoing steps are completed, specific requests from eligible medical staff appointees who wish to perform the procedure or service shall be handled as set forth above.

3.A.4. Interns, Residents and Fellows

(a) Interns, residents and fellows in an ACGME accredited training program who are working in a training capacity:

Interns, residents and fellows in training programs at the Medical Center shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in

curriculum requirements, affiliation agreements, and/or training protocols developed by the Program/Residency Director of each residency program and approved by the Board.

(b) Residents in an ACGME accredited training program who are working outside their training program in a paid position (moonlighting):
In these circumstances, the residents are working independently and must be credentialed using the usual medical staff process for either regular or temporary privileges. Privileges may be granted by the board on recommendation of the MEC to this group of practitioners who are not members of the medical staff. These residents may apply to the medical staff for clinical privileges commensurate with the job responsibilities of the paid position and for which the resident is certified by his/her program director to be performing in the training program without direct supervision. In exercising such privileges, the applicant shall act under the supervision of the medical staff member for whom the applicant is working in a paid position.

c) Fellows in a non-ACGME accredited training program:
In these circumstances, practitioners will be credentialed in the same manner as applicants for regular or temporary medical staff membership and privileges, but will not be considered members of the medical staff. They may not hold office, serve on committees, or vote on any matter. These fellows may exercise only those clinical privileges approved by the Board upon recommendation of the medical staff.

3.B. PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

3.B.1. Temporary Clinical Privileges for Applicants:

(a) Temporary privileges may be granted by the Chief Medical Officer only after there has been a favorable recommendation made by the Credentials Committee according to Section 2.A.6.

(b) Temporary privileges shall be granted for a specific time period not to exceed one hundred twenty (120) days. In exercising such privileges, the applicant shall act under the supervision of the chairperson of the department in which the applicant has requested primary privileges.

(c) Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following: Current licensure, relevant training or experience, current competence, ability to perform the privileges requested, other criteria required by the organized medical staff bylaws, a query and evaluation of the NPDB information, a complete application, no current or previously successful challenge to licensure or

registration, no subjection to involuntary termination of medical staff membership at another organization, and no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges. Temporary privileges for applicants will only be granted once the applicant has completed medical staff orientation.

3.B.2. Temporary Clinical Privileges for Non-Applicants:

(a) Temporary clinical privileges for the care of a specific patient or patients may be granted to a non-applicant by the Chief Medical Officer with the concurrence of the appropriate department chairperson and the Chairperson of the Credentials Committee. Prior to granting such privileges, the individual shall provide, and the Chief Medical Officer shall verify, appropriate information regarding the individual's licensure, DEA certification, competence, character, ethical standing, ability to safely and competently exercise the privileges requested, and professional liability insurance coverage.

(b) Prior to temporary privileges being granted, the individual must agree, in writing, to be bound by all of the bylaws, policies, and rules and regulations of the Medical Staff and the Medical Center as determined by the Medical Executive Committee to apply to the medical staff, which are then in force.

(c) Clinical privileges shall be restricted to the specific patients for which they were granted.

3.B.3. Locum Tenens:

(a) The Chief Medical Officer may grant an individual serving as a locum tenens for an appointee of the Medical Staff temporary admitting and clinical privileges to attend patients of that appointee for an initial period not to exceed one year.

(b) The Chief Medical Officer may grant such privileges after receiving a completed application and a request for clinical privileges form, after making inquiry to the National Practitioner Data Bank and verifying information as to licensure, DEA certification, competence, character, ethical standing, ability to safely and competently exercise the clinical privileges requested, and professional liability insurance coverage.

(c) Prior to granting locum tenens privileges, the Chief Medical Officer shall consult with the appropriate department chairperson and the Chairperson of the Credentials Committee or the Chief of Staff.

(d) As part of the application for locum tenens privileges, the individual shall sign an acknowledgment that he or she has had an opportunity to read copies of the Medical Staff Bylaws and the Rules and Regulations which are currently in force,

and must agree to be bound by the terms thereof. Locum tenens privileges will only be granted once the applicant has completed that portion of medical staff orientation that includes education and review of applicable hospital policy, as well as applicable federal and state law, including the Emergency Medical Treatment and Active Labor Act.

(e) Locum Tenens providers are not eligible for Medical Staff membership and are not entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment. These practitioners may not hold office, serve on committees, or vote on any matter. They shall be placed in a category of privileges referred to as "Locum Tenens" for the purpose of distinguishing these practitioners from other categories of medical staff membership.

3.B.4. Special Requirements

Special requirements of supervision and reporting may be imposed by the appropriate department chairperson on any individual granted temporary clinical privileges or locum tenens privileges. Temporary privileges or locum tenens privileges shall be immediately terminated by the Chief Medical Officer upon notice of any failure by the individual to comply with such special conditions.

3.B.5. Termination of Temporary Clinical or Locum Tenens Privileges:

(a) The Chief Medical Officer may, at any time after consulting with the Chief of Staff, the Credentials Committee Chairperson, or the chairperson of the appropriate department responsible for the individual's supervision, terminate temporary or locum tenens privileges. Clinical privileges shall then be terminated when the individual's inpatients are discharged. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary or locum tenens privileges, a termination of such privileges may be imposed by the Chief Medical Officer, the appropriate department chairperson, or the Chief of Staff, and such termination shall be immediately effective.

(b) The appropriate department chairperson or the Chief of Staff shall assign to another medical staff appointee responsibility for the care of such terminated Individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary or locum tenens privileges is a courtesy on the part of the Medical Center and any or all may be terminated if a question or concern has been raised. Neither the granting, denial, nor termination of such

privileges shall entitle the individual concerned to any of the procedural rights provided in these bylaws.

3.C. TELEMEDICINE SERVICES

(a) Practitioners providing telemedicine services at the Medical Center of Central Georgia must be licensed to practice medicine in the state of Georgia and must be adequately insured as defined by Section 1.A.2.(a)(5) of these bylaws.

(b) The medical staffs at both the originating site (MCCG) and distant site recommend the clinical services that are appropriate to be provided by licensed independent practitioners through a telemedicine link at their respective sites.

(c) The originating site (MCCG) uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:

(1) The distant site is a Joint Commission-accredited hospital or ambulatory care organization;

(2) The practitioner is privileged at the distant site for those services to be provided at the originating site;

(3) The distant site provides the originating site with a current list of licensed independent practitioners' privileges;

(4) The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site.

(d) Practitioners providing telemedicine services from a distant site, which does not meet the requirements outlined above in (c), shall be credentialed and privileged in accordance with Article 2 and Article 3 set forth in these bylaws.

(e) Practitioners providing telemedicine services to MCCG, regardless of the means by which they are credentialed, are not eligible for Medical Staff membership and are not entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment. These practitioners may not hold office, serve on committees, or vote on any matter. They shall be placed in a category of privileges referred to

as "Telemedicine" for the purpose of distinguishing these practitioners from other categories of medical staff membership.

3.D. CLINICAL PROCTORING

(a) Applicants for clinical proctoring by an Active staff member must complete an application which shall be processed in accordance with these bylaws.

(b) Applications for clinical proctoring must be submitted to the Chief Medical Officer at least 30 days prior to the anticipated date of service with the appropriate application fee.

(c) Practitioners applying for clinical proctoring must hold an unrestricted license to practice medicine in the state of Georgia and must be adequately insured as defined by 1.A.2.(a)(5) of these bylaws.

(d) The proctoring practitioner must provide the dates the applicant is scheduled for the clinical proctorship, as well as a list of patient names and the type of clinical proctorship in which the applicant will be participating.

(e) Denial of an application for clinical proctoring does not entitle the applicant to any rights or fair hearing as defined in these bylaws.

3.E. TEMPORARY EMERGENCY CLINICAL PRIVILEGES

(a) In an emergency involving a particular patient, a practitioner who is not currently appointed to the medical staff may be permitted to exercise clinical privileges to act in such emergency using all necessary facilities of the hospital, including calling for any consultation necessary or desirable.

(b) Similarly, in the event of an emergency, any practitioner currently appointed to the medical staff, regardless of department, staff status, or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm.

(c) For the purpose of this Section, an "emergency" is defined as the 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 or danger.

(d) When the emergency situation no longer exists, the patient shall be assigned by the Chief of Staff to an appointee with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a physician.

3.F. DISASTER CLINICAL PRIVILEGES FOR NON-APPLICANTS

(a) For the purpose of this section, a disaster is defined as an environmental disaster, natural disaster, terrorist attack, events involving mass evacuations, and

any emergency that, due to its complexity, scope, or duration, threatens the hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

(b) In the event of such a defined disaster, the hospital may grant disaster privileges to volunteer licensed independent practitioners once the Emergency Management Plan has been activated, and the disaster credentialing procedure would be in immediate effect and implemented as follows:

(1) The Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, or their designee(s) may grant such disaster clinical privileges upon the presentation of a valid government-issued photo identification AND at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation;
- A current license to practice;
- Primary source verification of licensure;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization group;
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

(2) Practitioners granted disaster clinical privileges would be assigned to an appropriate member of the medical staff who shall oversee the performance of volunteer licensed independent practitioners through direct observation, mentoring, and medical record review.

(3) Those granted such privileges would be required to wear hospital emergency identification at all times as outlined in the Emergency

Operations Plan, which will distinguish volunteer licensed independent practitioners from other licensed independent practitioners.

(4) Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

(5) Primary source verification of licensure begins as soon as the immediate emergency situation is under control, or within 72 hours from the time the volunteer licensed independent practitioner presents to the organization, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital will document all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival;
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services;
- Evidence of the hospital's attempt to perform primary source verification as soon as possible.

(6) If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon a possible.

ARTICLE 4
REAPPOINTMENT

4.A. PROCEDURE FOR REAPPOINTMENT

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

4.A.1. Qualifications:

(a) To be eligible to apply for reappointment, an individual must have, during the previous appointment term:

(1) completed all medical records;

(2) completed continuing education requirements as necessary to maintain state professional licensure;

(3) satisfied all medical staff responsibilities and fulfilled all duties assigned by the Chief of Staff; and

(4) continued to meet all qualifications and criteria for medical staff appointment and/or the clinical privileges requested as outlined in the bylaws, policies, rules and regulations of the Medical Staff and the Medical Center, including the qualifications outlined in Section 1.A.2 of these bylaws.

(b) Appointees may maintain Active staff eligibility by one of two mechanisms:

(1) members involved in a minimum of 20 patient contacts at the Medical Center every two years meet patient contact criteria. Patient contacts shall include any admission, consultation, procedure, or evaluation in the inpatient setting, the emergency department, or any outpatient clinic.

(2) the Medical Executive Committee may recommend exceptions to these requirements when it determines an exception is warranted due to the specific need for the specialty at the Medical Center, special or unique reasons for the appointee's failure to satisfy these requirements, or other exigent circumstances.

(c) The qualifications set forth in paragraphs (a) and (b) above are deemed to be threshold criteria for reappointment to the medical staff. Failure to satisfy any one or more of the threshold criteria will render an individual ineligible for reappointment and the individual's application for reappointment, to the extent one has been returned, will not be processed further. In this situation, an individual's appointment will expire at the end of the then current appointment term.

4.A.2. Submission of Application:

(a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form.

(b) The reappointment application shall be furnished to the appointee at least three (3) months prior to the expiration of the appointee's current appointment term. The completed reappointment application shall be submitted to the Medical Staff Office at least two (2) months prior to the expiration of the appointee's current appointment period. Failure to submit a completed application within this time frame will result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current term of appointment.

(c) An application shall be deemed to be complete when it is submitted in writing on a form approved by the Medical Executive Committee and the Board, and with all questions answered and all supporting documentation supplied and including any additional information needed to perform the required review of qualifications and competence of the applicant. If during the processing of the application the Board or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered completed until such additional information or verification is received, or the interview is conducted.

(d) Failure to provide a complete reapplication, as defined in ¶4.A.2(c), within thirty (30) days of being provided with an application form for reappointment, or failure to provide additional information within thirty (30) days after being notified of the additional information required or failure to appear for any requested interview, shall be deemed to be a voluntary withdrawal from the application process. Voluntary withdrawal from the application process is not an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws. The Chief Medical Officer shall provide notice to the individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview.

(e) Reappointment, if granted, shall be for a period of not more than two (2) years. The specific staggering of reappointment shall be in a manner established by the Medical Center.

(f) If a complete application for reappointment is filed timely, and the Board has not acted on it prior to the expiration of the appointee's current term of appointment, that appointment shall continue in effect until such time as the Board acts on the reappointment application.

4.A.3. Factors to be Considered

(a) Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee's:

(1) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;

(2) compliance with the bylaws, policies, and rules and regulations of the Medical Center and the Medical Staff:

(3) appropriate professional behavior at the Medical Center, including cooperation with Medical Staff and Medical Center personnel as it relates to patient care, the orderly operation of the Medical Center, and general attitude toward patients, the Medical Center and its personnel;

(4) willingness to support the mission, vision and values of the Medical Center;

(5) ability to safely and competently exercise the clinical privileges requested;

(6) capacity to satisfactorily treat patients as indicated by the results of the Medical Center's performance improvement activities or other reasonable indicators of continuing qualifications. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s);

(7) any past or pending malpractice challenges, including claims, lawsuits, judgments, and settlements not previously reported to the Chief Medical Officer;

(9) past or pending challenges to any license or registration or any voluntary or involuntary relinquishment of any license or registration not previously reported to the Chief Medical Officer;

(10) voluntary or involuntary termination of medical staff appointment or voluntary or involuntary limitation, reduction, relinquishment, probation or loss of clinical privileges at another hospital or health care facility;

(11) successful attainment of appropriate specialty or subspecialty board certification if not certified at the time of original medical staff application, or documentation of successful attainment of appropriate specialty or subspecialty board certification within 7 years of completion of residency, and recertification within no more than two years beyond expiration of original board certification. The Medical Executive Committee has the authority to grant a one-year extension on a case-by-case basis.

(Recertification requirements for Advanced Dependent Practitioners (ADPs) are addressed in Article 7);

(12) documentation of health status;

(13) morbidity and mortality data (where available) and other relevant information, including peer recommendations and a written report of the findings by the chairperson of each clinical department in which such privileges are sought;

(14) compliance with HIPAA privacy notice; and

(15) other reasonable indicators of continuing qualifications.

(b) In no event shall an applicant for appointment or reappointment to the medical staff be denied appointment on the basis of inclusion or exclusion from any third party payer or managed care organization network panel membership.

4.A.4. Department Chairperson Procedure:

(a) At least one month prior to the end of each individual's current appointment period, the Chief Medical Officer or designee shall, on behalf of the Credentials Committee, send to the chairperson of each department in which the individual has privileges the individual's application for reappointment and a description of the individual's clinical privileges.

(b) No later than fifteen (15) days after receipt of the application, the department chairperson shall prepare a written report to the Credentials Committee concerning the individual seeking reappointment. The report shall include, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment.

(c) The department chairperson concerned shall be available to answer any questions that may be raised with respect to any such report.

4.A.5. Credentials Committee Procedure:

(a) All applications for reappointment and clinical privileges shall be processed as set forth in Section 4.A.4 through 4.A.7.

(b) The Credentials Committee, after receiving the report from each appropriate department chairperson, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(c) The Credentials Committee shall have the right to require the appointee to meet to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(d) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the appointee's qualification for reappointment or for any of the clinical privileges requested.

(e) If, after considering the report of the appropriate department chairperson, the Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.

(f) If, during the processing of an individual's reappointment, it becomes apparent that the Credentials Committee is considering a recommendation that would deny reappointment, deny clinical privileges, or reduce clinical privileges, the Chairperson of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the Committee prior to any final recommendation. At such meeting, the affected 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 interview shall not constitute a hearing and none of the procedural rules provided in these bylaws with respect to hearings shall apply. Minutes of the meeting shall be kept and the Committee shall indicate as part of its report to the Medical Executive Committee and the Board that such a meeting occurred.

(g) Where reappointment of a current appointee is not recommended, or a change in staff category or clinical privileges is recommended, the Credentials Committee shall state the reason(s) for such recommendation(s).

(h) The Chairperson of the Credentials Committee shall be available to meet with the Medical Executive Committee and the Board to answer any questions that may be raised with respect to the recommendation.

(i) The Credentials Committee shall forward its written findings and recommendations to the Medical Executive Committee in time for the Medical Executive Committee to consider the individual's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period. The completed application and all supporting documentation shall accompany the Credentials Committee's findings and recommendation.

4.A.6. Medical Executive Committee Procedure:

(a) At its regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical 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 preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, through the Chief Medical Officer to the Board.

(b) If the recommendation of the Medical Executive Committee is favorable, it shall transmit its recommendation through the Chief of Staff or designee to the Board, including the findings and recommendations of the Credentials Committee. All recommendations to reappoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) Any recommendation by the Medical Executive Committee that would entitle the affected individual to the hearing and appeal procedures provided in these bylaws shall be forwarded to the Chief Medical Officer, who shall promptly notify the affected individual by Special Notice. The Chief Medical Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in these bylaws.

(d) The Chairperson of the Medical Executive Committee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

4.A.7. Action of the Board:

(a) Upon receipt of a recommendation from the Medical Executive Committee that an individual be reappointed with the clinical privileges requested, the Board may:

(1) reappoint the applicant and grant renewed clinical privileges as recommended; or

(2) refer the matter back to the Medical Executive Committee or to another source inside the hospital for additional research or information; or

(3) reject the recommendation

(b) If the Board determines to reject the favorable recommendation, it should first discuss the matter with the Chairperson of the Credentials Committee and/or the Chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable to the individual, that determination and the reasons in support thereof shall be sent to the Chief Medical Officer, who shall promptly notify the individual by Special Notice. The Board shall make no final decision until the individual has exercised or waived the right to a hearing and appeal as outlined in these bylaws.

(c) If the Board's decision is favorable, the Board shall send notice of its action to the individual by mail within 30 days.

(d) The decision to grant, limit, revise, or deny an applicant's privileges will also be disseminated to all appropriate internal hospital personnel and external agencies, as defined by state and federal laws.

ARTICLE 5
CORRECTIVE ACTION

5.A. PROCEDURE FOR RESOLVING COMPLAINTS INVOLVING MEDICAL STAFF

5.A.1. Initial Procedure:

(a) Whenever a concern or question has been raised regarding:

(1) the clinical competence or clinical practice of any medical staff appointee;

(2) the care or treatment of a patient or patients or management of a case by any medical staff appointee;

(3) the known or suspected violation by any medical staff appointee of applicable ethical standards or the bylaws, policies, rules or regulation of the Medical Center or the Medical Staff including, but not limited to, the Medical Center's performance improvement, risk management, and utilization review programs; and/or

(4) behavior or conduct on the part of any medical staff appointee that is considered lower than the standards of, or disruptive to the orderly operation of, the Medical Center or the Medical Staff, including the inability of the appointee to work harmoniously with others.

(b) The Chief of Staff, appropriate department chairperson, Chairperson of the Credentials Committee, Chief Medical Officer or Chief Executive Officer shall make sufficient inquiry to satisfy himself or herself that the concern or question raised is credible. After such a determination has been made, the matter shall be turned over to the Credentials Committee via a written request for an investigation.

(c) Any of the above individuals, if he or she believes it to be in the best interest of the Medical Center and the physician, may, but are not required to, discuss the matter with the physician in question.

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

5.A.2. Initiation of Investigation:

(a) The Credentials Committee shall meet promptly after receiving a request and any supporting documentation and determine whether there is a need to conduct an investigation. An investigation shall begin only after the Credentials Committee has passed a resolution to that effect.

(b) If after evaluating the request, the Credentials Committee determines that there is no basis for an investigation, the Committee may make a recommendation that

no action is justified. This recommendation may be made with or without a personal interview with the affected individual.

(c) If the Credentials Committee determines to begin an investigation, it shall pass a resolution to that effect and may delegate the responsibility for carrying out the investigation.

(d) The Credentials Committee may also, by resolution, initiate an investigation on its own motion. The Medical Executive Committee and the Chief Medical Officer shall be kept fully informed of all action taken in connection therewith.

5.A.3. Investigative Procedure:

(a) Once the Credentials Committee has determined that there is a basis for an investigation, it shall immediately investigate the matter. The Committee shall have the discretion to conduct the investigation itself or it may appoint a subcommittee or an ad hoc committee to do so.

(b) In the event the Credentials Committee appoints an ad hoc committee, that committee shall consist of at least three persons, who hold appointments to the Medical Staff. This committee shall not include partners and associates in the same specialty, as, or relatives of, the individual being investigated.

(c) The committee conducting the investigation shall have the authority to review relevant documents and interview individuals with relevant information. 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. Matters to consider when determining whether external review is needed include, but are not limited to the following:

(1) need for the specialty review, when there are not medical staff members of the institution with the identified specialty within the organization or those medical staff members with the identified specialty are in economic competition with the individual whose case is under review ;

(2) the peer review committee cannot make a determination and requests external review;

(3) the individual whose case is under review requests external peer review;

(4) the Performance Improvement, Credentialing and/or Medical Executive Committee request external review.

(d) The committee may also require a physical and mental examination, including diagnostic testing, and a complete neuropsychiatric evaluation, of the individual being investigated by a physician or physicians satisfactory to the committee,

and shall require that the results of such examination be made available to the committee for its consideration.

(e) The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. At least 10 days prior to this meeting the individual shall be informed of the general nature of the information supporting the question being investigated and the patient whose care is reflective of the issues being investigated. At the meeting the individual shall be invited to discuss, explain, or refute the concerns identified about the care or services he or she furnished. The individual being investigated shall not have a right to be represented by legal counsel at this meeting.

(f) The interview with the affected individual shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings shall apply. A summary of such interview shall be made by the investigating committee and included with its report.

(g) The subcommittee or ad hoc investigating committee if used, shall submit its report to the Credentials Committee. The Credentials Committee may accept, modify or reject any recommendation it receives from that committee.

5.A.4. Procedure Thereafter:

(a) In acting after the investigation, the Credentials Committee may:

(1 determine that no action is justified;

(2) issue a written warning;

(3) issue a letter of reprimand;

(4) impose terms of probation;

(5) impose a requirement for consultation;

(6) recommend reduction of clinical privileges;

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

(8) recommend revocation of staff appointment; or

(9) make such other recommendations as it deems necessary or appropriate.

(b) The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee. Thereafter, the Medical Executive Committee shall determine to:

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

(2) refer the matter back to the Credentials Committee for its further investigation and preparation of responses to specific questions; or

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

(c) If the recommendation of the Medical Executive Committee does not entitle the individual to a hearing, the recommendation shall take effect immediately, upon Board approval, without the right of appeal. The recommendation shall stand unless modified by the Board. In the event the Board is considering modification of the action of the Medical Executive Committee and such modification would entitle the individual to a hearing in accordance with these bylaws, it shall so notify the affected individual by Special Notice, through the Chief Medical Officer, and shall take no final action thereon until the individual has had an opportunity to exercise the right to a hearing and appeal as provided in these bylaws.

(d) If the recommendation of the Medical Executive Committee would entitle the individual being investigated to the hearing and appeals procedure provided in these bylaws, it shall be forwarded to the Chief Medical Officer, who shall promptly notify the affected individual by Special Notice. The Chief Medical Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing.

(e) The Chairpersons of the Credentials and Medical Executive Committees shall be available to the Board to answer any question that may be raised with respect to the recommendations.

5.B. ADMINISTRATIVE SUSPENSIONS OF CLINICAL PRIVILEGES

5.B.1. Administrative Suspension

(a) Whenever questions arise concerning the actions or condition of a medical staff member that may result in imminent danger to the health and/or safety of another, an administration suspension of that medical staff member's clinical privileges may be imposed by an Administrative Suspension Panel. The Administrative Suspension Panel composed of the CEO, Chair of the Credentials Committee, Chief of Staff, Chief Medical Officer, and the Elected Chair of the Department of the staff member, by majority agreement may impose an administrative suspension or restriction of any or all of a medical staff member's clinical privileges in order to allow time to determine whether more formal action or investigation should be undertaken, for a period not to exceed fourteen days. An Administrative Suspension does not imply any final finding on the merits of the issues. The Panel shall promptly notify the staff member of the suspension. In the event a member, or members, of the Administrative Suspension Panel is,

or are, unavailable or are the subject of the proposed administrative suspension, then the Chief of Staff shall appoint an alterative or alternatives to serve on the Panel. In the event that a majority of the Administrative Suspension Panel is unavailable, the Chief Medical Officer shall have the authority to impose an administrative suspension under this provision for a period of 24 hours pending review by the panel.

(b) There are no rights under these Bylaws to appeal the imposition of an Administrative Restriction or Suspension of privileges under this provision.

5.B.2. Credentials Committee Procedure:

(a) Upon imposition of an administrative suspension on a medical staff member the Credentials Committee shall immediately take further action in the manner specified in Section 5.A of these bylaws.

(b) A review of the matter resulting in administrative suspension shall be completed within a reasonable time period, not to exceed fourteen (14) days, or reasons for the delay shall be transmitted to the Chief Medical Officer so that the Chief Medical Officer and the Credentials Committee may consider whether the suspension should be lifted.

5.B.3. Care of Suspended Individual's Patients:

(a) Immediately upon the imposition of an administrative suspension, the appropriate department chairperson or, if unavailable, the Chief of Staff, shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients. The assignment shall be effective until such time as the patients are discharged or the suspension is terminated, whichever first occurs. The wishes of the patient shall be considered in the selection of the assigned appointee.

(b) It shall be the duty of all medical staff appointees to cooperate with the Chief of Staff, the department chairperson concerned, the Credentials Committee, and the Chief Medical Officer in enforcing all suspensions.

5.C. OTHER ACTIONS

5.C.1. Failure to Complete Medical Records:

Failure by a medical staff member to complete medical records in accordance with applicable MCCG regulations shall be managed according to current medical staff policy

in effect at the time, including, but not limited to, referral to the Medical Executive Committee for disciplinary action up to and including relinquishment of clinical privileges.

5.C.2. Action by State Licensing Agency:

Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason shall result in automatic relinquishment of all clinical privileges as of that date. The relinquishment shall remain in effect until the matter is resolved and a request by the affected individual for reinstatement of privileges has been approved by the Credentials Committee, the Medical Executive Committee, and the Board. Imposition of any other conditions on licensing shall require review by the Credentials Committee for appropriate action regarding continued privileges.

5.C.3. Failure to be Adequately Insured:

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges that would be affected shall automatically be relinquished or limited, as applicable, as of that date. The relinquishment or limitation shall remain in effect until the matter is resolved, adequate professional liability insurance coverage is restored, and the Medical Center has been provided with verification of the same. This requirement may be waived for Honorary and Affiliate Staff members who do not hold clinical privileges.

5.C.4. Failure to Provide Requested Information:

If at any time an appointee fails to provide information, subject to a formal request by the Credentials Committee, the Medical Executive Committee, or the Chief Medical Officer or designee, the appointee's clinical privileges shall be automatically relinquished until the information is provided. For purposes of this section, "information" shall include but not be limited to information necessary to explain an investigation, professional review action, or resignation from another facility or agency and information pertaining to professional liability actions involving the appointee.

5.C.5. Medicare and Medicaid Participation:

(a) Any medical staff appointee whose participation in the Medicare or Medicaid programs, or any other program funded in whole or in part by the federal government, is involuntarily terminated, or who is otherwise excluded or precluded from participation in any such programs, shall automatically

relinquish all clinical privileges as of the effective date of the termination, exclusion, or preclusion. The relinquishment shall remain in effect until the matter is resolved, and a request for reinstatement of privileges has been approved by the Credentials Committee, the Medical Executive Committee, and the Board.

(b) It shall be the duty of all appointees to promptly inform the Chief Medical Officer of any action taken by such programs in this regard.

5.C.6. Practitioner Health Issues

MEDICAL CENTER OF CENTRAL GEORGIA
MEDICAL STAFF HEALTH POLICY

It is the policy of the Medical Staff and Hospital to be sensitive to a practitioner's health or condition that may adversely affect that practitioner's ability to provide safe, competent care to patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way due to age or illness. To address such potential concerns, the Hospital and Medical Staff create a Medical Staff Health Committee to be initially composed of the Chief Medical Officer, the elected Chair of the Psychiatry Department of the Medical Center, and other medical staff members as may be appointed by the Medical Executive Committee. The Committee membership will be expanded as necessary to address the situation before it.

PURPOSE

Medical staff policy regarding structuring clinical privileges in light of illness or limitation.

PROCEDURE

1. The Committee shall make the medical staff aware of its existence and the nature of the work through announcements or presentations at medical staff meetings, articles in the medical staff newsletter, and/or seminars related to physician health (See Attachment A, Recognition of Health Problems).
2. The Committee may receive a referral from the physician whose health is at issue, the Credentials Committee, administration, the Board of Directors, or any concerned individual (See Attachment A, Recognition of Health Problems). The report should state the nature of the concern and the reasons in support of it. All reports will remain confidential and the individual making the report will not be revealed to the practitioner whose health is at issue.

3. The report shall be directed to the Chief Medical Officer, who shall on behalf of the committee immediately direct whatever brief investigation is necessary to understand the nature of the concern. That may include meeting with the individual who filed the report.
4. The physician whose health or behavior is in question should be invited to meet with the Medical Staff Health Committee.
    a. The practitioner should be informed of the nature of the meeting and the opportunity to be accompanied by a practitioner who may be treating the condition at issue.
    b. The representative accompanying the practitioner should not be an attorney. The purpose of this Committee and this meeting is to discuss what, if any, problems exist and to work mutually towards a solution in the best interest of the practitioner's health and patient care.
    c. This meeting does not constitute a hearing under the due process provisions of the Medical Staff Bylaws or pertinent policies;
5. If the practitioner declines to meet with the Committee and there continues to be a concern about the practitioner's health or ability to care for patients safely and competently, that question shall be forwarded to the Credentials Committee for investigation in accordance with the policies of the Credentials Committee.
6. The practitioner and the Committee shall discuss the nature of the problem, what if any modifications of the practitioner's practice is appropriate, and what if any accommodations can be made to enable the practitioner to continue clinical practice.
7. If the extent of the practitioner's illness or limitation is not easily determined, the Committee shall require the practitioner to submit to an appropriate evaluation by an individual or entity acceptable to the Composite State Board of Medical Examiners (the Chief Medical Officer will maintain the approved list). The practitioner must also authorize release of the report of the evaluation to the members of the Medical Staff Health Committee. If the practitioner declines such evaluation, the Committee's work shall be concluded and it shall direct this matter to the Credentials Committee for further evaluation.
8. Once the report of the evaluation has been received the Committee shall agree upon accommodations and limitations for the practitioner's practice and placed in a written document and maintained in a confidential practitioner file. If the practitioner declines to accept these accommodations and limitations, then the Committee's work shall be concluded and it shall direct this matter to the Credentials Committee for further action.
9. Any ongoing monitoring that is required shall be the responsibility of the Medical Staff Health Committee or the person or entity to which the responsibility is delegated by the Committee.

10. Any reporting requirements of the Composite State Board of Medical Examiners shall override this policy.
11. If patient notice is required for any of the conditions, limitations or accommodations as dictated by the situation, then the Committee shall outline such notice with the practitioner.
12. Throughout the process, all parties shall avoid speculation; conclusions, gossip and any discussion of this matter with anyone outside those described in this policy.
13. In the event of an apparent or actual conflict between this policy and the bylaws, rules and regulations, or other policies of the Hospital or its Medical Staff, including the due process section of those bylaws and policies, the provisions of this policy shall control. Actions taken and determinations made by the Medical Staff Health Committee pursuant to the procedures of the Medical Staff Health Policy do not constitute grounds for a hearing under these bylaws.
14. The Medical Executive Committee will receive an annual report from the Chief Medical Officer indicating the number of practitioners assisted, the assistance provided, and as appropriate, additional reports on the data and trends concerning practitioner health. No individual practitioners will be identified in the report.

RECOGNITION OF HEALTH PROBLEMS
MEMBERS OF THE MEDICAL STAFF

Practitioners are at risk for the health problems of the general population, including physical, emotional, and behavioral health problems. Recognition of the signs and symptoms of impairment and prompt, appropriate response is important to assure that practitioners can and do provide quality health care to patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way. To address such potential concerns, the Hospital and the Medical Executive Committee created a Medical Staff Health Committee that will function independently of the Credentials Committee. This independent function is designed to encourage prompt reporting of concerns about the health of any medical staff member.

Any concerned individual may make a report to the Medical Staff Health Committee about a practitioner whose health is at issue. All reports received shall be directed to the Chief Medical Officer who shall direct on behalf of the committee whatever information is necessary to understand the nature of the concern. All reports are considered confidential and the individual making the report will not be revealed to the practitioner whose health is at issue. The report will be evaluated and appropriate follow-up arranged according to the Medical Staff Health Policy.

The following manifestations of impairment might prompt any concerned individual to make a report about a practitioner:

- Dramatic decrease in performance
- Persistent or repetitive absenteeism or lateness
- Mood swings
- Difficulties in interpersonal interactions
- Complaints from patients and colleagues
- Disruptive behavior
- Medications missing from the work area
- Disappearances from work
- Disordered thought
- Alcohol on the breath or other stigmata of drug use
- Diminished physical appearance

5.D. LEAVE OF ABSENCE

5.D.1. Procedure for Leave of Absence:

(a) Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definitively stated period of time not to exceed one year. Absence for longer than one year shall constitute voluntary resignation of Medical staff appointment and clinical privileges, unless an exception is made by the Board upon recommendation of the Credentials Committee.

(b) Requests for leaves of absence shall be made to the relevant department chairperson and shall state the beginning and ending dates of the requested leave and the reasons for the leave. The department chairperson shall report favorably or unfavorably on the request and forward the same to the Credentials Committee. The Credentials Committee shall make a recommendation, which shall be forwarded to the Medical Executive Committee and then the Board.

(c) No later than thirty (30) days prior to the conclusion of the leave of absence, the individual must request, in writing, to be reinstated. The request shall summarize the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Medical Center at that time.

(d) If the leave of absence was for medical reasons, the appointee must submit a report from his or her attending physician indicating that the appointee is

physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested.

(e) After considering all relevant information, requests for reinstatement shall follow the procedure outlined in paragraphs 2.A.5 through 2.A.9

(f) In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

5.D.2. Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Board. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions in these bylaws, but may be granted subject to monitoring and/or proctoring.

ARTICLE 6

HEARING AND APPEAL PROCEDURES

6.A. INITIATION OF HEARING

6.A.1. Grounds for Hearing:

(a) A medical staff appointee shall be entitled to request a hearing whenever an unfavorable recommendation has been made by the Medical Executive Committee or the Board regarding the following:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of Medical Staff appointment;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for any duration (other than administrative suspension); or

(7) imposition of any consultation requirement

(8) terms of probation

(b) No other recommendations except those enumerated in (a) of this Section shall entitle the individual to request a hearing.

(c) The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar recommendation from the Medical Executive Committee, to take any action set forth above.

(d) The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these bylaws.

6.A.2. Actions Not Considered Grounds For a Hearing:

None of the following actions shall constitute grounds for a hearing, and shall take effect without hearing or appeal:

(a) a letter of warning, a letter of admonition, or a letter of reprimand;

(b) denial, termination or reduction of temporary privileges;

(c) denial of an application for extension of privileges on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the hospital or are not granted due to closed staff or exclusive contract or in accord with a Medical Staff development plan;

(d) Hospital policy decisions (e.g. the closure of a department or physical plant changes) that adversely affect the Staff membership or clinical privileges of any staff member or other individual;

(e) The suspension, termination, revocation or relinquishment of staff membership or clinical privileges for reasons not based on the hospital's evaluation of a practitioner's qualifications, competence or professional conduct, such as the actions specified in Article 5.C. of the Bylaws.

(f) Administrative suspensions of the type discussed in regard to ¶5.B.

6.B. THE HEARING

6.B.1. Notice of Recommendation

When a recommendation is made which, according to these bylaws, entitles an individual to a hearing prior to a final decision by the Board, the affected individual shall promptly be given Special Notice by the Chief Medical Officer. This notice shall contain the following:

(a) a concise statement of the Practitioner's alleged acts or omissions, and a list, by number, of any specific or representative patient matter forming the basis for the adverse recommendation;

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

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

(d) a copy of this Article outlining the rights in the hearing as provided for in these bylaws;

(e) a statement that the failure to file a request for hearing within the specified time will result in waiver of any right to a hearing and appellate review.

6.B.2. Request for Hearing:

An individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing and delivered to the Chief Medical Officer within such 30-day period. In the event the individual does not request a hearing within the time and in the manner required by these bylaws, the individual shall be deemed to have waived the right to the hearing and to have accepted the recommendation. Such recommendation shall become effective immediately upon final action by the Board.

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

(a) The Chief Medical Officer shall schedule the hearing and shall give Special Notice to the person who requested the hearing. The notice shall include:

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

(2) a proposed list of witnesses, as known at that time, who will give testimony or present evidence at the hearing in support of recommendation;

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

(4) a statement of a specific reasons for the recommendation, as well as the list of patient records and other information supporting the recommendation. This statement, and the list of supporting patient record numbers and other supporting information, may be revised or amended at any time, even during the hearing, as long as the additional material is relevant and reasonable notice is given to the other party.

(b) The hearing shall begin no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

6.B.4. Witness List:

(a) Within ten (10) days after receiving notice of the hearing, the individual requesting the hearing shall provide to the Chief Medical Officer a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf.

(b) The affected individual's witness list, as well as the witness list of the Medical Executive Committee or the Board, shall include a brief summary of the nature of the anticipated testimony. Witness lists shall be finalized at the time of the pre-hearing conference. However, the witness list of either party may, thereafter, in the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that reasonable notice of the change is given to the other party.

6.B.5. Hearing Panel and Presiding Officer:

(a) Hearing Panel:

(1) When a hearing is requested, the Chief Medical Officer, acting for the Board and after considering the recommendation of the Chief of Staff (or the Chairperson of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The Hearing Panel shall be composed of medical staff appointees who shall not have actively

participated in the consideration of the matter involved at any previous level, or of physicians or laypersons not connected with the Medical Center, or any combination of such persons. Prior knowledge of the issue involved shall not preclude any individual from serving as a member of the Hearing Panel.

(2) The Hearing Panel shall not include any individual who is in direct economic competition with the affected person. Any individual who is professionally associated with or related to the affected person shall also not serve on the Hearing Panel.

(3) In addition to the appointment of a Hearing Panel, the Chief Medical Officer shall also appoint a Presiding Officer or a Hearing Panel Chairperson.

(b) Presiding Officer:

(1) The Presiding Officer should be an attorney at law and should be familiar with conducting administrative procedures.

(2) The Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. 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.

(3) If a chairperson of the Hearing Panel is appointed in lieu of a Presiding Officer, such chairperson shall exercise all the authority otherwise vested in the Presiding Officer and shall also be entitled to vote.

(4) The Presiding Officer shall perform the following functions:

(i) act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure throughout the hearing;

(v) have the authority and discretion, in accordance with these bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, including the

discretion to refuse to allow a witness to testify if the other party was not provided with adequate notice;

(vi) act in such a way that all information relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

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

(5) The Presiding Officer may be advised by legal counsel to the Medical Center.

6.C. PRE-HEARING AND HEARING PROCEDURE

6.C.1. Discovery:

(a) There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request, to the documents listed below. These documents shall be provided only after both parties have signed a stipulation stating that the documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing and that production of such documents shall not constitute a waiver of the protection afforded by applicable peer review statutes:

(1) copies (at the individual's expense) of, or reasonable access to, all patient medical records relevant to the adverse recommendation;

(2) reports of experts relied upon by the Credentials Committee, the Medical Executive Committee or the Board;

(3) redacted copies of relevant committee or department minutes; and

(4) copies of any other documents relied upon by the Credentials Committee, the Medical Executive Committee or the Board.

(b) Neither the affected individual, nor his or her attorney, nor any other person acting on behalf of the affected individual, shall contact Medical Center employees appearing on the other party's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

6.C.2. Pre-Hearing Conference:

The Presiding Officer shall require the affected individual and the Medical Executive Committee (or the Board) to participate in a pre-hearing conference for the purpose of

resolving all procedural questions in advance of the hearing. The Presiding Officer shall specifically require that:

(1) all documentary evidence to be submitted by the parties be presented to each other prior to this conference and that any objections regarding the documents be made at this conference and resolved by the Presiding Officer;

(2) evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges be excluded;

(3) any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;

(4) the time granted to each witness' testimony and cross-examination be generally agreed upon, or determined by the Presiding Officer, in advance; and

(5) witnesses and documentation not provided and agreed upon in advance of the hearing may, at the discretion of the Presiding Officer, be excluded from the hearing.

6.C.3. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed on the designated date shall be deemed to constitute voluntary acceptance of the pending recommendations or actions, which shall then be forwarded to the Board for final action.

6.C.4. Record of Hearing:

A record of the hearing shall be maintained by a stenographic reporter or by a recording of the proceedings. The cost of such reporter shall be borne by the Medical Center, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. Unless otherwise agreed to by the parties, oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

6.C.5. 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 available;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

(4) representation by a practitioner who may call, examine, and cross-examine witnesses;

(5) representation by counsel who may advise the respective party but who shall not, unless agreed upon by all involved parties, present the case; and

(6) to submit a written statement at the close of the hearing.

(b) Any individual requesting a hearing who does not testify in his or her own behalf may be called and examined as if under cross-examination.

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

6.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes 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 Board, which must decide ultimately about the individual's appointment and clinical privileges, shall have before it all information relevant to the individual's qualifications for appointment and/or clinical privileges.

6.C.7. Persons Present at Hearing:

The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel are permitted to be present as requested by the Chief of Staff and the Chief Medical Officer.

6.C.8. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in these bylaws may be requested by anyone, but shall be permitted only by the Presiding Officer or the Chief Medical Officer on a showing of good cause.

6.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

6.D.1. Order of Presentation:

The Medical Executive Committee or the Board, depending on whose adverse recommendation or action occasioned the hearing, shall have the initial burden to

present evidence in support of their recommendation or action. The burden then shifts to the Practitioner who must prove by a preponderance of the weight of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is arbitrary, unreasonable, or capricious.

6.D.2. Basis of Decision:

(a) The Hearing Panel shall recommend in favor of the Medical Executive Committee or the Board, unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

(b) The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(1) oral or sworn written testimony of witnesses;

(2) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(3) any and all applications, references, and accompanying documents;

(4) other documented evidence, including medical records; and

(5) any other evidence that has been admitted.

6.D.3. Adjournment and Conclusion:

The Presiding Officer may, in his or her discretion and without special notice, adjourn the hearing and reconvene the same, taking into consideration the convenience and any objections of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed. The practitioner whose care or service is in question and the Medical Executive Committee both shall have the right to submit a post-hearing memorandum. The Presiding Officer may in his or her discretion request the parties to submit post-hearing memoranda within a specified number of days following closure of the hearing.

6.D.4. Deliberations and Recommendation of the Hearing Panel:

Within twenty (20) days after final adjournment of the hearing (which shall be designated as the time the Hearing Panel receives the post-hearing memoranda), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the

Presiding Officer. The Hearing Panel shall prepare a written statement of its recommendation, which shall include the basis of the recommendation.

6.D.5. Disposition of Hearing Panel Recommendation:

The Hearing Panel shall deliver its written recommendation to the Chief Medical Officer. The Chief Medical Officer shall send a copy of the recommendation by Special Notice to the individual who requested the hearing. The Chief Medical Officer shall also provide a copy to the Chairperson of the Medical Executive Committee and the Chairperson of the Credentials Committee.

6.E. APPELLATE REVIEW

6.E.1. Request for Appeal:

Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appellate review. The request shall be in writing and shall be delivered to the Chief Medical Officer by Special Notice within such 10-day period. A request for an appeal shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not delivered within ten (10) days as provided herein, both parties shall be deemed to have waived appellate review, and the Hearing Panel's recommendation shall be forwarded to the Board for final action.

6.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with the medical staff bylaws, during or prior to the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; or

(c) the recommendations of the Hearing Panel were not supported by substantial evidence.

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

(a) Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, within ten (10) days after receipt of such request, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place, and date of the appellate review.

(b) The date of appellate review shall be not less than fifteen (15) days, nor more than forty (40) days from the date of receipt of the request for appellate review;

provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the Chairperson of the Board for good cause.

6.E.4. Nature of Appellate Review:

(a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, which may include reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made. In the discretion of the Board Chairperson, the Board, as a whole, may hear the appeal.

(b) The Review Panel may in its discretion decide to accept additional oral or written evidence subject to the same right 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 not available at the time of the hearing or that any opportunity to admit it at the hearing was improperly denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make an oral argument. The Review Panel shall recommend final action to the Board.

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

(a) The Board may affirm, modify or reverse the recommendation of the Review Panel, refer the matter for further review and recommendation, or make its own decision in light of the Board's ultimate legal responsibility to make appointments and grant clinical privileges.

(b) Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall deliver a copy thereof to the affected individual by Special Notice. A copy shall also be provided to the Medical Executive Committee and the Credentials Committee for their information.

6.E.6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 6.E.5, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred pursuant

to Section 6.E.5. for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall not exceed thirty (30) days except as the parties may otherwise stipulate.

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

No applicant or Medical Staff appointee shall be entitled to more than one hearing and one appellate review on any matter which may be the subject of an appeal. If the Board determines to deny reappointment or to revoke or terminate the medical staff appointment and/or clinical privileges of a current appointee, that individual may not apply for staff appointment or for those clinical privileges for a period of five (5) years unless the Board provides otherwise.

ARTICLE 7

ALLIED HEALTH PROFESSIONALS

7.A. DEFINITION AND CATEGORIES OF ALLIED HEALTH PROFESSIONALS

(1) Allied Health Professionals (AHP) are individuals, other than independent practitioners, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. All AHPs are classified as either "Advanced Dependent Practitioners" (ADPs) or "Dependent Practitioners" (DPs).

(2) ADPs are credentialed in the Medical Staff model and are granted clinical privileges as advanced dependent healthcare professionals. ADPs include physician assistants (PA) and advance practice nurses, i.e., certified registered nurse anesthetists (CRNA), registered/certified nurse practitioners (RNP/CNP), clinical nurse specialists (CNS), and certified nurse midwives (CNM).

(3) DPs are credentialed in the Human Resources model and are granted a scope of practice. All other categories of Allied Health Professionals not defined above as an ADP shall be classified as Dependent Practitioners.

(4) Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital.

7.B. GENERAL CONDITIONS OF PRACTICE

7.B.1. No Entitlement to Appointment

AHPs are not eligible for Medical Staff membership and are not entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

7.B.2. Assumption of Duties and Responsibilities

All AHPs are subject to the Medical Staff Rules and Regulations and policies of the hospital.

7.B.3. Clinical Privileges

Written guidelines outlining clinical privileges appropriate for each category of ADP shall be developed by the hospital with input, where applicable, from the Medical Director of the clinical service or Medical Center department, and approved by the Medical Executive Committee and Board.

7.C. QUALIFICATIONS

ADPs must possess the following qualifications to be granted clinical privileges:

(1) All Advanced Dependent Practitioners must be a graduate of an approved school pertinent to their area of specialty;

(2) All Advanced Dependent Practitioners must have a current license and/or authorization from the appropriate State Licensing Board;

(3) All Advanced Dependent Practitioners must be certified by the appropriate specialty certification body. APRNs must be certified by a national certifying board recognized by the Georgia Board of Nursing. Physician Assistants must be certified by the National Commission for Certification of Physician Assistants. Anesthesia Assistants must be certified by the National Commission for Certification of Anesthesia Assistants;

(4) All AHPs must be sponsored by a physician who is a member of the medical staff. A Physician Assistant or Advanced Practice Nurse may be supervised by more than one physician, provided one physician accepts primary sponsoring responsibility and all sponsoring or supervising physicians agree to such supervision requirements, as set forth in applicable Georgia law and regulations or requirements of the applicable State Board;

(5) All Advanced Practice Nurses must have a collaborative practice/nurse protocol agreement where required by law, which includes clinical protocols or practice guidelines consistent with their specialty and approved by his/her primary sponsoring physician and any other supervising physician. This agreement must be updated annually by the APRN, the delegating physician, and any designated physician(s), and meet the requirements of all applicable state statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Advanced Practice Nurse and the supervising physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement, including revisions to physician sponsorship. Any changes to the agreement which involve clinical practice changes must be approved in accordance with Article 3 of these bylaws.

7.D. INITIAL APPLICATION PROCESS FOR ADPs:

(1) An ADP applying for clinical privileges shall complete an application approved by the Board which contains the information in Paragraph 1.C.3 of these bylaws, as applicable;

(2) The applicant must sign the application and in so doing agrees to the provisions specified in Paragraph 1.C.2 of these bylaws, as applicable;

(3) The application will be reviewed for completeness and adequacy of information and the data verified;

(4) Action on the application shall be the same as set forth in Paragraphs 2.A.1. through 2.A.10 and 3.A.1. of these bylaws, as applicable, except that after the review by the Department Chairperson, as specified in paragraph 2.A.5 and before the review by the medical staff Credentials Committee, as specified in paragraph 2.A.6, the application shall be reviewed by the Allied Health Professional Committee ("AHP Committee"). The AHP Committee shall examine evidence of the applicant's character, credentials, professional competence, qualifications, prior behavior, and ethical standing and shall determine through information contained in references given by the applicant and by recommendations from peers, and from other sources available to the committee, including the report and findings from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for granting the clinical privileges requested. As part of this process of making its recommendation the AHP Committee may meet with the applicant to discuss the applicant's application, qualifications and clinical privileges requested. The AHP committee shall prepare and send a report to the Medical Staff Credentials Committee concerning the applicant's qualifications for the requested clinical privileges. The AHP Committee's report shall be prepared not later than thirty (30) days from the date the Committee received the report of the department chairperson.

7.E. APPLICATIONS FOR RENEWAL TO PRACTICE

The procedure for renewal of clinical privileges for ADPs shall be the same as set forth in Paragraph 4.A.2. through 4.A.7. of these bylaws, as applicable.

(1) If Physician Assistant's board certification expires for any reason, he/she will be granted a one-year grace period from date of expiration in which to recertify. Failure to recertify within this time frame may result in loss of clinical privileges.

(2) Advanced Practice Nurses must maintain national certification as authorized by the Georgia Board of Nursing for renewal to practice and continued clinical privileges.

7F. PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ADPs AND PROCEDURALRIGHTS

(1) The Medical Executive Committee shall receive and evaluate any report regarding the performance of an ADP. If the Medical Executive Committee concludes that the performance does not meet expected standards of care, poses a threat to patient well-being, exceeds the scope of the ADP's privileges, impedes the operation of the hospital or violates any rules, regulations, policies or procedures the ADP is bound to follow, the Medical Executive Committee may issue a reprimand or may limit, suspend or revoke the privileges of the ADP. The privileges of an ADP also may be revoked, suspended or limited by the Chief of Staff. Notice of any such action shall be provided to the Medical Executive Committee. The ADP and his or her supervising or collaborating physician shall be given written notice of any adverse action taken under this section. Denial of privileges or limitation, suspension or revocation of privileges shall constitute appealable actions, and shall be effective immediately or as otherwise set forth in the written notice to the ADP, and may be appealed by the ADP as set forth in Paragraph 6.A through E, which are hereby incorporated by reference. Any such appealable action, which is not appealed in a timely manner under Paragraph 6.B.2. shall be final;

(2) Activities of the hospital, the Board, the Allied Health Professional Committee, the Credentials Committee, and the Medical Executive Committee and those who may assist them or to whom they report in connection with credentialing or privileges of ADPs, reviewing quality and appropriateness of care or corrective action with respect to ADPs and considering and acting on any appeal of an appealable action are intended to and shall be review activities within the scope and context of O.C.G.A. §31-7-132 and the Health Care Quality Improvement Act of 1986.

7.F.1. ADP Non-Appealable Determinations

Not every action entitles an ADP to rights pursuant to the ADP Appeals Process. In addition to any other adverse action identified in the bylaws as non-appealable, the following occurrences are not reviewable under the adverse action appeals process:

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process appeals rights;

(b) Issuance of a warning or a letter of admonition or reprimand;
(c) Imposition of monitoring or proctoring through direct observation of professional practices;
(d) Termination or limitation of temporary permission to provide patient care services;
(e) Any recommendation voluntarily imposed or accepted by an ADP;
(f) Denial of privileges for failure to complete an application for privileges or permission to provide patient care services;
(g) Removal of privileges for failure to complete the minimum supervisory requirements;
(h) Removal of privileges and permission to provide patient care services for failure to submit an application for re-credentialing within the allowable time frame;
(i) Any requirement to complete an educational assessment or training program;
(j) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional;
(k) Retrospective chart review;
(l) Removal of privileges and permission to provide patient care services for lack of a sponsoring physician.
(m) Removal of privileges and permission to provide patient care services for failure to practice within approval clinical privileges.

7.G. HOSPITAL EMPLOYED ADPs

(1) A request for clinical privileges, on an initial basis or for renewal, submitted by an Advanced Dependent Practitioner who is seeking employment or who is employed by the Hospital will be processed in accordance with these bylaws;

(2) Except as provided in paragraph (3) below, any disciplinary concern or action with respect to an employed ADP will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an ADP's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in the Medical Staff Bylaws;

(3) If a concern about an employed ADP's clinical competence or conduct originates with the Medical Staff, the concern will be reviewed and addressed in

accordance with these bylaws, after which a report will be provided to Human Resources;

(4) Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with these bylaws, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

ARTICLE 8
OFFICERS

8.A. OFFICERS

8.A.1. Officers of the Medical Staff:

The officers of the Medical Staff shall be:

(a) Chief of Staff; and

(b) Chief of Staff-Elect.

8.A.2. Qualifications of Officers, Department Chairpersons and Committee Chairpersons:

Except as otherwise provided, only those members of the Active Staff who satisfy the following criteria shall be eligible to serve as officers of the Medical Staff, department chairpersons and/or committee chairpersons:

(a) are appointed in good standing to the Active Staff, have served on the Active Staff for at least two (2) years, and continue to be in good standing during their term of office;

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

(c) have demonstrated interest in maintaining quality medical care at the Medical Center;

(d) are certified by the appropriate specialty or subspecialty board of practice as defined in Article 1.A.2. This requirement may be waived by the Medical Executive Committee upon a determination that the individual possesses comparable competence affirmatively established through the credentialing process.

(e) possess the time to devote to the duties and responsibilities of the position;

(f) are willing to faithfully discharge the duties and responsibilities of the position to which they are elected or appointed;

(g) have actively served on at least two (2) committees of the Medical Staff;

(h) possess and have demonstrated an ability for harmonious interpersonal relationships;

(i) have constructively participated in medical staff affairs, including peer review activities;

(j) are knowledgeable concerning the duties of the office;

(k) possess written and oral communication skills; and

(l) Provide a completed conflict of interest statement disclosing employment, other contractual arrangements with other health care entities, payer organizations, business interests or compensations arrangements that might influence the judgment or create potential conflicts on medical staff issues raised to the medical staff leader for a decision or recommendation.

8.A.3. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with the Chief Executive Officer and the Chief Medical Officer in matters of mutual concern involving the Medical Center;

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

(c) make recommendations for the appointment of committee chairpersons and appoint all committee members (except members of the Medical Executive Committee) to standing and special medical staff committees in accordance with these bylaws;

(d) serve as Chairperson of the Medical Executive Committee;

(e) serve as an *ex officio* member, without vote, on all medical staff committees (except the Medical Executive Committee);

(f) report to the Board monthly to represent the views, policies, needs, and grievances of the Medical Staff;

(g) serve as a liaison on medical matters to the Board and Chief Medical Officer;

(h) receive and interpret the policies of the Board to the Medical Staff;

(i) report to the Board on the performance and maintenance of the Medical Staff in providing quality medical care; and

(j) work in conjunction with the department chairpersons to meet the requirements for accreditation and report accreditation status to the Medical Executive Committee, the Medical Staff, and the Board.

8.A.4. Chief of Staff-Elect:

The Chief of Staff-Elect of the Medical Staff shall:

(a) assume all the duties and have the authority of the Chief of Staff in the event the Chief of Staff becomes temporarily unable to perform his/her duties due to illness, absence from the community, or for any other reason;

(b) serve on the Medical Executive Committee;

(c) automatically succeed the Chief of Staff; and

(d) perform such duties as are assigned by the Chief of Staff.

8.B. NOMINATION AND ELECTION PROCESS

8.B.1. Election of Officers:

(a) The Chief of Staff shall appoint a nominating committee of four (4) individuals with three prior Chiefs of Staff and one member of the Medical Executive Committee. Any unavailable prior Chief of Staff shall be replaced by another member of the Medical Executive Committee to reach the required number of four (4) members. The Nominating Committee shall prepare a slate of nominees for each available office and for each at-large seat on the Medical Executive Committee to be filled at the upcoming election. In preparation of the slate of nominees, the Nominating Committee shall take care to ensure that all nominees meet the qualifications set forth in Section 8.A.2. The Nominating Committee shall also contact all nominees regarding their willingness to serve.

(b) The Medical Staff Office shall provide notification to the Medical Staff of the nominees at least four (4) weeks prior to the annual election.

(c) No later than two (2) weeks prior to the election, any member of the Active Staff may submit to the Nominating Committee the name of a qualified member of the Medical Staff for inclusion as a candidate on the ballot. The Nominating Committee shall review the qualifications of the proposed candidate and if the candidate satisfies the qualifications for office, as set forth in Section 8.A.2 of these bylaws, the Medical Staff Office shall provide notice to all Active Staff members of the additional nominee. Nominations may also be made from any member of the Active Staff at the time of election. The proposed candidate must satisfy the qualifications for office, as set forth in section 8.A.2 of these bylaws.

(d) The election of officers and at-large members of the Medical Executive Committee shall take place at the last medical staff meeting of the year. The candidate who receives a majority of the votes of those members of the Active Staff present at the meeting and eligible to vote shall be elected. The vote shall be by written secret ballot or by voice vote.

(e) In any election, if there are three or more candidates for office and no candidate receives a majority vote, there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

(f) The election of each officer and at large member of the Medical Executive Committee shall become effective upon notification to the Board.

8.B.2. Term of Office:

All officers shall take office on the first day of the calendar year and shall serve a term of two years.

8.B.3. Vacancies in Office:

A vacancy in the office of the Chief of Staff-Elect, during the medical staff year, shall be filled by the Medical Executive Committee, provided, however, that the appointed replacement shall not automatically succeed the Chief of Staff. Rather, the Chief of Staff for the following medical staff year shall be elected pursuant to the nomination and election process set forth in Section 8.B.1. If there is a vacancy in the office of the Chief of Staff, the Chief of Staff-Elect shall serve the remainder of the term.

8.B.4. Removal from Office:

(a) Removal of an elected officer may be recommended by the Board or initiated by the Medical Executive Committee. In either case, it will require an approval of two-thirds vote of the Medical Executive Committee. Grounds for removal include:

  (1) removal or suspension from the Active Staff or failure to be reappointed to the Medical Staff;

  (2) failure to comply with the policies, bylaws, or rules and regulations of the Medical Center or the Medical Staff;

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

  (4) exhibiting conduct detrimental to the interests of the Medical Center and/or the Medical Staff; or

  (5) suffering from an infirmity that renders the individual incapable of fulfilling the duties of that office.

(b) Prior to the initiation of any removal action, the individual in question must be provided with notice of the date of the meeting at which such action will be undertaken. The notice must be in writing and must be given at least ten (10) days prior to the meeting. The officer shall be afforded an opportunity to speak to the Medical Executive Committee prior to the vote on removal.

(c) Removal proceedings undertaken by the Medical Executive Committee shall be effective when notification is provided to the Board.

ARTICLE 9
MEETINGS

9.A. MEETINGS OF THE MEDICAL STAFF

9.A.1. Annual Meeting:

The annual meeting of the Medical Staff shall be held each year in the month of November. Officers shall be elected at this meeting.

9.A.2. Special Staff Meetings:

(a) A special meeting of the Medical Staff may be called at any time by the Board, the Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, a majority of the Medical Executive Committee, or a petition signed by at least seventy-five (75) members of the Active Staff or one third of the active staff, whichever is greater.

(b) At any special meeting, no business shall be transacted except that stated in the notice calling the meeting.

9.A.3. Voting by Mail Ballot

Any action that can be taken by the Medical Staff at a meeting may be taken by mail ballot if the Medical Executive Committee so directs. Such ballot must (1) state the date by which it must be received by the Chief of Staff in order to be counted ("Vote Date"), and (2) describe the proposed action to be taken. The ballot must be mailed to each Active Medical Staff member not later than two (2) weeks before the Vote Date. To be effective a majority of the Active Medical Staff members must vote on the matter and it must receive the affirmative vote of a majority of votes cast (or such greater majority as may be required for such matter by provisions of these Bylaws). Each member must maintain a current email address on file in the Medical Staff Office to allow notification of the availability and location of relevant material.

9.B. DEPARTMENT AND COMMITTEE MEETINGS

9.B.1. Department Meetings:

(a) Each department shall meet at least quarterly, at a time set by the chairperson. At such meetings, the department shall review and evaluate the clinical work of the department, consider the findings of ongoing quality improvement and monitoring and evaluation activities, and discuss any other matters concerning the department.

(b) Each department shall maintain a record of its findings, proceedings, and actions. Departments shall make a report thereof, after each meeting to the Medical Executive Committee and the Chief Medical Officer.

9.B.2. Committee Meetings:

(a) Committees shall meet as set forth in these bylaws at a time set by the chairperson of the committee.

(b) Each committee shall maintain a permanent record of its findings, proceedings, and actions, and shall make a report thereof. Committees shall submit their reports to the Medical Executive Committee and the Chief Medical Officer.

9.B.3. Special Department and Committee Meetings:

A special meeting of any department of committee may be called by or at the request of the appropriate chairperson, the Chief of Staff, or by a petition signed by not less than one-third of the Active Staff members of the department or committee, but not by fewer than two such members.

9.B.4. Voting by Mail Ballot

Any action that can be taken by a department or committee at a meeting may be taken by mail ballot if the chairperson of the department or committee so directs. Such ballot must (1) state the date by which it must be received by the Chairperson in order to be counted ("Vote Date"), and (2) describe the proposed action to be taken. The ballot must be mailed to each Active Medical Staff member not later than two (2) weeks before the Vote Date. To be effective a majority of the Active Medical Staff members must vote on the matter and it must receive the affirmative vote of a majority of votes cast (or such greater majority as may be required for such matter by provisions of these Bylaws).

9.C. PROVISIONS COMMON TO ALL MEETINGS

9.C.1. Notice of Meetings:

(a) Notice of all department, and committee meetings shall be emailed to the members and posted on the Medical Affairs website at least one week in advance of the meeting. The notice shall state the date, time, and place of the meeting.

(b) Notice of meetings of the Medical Staff shall be emailed to members and posted on the Medical Affairs website at least 30 days in advance of the meeting. The notice shall state the date, time, and place of the meeting.

(c) The attendance of any medical staff member at any meeting shall constitute a waiver of that member's notice of said meeting.

9.C.2. Quorum:

(a) For any special meeting or annual meeting of the Medical Staff, those present shall constitute a quorum provided at least fifty (50) members are present. For any regular or special meeting of a department or committee, those present shall constitute a quorum provided at least the Chair or Vice Chair and 25% of all eligible members are present. At meetings of the Medical Executive Committee, Credentials Committee, and AHP Committee, the presence of two-thirds of the persons eligible to vote shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even if less than a quorum exists at a later time in the meeting.

9.C.3. Attendance Requirements:

Members of the Active Staff are expected to attend all meetings of the Medical Staff and relevant department and committee meetings. However, whether or not they attend, Active staff members are required to maintain current knowledge of all actions taken and matters discussed at each Medical Staff meeting and each relevant department and committee meeting, either by attending the meeting, reviewing the minutes of the meeting, or reviewing the materials of the meeting sent via email or posted on the Medical Staff website. Committee members are expected to attend 75% of committee meetings. Failure to meet this minimum attendance requirement may result in removal of that committee member. Any such vacancy may be filled at the discretion of the Committee Chair, in consultation with the Chief of Staff.

9.C.4. Agenda:

(a) The Chief of Staff shall set the agenda for the medical staff meetings.

(b) Department and committee chairpersons shall set the agenda for regular and special meetings of their respective departments and committees.

9.C.5. Minutes:

(a) Minutes of all medical staff, department and committee meetings shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) Copies of the medical staff meeting minutes shall be forwarded to the Chief Medical Officer.

(c) Copies of all department and committee minutes shall be forwarded to the Medical Executive Committee and the Chief Medical Officer.

(d) A permanent file of the minutes of all medical staff, department and committee meeting shall be maintained by the Medical Center.

9.C.6. Rules of Order:

Wherever they do not conflict with these bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

9.C.7. Voting:

(a) Medical staff members shall constitute the voting members of department meetings and medical staff committees. Department and Committee Chairs shall have voting rights. ADPs and DPs appointed as members to the AHP Committee shall have voting rights within the AHP Committee.

(b) The Chief of Staff and the Chief Medical Officer shall be ex-officio members, without vote, on all medical staff committees, except that the Chief of Staff shall be a voting member of the Medical Executive Committee.

(c) Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

ARTICLE 10
DEPARTMENTS

10.A. MEDICAL STAFF CLINICAL DEPARTMENTS

10.A.1. Organization of Departments:

Each department shall be organized as a clinical unit and shall have a chairperson who is elected and who has the authority, duties, and responsibilities as set forth in these bylaws. The following clinical departments are established. Additional departments or divisions, as required from time to time, may be established by the Board after considering recommendations from the Medical Executive Committee. For purposes of these bylaws, a "department" shall mean a major organizational unit of the Medical Staff charged with the administrative responsibility for quality review and performance improvement of care provided within a specific specialty. A "division" is a subordinate administrative unit within a department. These Departments and Divisions establish their own procedural rules and regulations in accordance with the Medical Staff Bylaws.

- DEPARTMENT OF ANESTHESIOLOGY
- DEPARTMENT OF EMERGENCY MEDICINE
- DEPARTMENT OF FAMILY MEDICINE
- DEPARTMENT OF MEDICINE, including the Divisions of:
  - Cardiology
  - Dermatology
  - Gastroenterology
  - Hematology/Oncology
  - Internal Medicine
  - Nephrology
  - Neurology
  - Pulmonary Medicine
- DEPARTMENT OF OBSTETRICS/GYNECOLOGY
- DEPARTMENT OF PATHOLOGY
- DEPARTMENT OF PEDIATRICS
- DEPARTMENT OF PSYCHIATRY
- DEPARTMENT OF RADIOLOGY
- DEPARTMENT OF SURGERY, including the Divisions of:
  - Dentistry
  - General Surgery
  - Hand Surgery
  - Neurosurgery

Orthopaedic Surgery
Ophthalmology
Otolaryngology – Head & Neck Surgery
Pediatric Surgery
Plastic Surgery
Podiatric Surgery
Thoracic Surgery
Urology

10.A.2. Creation and Dissolution of Departments:

(a) Departments shall be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

(b) The following factors shall be considered in determining whether a department should be created or maintained:

(1) there exists a number of medical staff appointees who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in these bylaws); and

(2) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis.

(c) The following factors shall be considered in determining whether the dissolution of a department is warranted:

(1) there is no longer an adequate number of medical staff appointees in the department to enable it to accomplish the functions set forth in these bylaws;

(2) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the appointees in the department;

(3) the department fails to fulfill all designated responsibilities and functions, including its meeting requirements;

(4) no qualified individual is willing to serve as chairperson of the department; or

(5) a majority of the Active Staff members of the department vote for the dissolution of the department.

10.A.3. Assignment to Medical Staff Clinical Departments:

(a) Upon initial appointment to the Medical Staff, each appointee shall be assigned to a department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.

(b) An individual may request a change in his or her department assignment to reflect a change in the individual's clinical practice.

10.A.4. Functions of Departments:

Ongoing and Focused Peer Review Standards: Each department determines, on a continuing basis, the type of patient care data to collect for use in ongoing professional practice evaluation, and the criteria to be used for focused peer review of a member or other practitioner's services provided under privileges held in the department, whenever quality patient care issues are identified. The Medical Executive Committee is responsible for consistent use of criteria in peer review. The results of ongoing and focused peer review are the bases for decisions regarding membership and privileges.

(a) Each department shall monitor and evaluate medical care in all major clinical activities of the department on a retrospective, concurrent and prospective basis. This monitoring and evaluation must include at least the following:

  (1) identification and collection of information about important aspects of patient care provided in the department;

  (2) identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and

  (3) periodic assessment of patient care information to evaluate the quality and appropriateness of care, to identify opportunities to improve care, and to identify important problems in patient care.

  (4) compliance with these Bylaws and the Rules and Regulations of the Medical Staff.

(b) When important problems in patient care and clinical performance or opportunities to improve care are identified, each department shall document the actions taken and evaluate the effectiveness of such actions.

(c) Each relevant department shall also conduct a comprehensive review to examine justification of surgery performed, whether tissue was removed or not, and to evaluate the acceptability of the procedure chosen for the surgery, unless this review is performed by a committee. Specific consideration shall be given to the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses. Written reports shall be maintained reflecting the

results of all evaluations performed and actions taken. In discharging these functions, each department shall report to the appropriate utilization and/or quality management committee detailing its analysis of patient care and to the Credentials Committee whenever further investigation and action is indicated involving any individual member of the department.

(d) Each department shall recommend, subject to the approval of and adoption by the Medical Executive Committee and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or by the Medical Center's quality assessment program to monitor and evaluate patient care.

10.A.5. Optional Divisions:

(a) Any group of physicians who practice in the same or similar areas and who wish to have a forum for discussion of those clinical areas may organize into a division. Any division, if organized, will not be required to hold any number of regularly scheduled meetings.

(b) Divisions may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs;

(4) development of recommendations for the department chairperson or Medical Executive Committee;

(5) participation in the development of criteria for clinical privileges (when requested by the department chairperson); and

(6) discussion of a specific issue at the special request of a department chairperson or the Medical Executive Committee.

(c) Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of divisions. Only when divisions are making formal recommendations to a department will a report be required.

10.B. DEPARTMENT CHAIRPERSONS

10.B.1. Selection and Service of Department Chairpersons:

(a) The chairperson of each department shall be a member of the Active Staff who shall possess the qualifications set forth in Section 8.A.2 of these bylaws.

(b) The members of the department shall elect a chairperson. The person elected by the department shall assume the position upon notification to the Board.

(c) Department chairpersons shall serve a two-year term of office.

(d) Removal of a department chairperson during a term of office may be initiated by a two-thirds vote of the Active Staff members in the department or by a two-thirds vote of the Medical Executive Committee, and shall be reported to the Board.

10.B.2. Roles and Responsibilities of Department Chairpersons:

Each department chairperson shall:

(a) be responsible for all clinical and administrative activities within the department;

(b) be a member of the Medical Executive Committee;

(c) monitor and evaluate the quality and appropriateness of patient care provided within the department;

(d) be responsible for enforcement within the department of the Medical Staff bylaws and rules and regulations;

(e) be responsible for the development and implementation of policies and procedures that guide and support the provision of services within the department, including the continuous assessment and improvement of the quality of care and services provided and, as appropriate, maintenance of quality control programs;

(f) prepare a report for the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all individuals seeking privileges in the department, including interviewing all such individuals, if necessary;

(g) recommend a sufficient number of qualified and competent individuals to provide care/clinical services;

(h) be responsible for implementation, within the department, of actions taken by the Board and the Medical Executive Committee;

(i) assist the Medical Center, in accordance with the provisions of these bylaws, with respect to the granting of locum tenens privileges within the department, and with the evaluation of requests for temporary privileges;

(j) monitor the professional performance of all individuals who have delineated clinical privileges in the department, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated, except that the credentials and performance of the department chairperson shall be monitored by the associate chairperson, if one exists, or by the Credentials Committee if there is no associate chairperson;

(k) recommend to the Credentials Committee criteria for clinical privileges in the department;

(l) make recommendations regarding the qualifications and competence of all individuals who are not licensed practitioners and who provide patient care within the department;

(m) be responsible for the coordination and integration of interdepartmental and intradepartmental services;

(n) appoint ad hoc committees or working groups, as necessary, to carry out performance improvement activities;

(o) be responsible for the establishment, implementation, and effectiveness of the orientation, teaching, education, and research programs in the department;

(p) report and recommend to the Chief Medical Officer, when necessary, with respect to matters affecting patient care in the department, including personnel, supplies, space, special regulations, standing orders, and techniques;

(q) assist the Chief Medical Officer in the preparation of annual reports and such budget planning pertaining to the department as may be required;

(r) assess and recommend to the Medical Center off-site sources for needed patient care services not provided within the department;

(s) be responsible for the integration of the department into the primary functions of the Medical Center;

(t) delegate to an associate chairperson such duties as appropriate, including the review of applications for appointment, reappointment, or clinical privileges or questions that may arise if the chairperson has a conflict of interest with the individual under review; and

(u) provide continuous assessment and improvement of the quality of care, treatment, and services;

(v) maintain quality control programs, as appropriate; and

(w) perform any other functions required by The Joint Commission or any other regulatory agency;

ARTICLE 11
COMMITTEES

11.A. MEDICAL STAFF COMMITTEES

This article outlines those medical staff committees responsible for performance improvement, quality assessment, peer review and other review functions delegated to the Medical Staff by the Board. Each committee established pursuant to these bylaws or otherwise appointed by the Chief of Staff is formed, in whole or in part, to review, evaluate or make recommendations regarding the professional services furnished by the Medical Center, the necessity for such services, the adequacy or quality of such professional services, or the competency and qualifications of persons performing or seeking to perform such services. In such capacity, each committee is acting as a professional review organization or peer review committee as contemplated under Georgia law. Each committee may, when appropriate, also delegate a responsibility to a committee member or a subcommittee to perform on behalf of the committee. The following committees are established:

MEDICAL EXECUTIVE COMMITTEE (MEC)
CREDENTIALS COMMITTEE
PROFESSIONAL PRACTICE EVALUATION COMMITTEE (PPEC)
CRITICAL CARE COMMITTEE
PHARMACY AND THERAPEUTICS COMMITTEE
UTILIZATION MANAGEMENT COMMITTEE (UM)
ONCOLOGY SERVICE COMMITTEE
ALLIED HEALTH PROFESSIONAL COMMITTEE (AHP)
HEALTH INFORMATION TECHNOLOGY COMMITTEE (HIT)
BYLAWS COMMITTEE

11.B. MEDICAL EXECUTIVE COMMITTEE

11.B.1. Composition:

(a) The Chief of Staff shall be Chairperson of the Medical Executive Committee.

(b) The Medical Executive Committee shall consist of the officers of the Medical Staff and the Department Chairs. Each department shall be entitled to one (1) additional representative per 60 active staff members, who shall be elected by the individual departments and serve a two (2) year term. In addition, one at-

large member from the full-time salaried faculty shall be nominated by the nominating committee and elected by the Medical Staff.

(c) The Chairperson of the Credentials Committee, the Chief Medical Officer, the Chief Quality Officer, the Chief Academic Officer, the Chief Medical Information Officer, the Chief Executive Officer or his/her designee and the Medical Director of Urgent Care shall be members, *ex officio*, without vote.

(d) Board members may attend meetings of the Medical Executive Committee and participate in its discussions, but without vote.

11.B.2. Duties:

(a) The Medical Staff delegates to the Medical Executive Committee the following duties and functions to be exercised on behalf of the Medical Staff. Notwithstanding this delegation the Medical Staff retains the authority to perform any of the delegated duties and functions directly, in accordance with the procedures set forth in Section (d) below:

(1) represent and act on behalf of the Medical Staff, subject to such limitations imposed by these bylaws;

(2) coordinate the activities and general policies of the various departments;

(3) receive and act upon reports and recommendations from committees and departments and other assigned activity group reports as specified in these bylaws, and make recommendations concerning them to the Chief Medical Officer and the Board;

(4) implement policies of the Medical Staff not otherwise the responsibility of the departments;

(5) provide liaison among the Medical Staff, the Chief Executive Officer, the Chief Medical Officer and the Board;

(6) ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Medical Center;

(7) enforce Medical Staff rules in the best interests of patient care and of the Medical Center with regard to all persons who hold appointment to the Medical Staff;

(8) review, at least yearly, the bylaws, policies, rules and regulations, and associated documents of the Medical Staff and recommend such changes as may be necessary or desirable for Board approval. This review will include, but not be limited to, the mechanisms designed to evaluate the credentials and delineate the clinical privileges of applicants

and appointees, to terminate appointment and clinical privileges, and if appropriate, to provide a fair hearing;

(9) be accountable to the Board for the medical care of patients admitted to or receiving treatment at the Medical Center;

(10) take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;

(11) perform such other functions as are necessary for the effective operation of the Medical Staff;

(12) report at the Medical Staff meetings;

(13) determine minimum continuing education requirements for Medical Staff members;

(b) The Medical Executive Committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on the following:

(1) Medical Staff membership

(2) Recommendations for medical staff termination;

(3) The organized medical staff structure;

(4) The process used to review credentials and delineate privileges;

(5) The delineation of privileges for each practitioner privileged through the medical staff process;

(6) Medical Executive Committee reviews and acts on reports from medical staff committees, departments, and other assigned activity groups.

(c) The Medical Executive Committee shall perform the following quality assurance/ performance improvement functions:

(1) coordinate the quality review and performance improvement activities of all medical staff clinical departments;

(2) review reports of designated committees to ensure that prospective and retrospective studies are appropriately integrated into the Medical Center's quality assurance/performance improvement program;

(3) assign responsibilities to medical staff clinical departments, committees, multidisciplinary subcommittees, ad hoc committees, and/or individuals to identify and make recommendations concerning the resolution of patient care problems and problems of institutional waste and duplication, and refer questionable patterns of care to the appropriate professional review body for further consideration and action;

(4) review QIO citations and quality denial letters received by medical staff appointees and Medical Center management regarding documentation to evidence appropriate care and follow-up regarding quality of care issues raised by the state reviewing body;

(5) document the effectiveness of the overall quality assurance/performance improvement program as it pertains to the Medical Staff; and

(6) ensure the integration of risk management findings into ongoing quality assurance and performance improvement processes at the Medical Center.

(d) The Medical Staff may, at a special meeting called by petition of the active staff pursuant to section 9.A.2 (a) and (b) at which 50% of the voting members of the staff are present, exercise any duty, perform any function and/or make any recommendation within the scope of the Medical Staff's retained authority pursuant to Section 11.D.2, above, upon the vote of two thirds (2/3) of the voting members. The Medical Staff may take such action notwithstanding any action taken, or recommendation made, by the Medical Executive Committee on the same subject matter. The action or recommendation of the Medical Staff pursuant to this provision is the definitive determination of the Medical Staff on the matter. At such meeting the Medical Staff may designate, by majority vote, a member or members to present the Medical Staff recommendation to the Board.

11.B.3. Meetings:

(a) The Medical Executive Committee shall meet monthly or more often if deemed necessary by the Chief of Staff to fulfill its responsibilities;

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions and shall include the reports and minutes of the various committees and departments;

(c) Recommendations of the Medical Executive Committee shall be transmitted to the Board through the Chief of Staff or his/her designee;

(d) The Chief of Staff shall be available to meet with the Board on all recommendations that the Committee shall make.

11.C. CREDENTIALS COMMITTEE

11.C.1. Composition:

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve a five (5) year term;

(b) The Credentials Committee shall consist of at least 10 members of the Active Staff selected by the Chief of Staff, in consultation with the Committee Chair, based on each member's commitment to credentialing and performance improvement and quality assessment activities. Members of the Credentials Committee shall serve for an initial term of three (3) years and may be reappointed for two (2) additional terms.

(c) Service on this Committee shall be considered as the primary medical staff obligation of each member of the Committee, and other medical staff duties shall not interfere.

(d) All new members of this Committee, either prior to beginning to serve on the committee or while serving on the Committee, will be provided specific education and training regarding the credentialing process by a process approved by the Credentials Committee.

11.C.2. DUTIES:

The duties of the Credentials Committee shall be to:

(a) review the credentials of all applicants for medical staff appointment, reappointment, and clinical privileges, prepare a written report of its findings and recommendations, and forward the same to the Medical Executive Committee;

(b) make recommendations regarding the duration and terms of each individual's appointment and reappointment;

(c) review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations and forward the same to the Medical Executive Committee; and

(d) make recommendations regarding whether new procedures or services should be offered to patients and, upon Board request, investigate the new procedure and recommend a delineation of criteria for clinical privileges.

11.C.3. Meetings, Reports and Recommendations:

(a) The Credentials Committee shall meet monthly or more often if deemed necessary by the Chair to fulfill its responsibilities;

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions;

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee;

(d) The Chairperson of the Credentials Committee shall be available, if requested, to meet with the Medical Executive Committee and/or the Board on all recommendations that the Credentials Committee shall make.

11.D. PROFESSIONAL PRACTICE EVALUATION COMMITTEE

11.D.1. Composition:

(a) The Professional Practice Evaluation Committee PPEC Chairperson shall be appointed by the MEC with nonbinding recommendations from the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve a five (5) year term;

(b) The PPEC shall consist of at least 12 members of the Active Staff. Committee membership shall be recommended by the Chief of Staff, in consultation with the PPEC Chairperson. All members of this committee shall be approved by the Medical Executive Committee.

(c) Members of the PPEC shall serve for an initial term of three (3) years and may be reappointed for two (2) additional terms; Membership of the committee shall consist of, at minimum, representatives of the following departments: three (3) Medicine , three (3) Surgery, one (1) Family Medicine, one (1) Obstetrics & Gynecology, one (1) Pediatrics, one (1) Emergency Medicine, one (1) Radiology, and one (1) Anesthesiology.

(d) Ex-officio members of this Committee without vote shall include the Chief of Staff-Elect, Chief Medical Officer, and Credentials Committee Chairperson;

(e) Additional ad hoc members of this committee shall be appointed by the PPEC chairperson in order to represent Advanced Dependent Practitioners as needed. Such ad hoc membership may include the Chief Nursing Officer or designee, an Advanced Practice Nurse, and/or a Physician Assistant for appropriate peer representation. These ad hoc members shall have full voting rights only when voting on credentialed providers of own like specialty and degree and are not present when physician matters are discussed.

(f) Service on this committee shall be considered as the primary medical staff committee obligation of each member, and other medical staff duties shall not interfere. Members of the committee may not serve as a voting member of the Credentials Committee or the Medical Executive Committee;

11.D.2. Duties:

The MEC delegates authority to the PPEC to propose and revise those Medical Staff policies necessary to implement the Professional Practice Evaluation process. Such Medical Staff policies will be posted for review in accordance with Article 15 and approved by the MEC and Board.

The duties of the Professional Practice Evaluation Committee (PPEC) shall be:

(a) Oversight of professional practice evaluation and appraisal of outcomes data of all providers credentialed through the Medical Staff model; such oversight and monitoring is inclusive of individual provider performance and medical staff department/service line performance;

(b) Oversight of the Professional Practice Evaluation and Performance Improvement Policies for the Medical Staff, such as the Focused Professional Practice Evaluation (FPPE) process and the Ongoing Professional Practice Evaluation (OPPE) process. Makes recommendations to the Medical Executive Committee regarding revisions or modifications to such policies as may be necessary;

(c) Development and oversight of provider peer review processes include review of aggregate data, quality referrals, sentinel events, and/or variations in practice patterns from objective criteria in the following: mortalities, clinical pertinence, focused clinical studies, credentialed provider related occurrences or concerns , infection prevention, core measure compliance, safety/risk management concerns, policy compliance, documentation issues, behavior issues, or other identified quality concerns. Makes recommendations to the appropriate Medical Staff Departments or Committees;

(d) Oversight of Focused Professional Practice Evaluation (FPPE) process to include review of provider FPPE outcomes and make recommendations to the Credentials Committee and Medical Executive Committee as appropriate;

(e) Oversight of Ongoing Professional Practice Evaluation (OPPE) process to include review and approval of specialty-specific performance metrics for OPPE proposed by medical staff departments or subspecialty divisions. Review OPPE metrics outcomes and make recommendations to Credentials Committee and Medical Executive Committee as appropriate;

(f) The PPEC has the authority to conduct the following business in collaboration with the Department Chairperson: report peer review findings; provide information/educational letters; recommend and participate as appropriate in collegial interventions with the Department Chairperson or his/her designee; require completion of targeted CME; require specific CME presentation by practitioner; initiate FPPE. Such activities do not involve limitations of provider privileges, and therefore, are not appealable pursuant to Article 6.A.2. of these bylaws or otherwise. The initiation of these activities will be reported to the Credentials Committee and Medical Executive Committee at their monthly meetings;

(g) The PPEC may recommend but does not have the authority to initiate performance improvement plans that would involve limitation of provider privileges;

(h) Make recommendations for approval and/or development of performance improvement plans for medical staff departments as performance issues are identified. Make recommendations for approval of such plans to the Medical Executive Committee, as well as monitor plans as appropriate as delegated by the Medical Executive Committee;

(i) Oversight and review of patient care outcomes data related to provider performance as reported by various MCCG registries or service line quality committees. Make performance improvement recommendations as appropriate to Credentials Committee and Medical Executive Committee;

(j) Review of moderate and deep sedation outcomes by credentialed non-anesthesia providers as monitored by the Anesthesiology Department. Consider recommendations for performance improvement as advised by Anesthesiology Department.

(k) Work closely with organizational multidisciplinary quality committees to ensure protocols and evidence based practice are followed by credentialed providers. Review referrals and make performance improvement recommendations as appropriate.

11.D.3. Meetings, Reports, and Recommendations:

(a) The PPEC shall meet monthly or more often if deemed necessary by the Chairperson to fulfill its responsibilities;

(b) The Committee shall maintain a permanent record of its findings, proceedings, and actions;

(c) The Committee shall make a written report of its outcome appraisals and recommendations after each meeting to the Credentials Committee and the Medical Executive Committee;

(d) The Chairperson of the PPEC shall be available, if requested, to meet with the Credentials Committee and Medical Executive Committee and/or Board on all recommendations the Committee shall make;

(e) The Chairperson of the PPEC will serve as an ex-officio member without vote on Credentials Committee and Medical Executive Committee ;

11.D.4. Peer Review Process:

Any subject of a peer review finding may request a second internal peer review within two weeks of notification to the provider of the peer review report and PPEC recommendations.

11.E. CRITICAL CARE COMMITTEE

11.E.1. Composition:

(a) The Medical Director of Critical Care shall serve as the Committee Chair.

(b) The Critical Care Committee shall consist of at least six (6) Active medical staff members representing each specialty within Adult Critical Care. The medical staff members shall be appointed by the Chief of Staff, in consultation with the Committee Chair, and shall serve an initial two (2) year term. Members may be reappointed for one (1) additional term.

(c) The Infection Control Nurse and at least one (1) representative each from Nursing Service and Administration shall serve as ex-officio members without vote.

11.E.2. Duties:

The Critical Care Committee shall perform the following duties:

(a) monitor and evaluate the quality and appropriateness of patient care as it relates to all major clinical functions in the critical care units of the Medical Center;

(b) be responsible for the formulation, review and implementation of the policies for the critical care units of the Medical Center;

(c) review and make recommendations regarding procedures and equipment in the critical care units; and

(d) formulate rules regulating admission to and discharge from the critical care units to ensure optimal utilization of these specialized areas and monitor and adjudicate questions regarding the utilization of critical care beds;

11.E.3. Meetings, Reports and Recommendations:

(a) The Critical Care Committee shall meet quarterly or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its findings, proceedings, and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee and the Chief Medical Officer.

(d) The Critical Care Committee shall also report (with or without recommendation) to the Credentials Committee and/or the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Center or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the medical staff. The Chair shall be available, if requested, to meet with the Credentials Committee, the Medical Executive Committee and/or the Board on all recommendations that the Critical Care Committee shall make.

11.F. PHARMACY AND THERAPEUTICS COMMITTEE

11.F.1. Composition:

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve an initial two (2) year term. After serving an initial term, a chairperson may be reappointed by the Chief of Staff for one additional term.

(b) The Pharmacy and Therapeutics Committee shall consist of at least nine (9) medical staff members appointed by the Chief of Staff, in consultation with the Committee Chair, and shall serve an initial two (2) year term. Members may be reappointed for one (1) additional term. Membership shall consist of one (1) representative from the service areas of Pediatrics, OB/GYN, Geriatrics, Anesthesiology, and Oncology two (2) at-large representatives from the Department of Medicine, and two (2) at-large representatives from the Department of Surgery.

(c) The Director of Pharmacy and another Pharmacy representative shall be *ex-officio* members of the Committee without vote. In addition, the Committee will include one representative each from Nursing (the Chief Nursing Officer), Medical Center Administration (Vice President of Professional Services), the Quality Department and Nutritional Services.

11.F.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) review the appropriateness of the prophylactic, empiric and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;

(b) develop and recommend to the Medical Executive Committee policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

(c) define and review all significant untoward drug reactions;

(d) maintain and periodically review the Medical Center formulary or drug list;

(e) review the appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics and anticoagulants in the Medical Center;

(f) recommend drugs to be stocked on the nursing unit floors and by other services;

(g) recommend policies concerning the safe use of drugs in the Medical Center, including new drugs, drug preparations requested for use in the Medical Center, hazardous drugs and investigational drugs; and

(h) monitor guidelines for automatic stop orders for drugs as specified in the rules and regulations of the Medical Staff.

11.F.3. Meetings, Reports and Recommendations:

(a) The Pharmacy and Therapeutics Committee shall meet quarterly or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee.

(d) The Committee shall also report (with or without recommendation) to the Credentials Committee and/or the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Center or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the medical staff. The Chair shall be available, if requested, to meet with the Credentials Committee, the Medical Executive Committee and/or the Board on all recommendations that the Pharmacy and Therapeutics Committee shall make.

11.G. UTILIZATION MANGEMENT (UM) COMMITTEE

11.G.1. Composition

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve an initial two (2) year term of office. After serving an initial term, a chairperson may be reappointed by the Chief of Staff for one additional term.

(b) The UM committee shall consist of at least twelve (12) medical staff members appointed by the Chief of Staff, in consultation with the Committee Chair, and shall serve a two (2) year term. Members may be reappointed for one (1) additional term.

(c) The following hospital department representatives shall serve as ex-officio members without vote: Logistics Hub/Clinical Care Coordination, Patient Registration, Patient Business Administration, and Corporate Compliance.

11.G.2. Duties

The UM Committee shall:

(a) provide oversight of processes related to the appropriate use of resources, settings and services, reimbursement of such services and compliance with State and Federal regulations;

(b) provide consultative services on denial management and appeals processing as well as the issuance of Hospital Issued Notices of Non-Coverage;

(c) review the utilization indicators and any major problems with the safety, adequacy, accuracy and availability of patient health information and make recommendations as needed to the Medical Executive Committee;

(d) educate the medical staff related to utilization management issues;

(e) develop committee operational policies and procedures as necessary to carry out the duties of the committee;

11.G.3. Meetings, Reports And Recommendations

(a) The Committee shall meet quarterly or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The UM Committee may choose to form an ad-hoc committee incorporating other physicians or staff as necessary to evaluate and correct any identified utilization issue. Any identified utilization issue may be referred to the most appropriate committee or department responsible for the related issue along with recommendations for improvement or resolution of the issue.

(c) The Committee shall maintain a permanent record of its findings, proceedings and actions.

(d) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee.

(e) The Committee shall also report (with or without recommendation) to the Credentials Committee and/or the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Center or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the medical staff. The Chair shall be available, if requested, to meet with the

Credentials Committee, the Medical Executive Committee and/or the Board on all recommendations that the UM Committee shall make.

11.H. Oncology Service Committee

11.H.1. Composition

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve a two (2) year term of office. After serving an initial term, a chairperson may be reappointed by the Chief of Staff for one additional term.

(b) The Oncology Service Committee shall consist of representative members of the medical staff involved in the treatment of the five major cancer sites (breast, prostate, lung, colorectal, and skin) and other cancer treatment programs. Members shall include medical oncology, surgical oncology, pediatric oncology, radiation oncology, radiology, pathology and primary care. The medical staff members shall be appointed by the Chief of Staff in consultation with the Committee Chair and the Cancer Liaison Physician, and shall serve a two (2) year term. Members may be reappointed for one (1) additional term. The Chief of Staff shall review the cancer program at the hospital in making appointments to the Oncology Service Committee to be sure committee members of the medical staff adequately represent the cancer program.

(c) Other ex-officio members of the committee without vote shall include the cancer registrar, oncology nurse, social worker, performance improvement, hospital administration and others as needed to allow the Oncology Service Committee to provide adequate oversight for the cancer program.

11.H.2. Duties

The Oncology Service Committee shall be responsible for the following duties:

(a) develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;

(b) Promotes a coordinated, multidisciplinary approach to patient management;

(c) Ensures that educational and consultative cancer conferences cover all major cancer sites and related issues;

(d) Ensures that an active supportive care system is in place for patients, families, and staff;

(e) Focuses on quality, access to care and clinical outcomes through performance improvement activities;

(f) Promotes clinical research;

(g) Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting;

(h) Performs quality control of registry data;

(i) Encourages data usage and regular reporting;

(j) Ensures content of the annual report meets reporting requirements;

(k) Publishes the annual report by November 1 of the following year;

11.H.3. Meetings, Reports and Recommendations

(a) The Oncology Service Committee shall meet quarterly or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee.

(d) The Oncology Service Committee shall also report (with or without recommendation) to the Credentials Committee and/or the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Center or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff. The Chair shall be available, if requested, to meet with the Credentials Committee, the Medical Executive Committee and/or the Board on all recommendations that the Oncology Service Committee shall make.

11.I. Allied Health Professional ("AHP") Committee

11.I.1. Composition

(a) The Chief of Staff will appoint a member of the Active Medical Staff to co-chair the committee, who shall serve a five (5) year term. The Chief Nursing Officer or his/her designee will serve as a standing co-chair.

(b) The membership of the AHP Committee shall consist of at least three (3) members of the Active Medical Staff, three (3) ADPs, and two (2) DPs selected by the Chief of Staff, in consultation with the Committee Chair, based on each member's commitment to credentialing and performance improvement and quality assessment activities as they pertain to AHPs. Members of the AHP Committee shall serve for an initial term of three (3) years and may be reappointed for two (2) additional terms.

(c) All new members of this Committee, either prior to beginning to serve on the Committee or while serving on the Committee, will be provided specific education

and training regarding the AHP credentialing process, approved by the AHP Committee.

11.I.2 Duties

The duties of the AHP committee shall be to:

(a) review the credentials of ADP applicants for clinical privileges, and for renewal of clinical privileges, prepare a written report of its findings and recommendations and forward the same to the Credentials Committee;

(b) make recommendations regarding the terms of each ADP's privileges;

(c) review, as questions arise, all information available regarding the clinical competence and behavior of persons currently granted privileges and, as a result of such review, make a written report of its findings and recommendations and forward the same to the Credentials Committee;

(d) review and approve application and scope of practice of Dependent Practitioners;

(e) evaluate the need for a new class of Dependent Practitioner not already approved for practice at the hospital and report findings and recommendations to the Medical Executive Committee;

(f) be responsible for the formulation, review and implementation of the policies for AHPs in the Medical Center.

11.I.3. Meetings, Reports and Recommendations:

(a) The AHP Committee shall meet monthly or more often if deemed necessary by the Co-Chairs to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its proceedings and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Credentials Committee.

(d) The Co-Chairs of the AHP Committee shall be available, if requested, to meet with the Credentials Committee, the Medical Executive Committee and/or the Board on all recommendations that the AHP Committee shall make.

11.J. HEALTH INFORMATION TECHNOLOGY (HIT) COMMITTEE

11.J.1. Composition

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve a two (2) year term of office. After serving an initial term, a chairperson may request to be reappointed by the Chief of Staff for one additional term.

(b) The Health Information Technology Committee shall consist of at least twelve (12) medical staff members appointed by the Chief of Staff in consultation with the Committee Chair. Membership shall consist of one (1) representative from the service areas of Pediatrics, OB/GYN, Family Medicine, Anesthesiology, General Surgery and Emergency Medicine, two (2) general internists from the Department of Medicine, two (2) subspecialty representatives from the Department of Medicine, and two (2) subspecialty representatives from the Department of Surgery. The medical staff members shall be appointed by the Chief of Staff in consultation with the Committee Chair, and shall serve a two (2) year term. Members may request to be reappointed for one (1) additional term.

(c) The Chief Medical Information Officer, Medical Information Officer(s), and Chief Information Officer shall be ex-officio members of the committee.

11.J.2. Duties

The Health Information Technology Committee shall:

(a) Provide medical staff input on the development of the Electronic Medical Record (EMR) to include, but not limited to:

- (1) physician adoption plan;
- (2) designating physician champions;
- (3) setting metrics and goals;
- (4) order sets;
  - i. rules and alerts;
  - ii. order sentence building
- (5) device strategy;
- (6) domain strategy;
- (7) security and remote access strategy;
- (8) downtime procedures;
- (9) physician communication plan;
- (10) physician training plan;
- (11) participation in testing;
- (12) go-live support;
- (13) system improvements.

(b) Make recommendations on policies to support medical staff use of Information Technology, and specifically Computerized Physician Order Entry (CPOE), that would necessitate changes to hospital policies, Medical Staff Bylaws, and Rules and Regulations.

(c) Provide oversight of policies and processes related to the safe documentation, computerization, storage and release of patient health information;

(d) Review for any major problems with the safety, adequacy, accuracy and availability of patient health information and make recommendations to the Medical Executive Committee;

(e) Educate the medical staff related to health information management issues.

11.J.3. Meetings, Reports and Recommendations

(a) The Health Information Technology Committee shall meet quarterly or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee.

(d) The Health Information Technology Committee shall also report (with or without recommendation) to the Credentials Committee for any situation in regard to information technology that involves professional ethics, infraction of Medical Center or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff. The Chair shall be available, if requested, to meet with the Credentials Committee, the Executive Committee and/or the Board on all recommendations that the Health Information Technology Committee shall make.

11.K. BYLAWS COMMITTEE

11.K.1. Composition

(a) The Committee Chair shall be appointed by the Chief of Staff, in consultation with the Chief Medical Officer, and shall serve a two (2) year term of office. After serving an initial term, a chairperson may be reappointed by the Chief of Staff for one additional term.

(b) The Bylaws Committee shall consist of at least four (4) additional representative members of the medical staff. The medical staff members shall be appointed by the Chief of Staff in consultation with the Committee Chair and shall serve a two (2) year term. Members may be reappointed for one (1) additional term.

(c) Other ex-officio members of the committee without vote shall include hospital and medical staff legal counsel.

11.K.2. Duties

The Bylaws Committee shall be responsible for the following duties:

(a) Conducts an annual review of the Medical Staff Bylaws, as well as the Rules and Regulations;

(b) Receives and evaluates recommendations for modification to Medical Staff Bylaws and Rules and Regulations;

(c) Submits recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current medical staff practices and/or changes in licensing or accreditation requirements.

11.K.3. Meetings, Reports and Recommendations

(a) The Bylaws Committee shall meet annually or more often if deemed necessary by the Chair to fulfill its responsibilities.

(b) The Committee shall maintain a permanent record of its findings, proceedings and actions.

(c) The Committee shall make a written report of its recommendations after each meeting to the Medical Executive Committee and the Chief Medical Officer.

(d) The Chair shall be available, if requested, to meet with the Medical Executive Committee and/or the Board on all recommendations that the Bylaws Committee shall make.

11.L. CREATION OF STANDING COMMITTEES

(a) The Medical Executive Committee may, by resolution, without amendment of these bylaws, establish additional committees to perform one or more staff functions.

(b) The Medical Executive Committee may, by resolution, dissolve or rearrange the committee structure, duties or composition as needed to better accomplish medical staff functions.

(c) Any function required to be performed by these bylaws, which is not assigned to a standing or special committee, shall be performed by the Medical Executive Committee.

11.M. SPECIAL COMMITTEES

Special committees shall be created, and their members and chairpersons shall be appointed by the Chief of Staff, as required. Such committees shall confine their activities to the purpose for which they were appointed, shall report to the Medical Executive Committee, and shall dissolve once they have completed the task with which they were charged.

ARTICLE 12
CONFLICT OF INTEREST

(a) In any instance where an officer of the Medical Staff, a chairperson of a department, a chief of a division, a chairperson of a committee or a member of any medical staff committee has or reasonably could be perceived as having a conflict of interest, or a bias, in any matter involving another member of the Medical Staff that comes before the individual, such individual shall first disclose the conflict and shall not vote on the matter or, as appropriate, shall not participate in the activity. However, the individual may be asked, and may answer, any questions concerning the matter.

(b) The existence of a potential conflict of interest or bias on the part of any member of a department, division or committee may be called to the attention of the department chairperson, the division chief or the committee chairperson by any other member with knowledge of such.

(c) A department chairperson shall have a duty to delegate review of applications for appointment, reappointment, clinical privileges and/or questions that may arise about another member of the department, if the chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased in his or her review of the matter.

(d) This provision does not prohibit any person from voting for himself/herself.

(e) The conflict or bias or the potential conflict or bias may be waived where all others who may be significantly affected by the particular conflict or bias or potential conflict or bias consent to the waiver.

ARTICLE 13
MEMBER RIGHTS AND RESPONSIBILITIES

13.A. MEMBER RIGHTS

(a) Each member of the Medical Staff has the right to an audience with the Medical Executive Committee. In the event a Medical Staff member is unable to resolve a difficulty working with his or her respective department chairperson, that member may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

(b) Any member of the Medical Staff has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be presented to the Medical Executive Committee and signed by at least seventy-five (75) members of the Active Staff or one-third of the Active Staff, whichever is greater. Upon presentation of such valid petition, the Medical Executive Committee will schedule a special meeting of the Medical Staff for the purpose of discussing the issue, and, if appropriate, to entertain a no-confidence vote.

(c) Any member of a medical staff clinical department shall have the right to initiate a recall election of a department chairperson. A petition for such recall must be presented to the Medical Executive Committee and signed by at least two-thirds of the Active Staff members of the department. Upon presentation of such valid petition, the Medical Executive Committee will schedule a special meeting of the department for the purpose of discussing the issue and, if appropriate, to entertain a no-confidence vote.

(d) Any member of the Medical Staff may call for a special meeting of the staff. Upon presentation of a petition signed by seventy-five (75) members of the Active Staff or one-third of the Active Staff, whichever is greater, the Chief of Staff will schedule a special meeting for the specific purpose addressed in the petition. No business other than that in the petition may be transacted.

(e) Any member of the Medical Staff may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any member of the Medical Staff may submit a petition signed by seventy-five (75) members of the Active Staff or one-third of the Active Staff, whichever is greater. When such petition has been received by the Medical Executive Committee, it will either:

   (1) provide information clarifying the intent of such rule, regulation or policy; and/or

(2) schedule a meeting with the Medical Staff members who filed the petition to discuss the issue.

(f) Any member of a department may call for a special meeting of the department. Upon presentation of a petition signed by at least one-third of the Active Staff members of the department, the department chairperson will schedule a special meeting for the specific purpose addressed in the petition. No business other than that in the petition may be transacted. This provision does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual credentialing actions.

13.B. MEMBER RESPONSIBILITIES

(a) Compliance with Rules and Regulations: All members of the Medical Staff are expected to comply with all rules and regulations imposed internally by Medical Staff policy including bylaws, credentialing, and department and hospital operational policies. Additionally, all members of the Medical Staff are expected to comply with all rules and regulations imposed externally such as local, state and federal law, as well as the requirements of Accreditation Organizations subscribed to by the hospital.

(b) Respectful Treatment: All members of the health care provider team (physicians, hospital staff, vendors, contract personnel, etc.) and all direct and indirect recipients of health care (patients, families, visitors, etc.) shall be treated in a respectful, dignified manner at all times. Language, nonverbal behavior and gestures, attitudes, etc. shall reflect this respect and dignity of the individual and affirm his/her value to the process of effective, efficient healthcare.

(c) Language: Physicians and staff agree not to use language that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or racially/ethnically/religiously slurring in any professional setting related to the hospital and the care of its patients.

(d) Behavior: Physicians and staff agree to refrain from any behavior that is deemed to be intimidating or harassing, sexually or otherwise, including, but not limited to, unwanted touching, sexual touching, sexually-oriented or degrading jokes or comments, requests for sexual favors, obscene gestures or physical throwing of objects, or making inappropriate comments regarding physicians, hospital staff, other providers, or patients.

(e) Confidentiality: Physicians and staff agree to maintain complete confidentiality of patient care information at all times in a manner consistent with generally accepted principles of medical confidentiality. The parties further recognize that

physicians and hospital staff may have concerns about specific performance problems, competency issues, or behavioral issues, e.g. disruptive or inappropriate behavior. Physicians and staff agree to maintain confidentiality with respect to these issues as they are addressed within the appropriate professional arena. This provision is not intended to alter the rules on proper documentation of patients' charts.

(f) Communication: When concerns of performance problems, competency issues, or behavioral issues arise, physicians and staff recognize the necessity of describing such issues in objective terms. This information should be provided to the appropriate medical staff or hospital staff member in accordance with the Medical Staff bylaws and hospital policies.

13.B.1. Duty to Report Adverse Actions:

(a) Each member of the staff shall notify the Medical Executive Committee in writing within thirty (30) days following the member's receipt of any notification:

(1) from another hospital, healthcare facility or healthcare institution where he or she holds medical staff membership or has the right to exercise privileges, or from any government agency or body (including but not limited to a QIO), initiating or in any way relating to the initiation of a process which could result in corrective or disciplinary action or an adverse finding being taken by such other hospital, healthcare facility, healthcare institution or government agency against him or her; or

(2) of the filing of charges or claims by a government agency relating directly or indirectly to his or her fitness to practice his or her profession.

(b) Each member of the staff shall further notify the Medical Executive Committee in writing within ten (10) days following the member's receipt of any notification of corrective action:

(1) from another hospital, healthcare facility or healthcare institution where he or she holds medical staff membership or has the right to exercise privileges, or from any government agency or body (including but not limited to a QIO), resulting in corrective or disciplinary action or an adverse finding being taken by such other hospital, healthcare facility, healthcare institution or government agency against him or her; or

(2) of adverse findings or charges or claims by a government agency relating directly or indirectly to his or her fitness to practice his or her profession.

(c) For purposes of this section, the term (corrective or disciplinary action" shall include but not be limited to action seeking to: institute probation or require consultation or supervision; reduce, suspend or revoke privileges; reduce staff status or limit any prerogatives directly related to patient care; suspend or revoke staff membership or suspend or revoke one's license or right to prescribe any medication. This section shall not apply to temporary suspensions of fewer than seven (7) days for failure to complete medical records.

(d) The affected member shall provide the Medical Executive Committee with complete information as to the reasons for the initiation of corrective or disciplinary action or of charges or claims, as well as the progress and results of any proceedings.

(e) The member's failure to notify the Medical Executive Committee within the time periods set forth in this section shall be deemed to constitute such member's automatic resignation of medical staff membership and privileges.

13.B.2. Responsibility for Patients

(a) Attending Responsibility:

In all cases the ultimate responsibility for the patient resides with the attending medical doctor. A physician member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for providing pre-certification information for elective admissions at the time the request for admission is made, for providing sufficient clinical information during the patient' hospitalization to ensure payment for the treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are permanently or temporarily transferred to another medical staff member, a note covering the transfer or responsibility shall be entered on the order sheet of the medical record. The attending physician shall be responsible for requesting a consultation when indicated. It is the responsibility of the attending physician to communicate required information to the consulting physician.

The attending physician must communicate the following information to the consultant:

(1) The urgency of the consultation;

(2) What is requested of the consulting physician. The attending physician may request an opinion, diagnostic and/or treatment recommendations or a transfer of care to the consulting physician;

(3) Pertinent information related to the reason for the consultation.

(b) Consultations:

Consultation with another Medical Staff Member (physician, dentist, podiatrist, or psychologist) should be considered if requested by a competent patient. If the patient is has been ruled temporarily or permanently incompetent, then a consultation may be requested by the patient's spouse, legal next of kin, or an individual granted power of attorney. Each consultation request should be weighed on its own merits with the final decision made in accordance with the attending physician's knowledge of the circumstances of the case and his/her personal expertise. Consultations shall be required as per specific operational policies defined by certain patient care units (i.e., intensive care units).

(1) The diagnosis is obscure after ordinary diagnostic procedures have been completed;

(2) There is doubt as to the best therapeutic measure(s) to be used;

(3) Unusually complicated conditions are present that may require specific skills of other practitioners;

(4) The patient exhibits severe symptoms of mental illness or psychosis; or

(5) The patient has significant medical or surgical risks.

(6) All consultation requests should be initiated by the attending physician. The attending physician is encouraged to communicate both the urgency and the nature of his/her consultation request directly with the consulting physician if at all possible (i.e., physician-to-physician communication). However, a senior-level resident physician or a mid-level provider (Nurse Practitioner or Physicians Assistant) may be authorized by his/her attending to communicate the consultation request directly to the consulting physician. The consultation request may be accepted by the consulting physician directly (i.e., *via* telephone) or by his/her mid-level designee (i.e., *via* telephone or other means of direct communication). A senior-level resident physician may also accept consultation requests if authorized to do so by his/her attending physician. Although a written or electronic order requesting a consultation is a necessary component of the consultation process, under no circumstances will a written or electronic order alone suffice as a consultation request.;

(7) When serving as the on-call physician for the Emergency Department, the EC on-call physician is under no obligation to accept inpatient

consultation requests. However, the on-call physician may choose to accept and respond to inpatient consultation requests according to the urgency of the situation and as his/her schedule permits;

(8) If accepted, a routine inpatient consultation should be performed and documentation (i.e., findings and recommendations) made available in the patient's medical record within twenty-four (24) hours. Urgent/emergency inpatient consultations should be performed as soon as the consultant's schedule allows and documented as soon as possible. It is anticipated that emergency/urgent consultations will be completed within four (4) hours from the time of notification;

(9) If the consultation has been performed on an urgent/emergency basis, the consulting physician should relate his/her opinions and recommendations directly to the attending physician, Nurse Practitioner, Physician's Assistant, or senior-level resident physician. For all consultations, urgent or otherwise, a written/dictated formal report detailing the consultant's opinions and recommendations should be prepared as soon as possible;

(10) The consulting physician may order diagnostic tests, treatments, perform procedures, or request additional consultations in order to expedite necessary patient care;

(11) Unless the attending physician has requested and the consulting physician has agreed, the patient remains the responsibility of the attending physician. All questions or concerns regarding the patient should be addressed to the attending physician, the involved Nurse Practitioner, the appropriate Physician's Assistant, or a senior-level resident physician involved in the case;

(12) Prior to requesting a consultation, the attending physician or his/her designee is expected to have performed and recorded on the patient's chart a written or electronic initial evaluation of the patient;

(13) On occasion, it may be appropriate for the attending physician and consulting physician to exchange their relationship by mutual agreement. In that event, a concerted effort must be undertaken to communicate the change to nursing staff and other personnel involved in the patient's care.

(c) History & Physical

(1) A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia.

(2) The medical history and physical examination must be completed by a physician, an oromaxillofacial surgeon, or the physician may delegate the performance of an H&P to a physician assistant or advanced practice nurse who has been granted privileges by the hospital to perform H&P's.

(3) Podiatric surgeons may perform the medical history and physical examination on uncomplicated podiatric patients who present for outpatient surgical procedures requiring anesthesia services. Uncomplicated patients are defined as those patients with an ASA Classification of 1, 2, or 3 at the time of medical history and physical examination, pre-op assessment or induction. For complicated outpatients and patients requiring inpatient admission, the podiatric surgeon is responsible for the part of his/her patients' medical history and physical examination that relates to podiatric medicine and should include, but not be limited to, a complete description of the examination of the foot, ankle, and their governing and related structures, and a pre-operative diagnosis.

(4) Dentists may perform the medical history and physical examination on uncomplicated dental patients who present for outpatient surgical procedures requiring anesthesia services. Uncomplicated patients are defined as those patients with an ASA Classification of 1, 2, or 3 at the time of medical history and physical examination, pre-op assessment or induction. For complicated outpatients and patients requiring inpatient admission, the dentist is responsible for the part of his/her patients' medical history and physical examination that relates to dentistry and should include, but not be limited to, a complete description of the examination of the oral cavity and pre-operative diagnosis.

(5) The H&P may be handwritten or transcribed, but always must be accessible within the patient's medical record within 24 hours of admission, or prior to surgery or a procedure requiring anesthesia. An H&P is required prior to a procedure being performed except when such a delay would constitute a hazard to the patient.

(6) If the H&P was completed within 30 days prior to admission or registration, an updated medical record entry must be completed within 24 hours of admission or registration, or prior to surgery/procedure requiring anesthesia services. This updated medical record entry shall be performed by a licensed practitioner who is credentialed and privileged by the hospital to perform an H&P. The H&P update note must document that an examination was performed to determine if there are any changes in the patient's condition, which might be significant for the planned course of treatment. If upon examination, the licensed practitioner finds no changes in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient examined, and that "no change" has occurred in the patient's condition since the H&P was completed. If changes are noted in the patient's condition they must be documented by the practitioner in the H&P update note and placed in the record prior to surgery/procedure.

ARTICLE 14

CONFLICT MANAGEMENT PROCESS

(a) A special meeting of the medical staff may be called to discuss a conflict between the medical staff and the MEC with respect to the following:

1) Proposed amendments to the Medical Staff Rules and Regulations;
2) A new policy proposed by the Medical Executive Committee, or;
3) Medical Executive Committee proposed amendments to existing policies;

(b) The special meeting shall be called according the provisions of Section 9.A.2. above. The agenda for the special meeting will be limited to the proposed bylaws, rules and regulations, policies or amendments at issue. All other provisions of these Bylaws related to special meetings shall apply.

(c) If the differences cannot be resolved at the special meeting, the MEC shall forward its recommendations to the Board, together with the proposed recommendations relating to the bylaw, rule or regulation, policy or amendment thereto proposed by the members of the medical staff voting at the special meeting.

(d) This conflict management process is limited to the matters specified in section 14.A.(a), and is not applicable to any other issue, including, but not limited to, professional review actions concerning individual members of the medical staff.

ARTICLE 15

REVIEW, REVISION, ADOPTION AND AMENDMENT OF THE BYLAWS

15.A. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review periodically, adopt and recommend to the Board, Medical Staff bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption and amendment of the related rules and regulations, policies and protocols developed to implement various provisions of these bylaws.

15.B. METHODS OF ADOPTION AND AMENDMENT

15.B.1. Amendments to Medical Staff Bylaws

(a) All proposed amendments to these bylaws, whether originated by a standing committee or by a member of the Active Staff, must be reviewed and discussed by the Medical Executive Committee. Prior to the Medical Executive Committee voting on any proposed amendment, it must first be distributed to the members of the Active Staff at least thirty (30) days prior to the vote.

(b) The Medical Executive Committee shall report on the proposed amendment, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The amendment shall be voted upon at that meeting provided that it shall have been posted on the Medical Staff bulletin board and/or electronic information system and/or delivered, either in person or by mail, to each member of the Medical Staff at least thirty (30) days prior to the meeting. Such postings and/or mailings shall be deemed to constitute actual notice to the person concerned. To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.

(c) As an alternative to the process described in the previous subsection, the bylaws may also be amended by mail ballot. In the event the Medical Executive Committee deems it convenient or necessary for a bylaw amendment to be voted on without the requirement of a regular or special meeting, the members of the Active staff may be presented with the question by mail and their votes returned, by mail or in person, to the Chief of Staff. Ballots must be mailed, first class mail, postage prepaid, to each member of the Active staff at least thirty (30) days prior to the date the votes will be due. Notice of the results of the mail ballot must be

provided within thirty (30) days after the due date for the ballots by either posting a notice of such results on the Medical Staff bulletin board and/or the electronic information system.

(d) The Medical Executive Committee shall have the power to adopt such amendments to these bylaws as are, in the Committee's judgment, technical or legal modifications or clarification that do not change the intent of the bylaws; reorganization or renumbering; or amendments needed because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be posted for 30 days prior to approval by the Medical Executive Committee, and shall be effective when approved by the Board.

(e) All amendments to these bylaws must be approved by the Board before becoming effective.

(f) Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

15.B.2. Amendments to Other Medical Staff Documents

a) All rules and regulations, policies and protocols developed to implement various provisions of these bylaws may be amended or repealed by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all such proposed amendments shall be posted on the Medical Staff bulletin board and web page after notification of the medical staff members by email at least thirty (30) days prior to the Medical Executive Committee meeting, and any Medical Staff member shall have the right to submit written comments to the Medical Executive Committee regarding the same. No such amendment shall be effective unless and until it has been approved by the Board.

b) Notwithstanding the foregoing, all rules and regulations, policies and protocols developed to implement various provisions of these bylaws may be amended or repealed in the circumstances and in accordance with the procedures described in ¶ 14.B, above.

15.B.3. Adoption

(a) These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws. All activities and actions of the Medical Staff and of each individual exercising clinical privileges in the Medical Center shall be taken under and pursuant to the requirements and provisions of these bylaws.

(b) Any medical staff officer, department chairperson, committee chairperson, committee member, or individual staff appointee who acts for and on behalf of the Medical Center in discharging duties, functions or responsibilities stated in the Medical Staff Bylaws and/or the Policy on Allied Health Professionals, shall be indemnified by the Board, to the fullest extent permitted by laws.

(c) The present rules and regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these bylaws, until such time as they are amended in accordance with the terms of these bylaws.

(d) Once submitted by the Medical Staff and approved by the Board, these Bylaws shall be binding to both parties.

Reviewed by the Medical Staff on November 14, 2013

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Robert Thornsberry, MD, Chief of Staff

Approved by the Board on December 4, 2013

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Ninfa Saunders, President/CEO

APPENDIX A

DEFINITIONS

(a) The following definitions shall apply to terms used in these bylaws:

(1) **"ALLIED HEALTH PROFESSIONAL" ("AHP")** means individuals other than medical staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.

(2) **"ADVANCED DEPENDENT PRACTITIONER" ("ADP")** means those Allied Health Professionals who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a practitioner(s) appointed to the Medical Staff. The supervising practitioner is responsible for the actions of the Advanced Dependent Practitioner.

(3) **"APPOINTEE" or "MEMBER"** means a physician, dentist, podiatrist, or psychologist who has been granted medical staff appointment and clinical privileges by the Board to practice at the Medical Center;

(4) **"BOARD"** means the Board of Trustees of the Medical Center of Central Georgia, Inc., which has overall responsibility for the conduct of the Medical Center;

(5) **"CHIEF EXECUTIVE OFFICER"** means the President of the Medical Center or the President's designee;

(6) **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the authorization granted by the Board to an applicant, medical staff appointee or other independent practitioner to render specific patient care services in the Medical Center within defined limits;

(7) **"DENTIST"** means a doctor of dental surgery or doctor of dental medicine;

(8) **"DEPENDENT PRACTITIONER"** means those allied health professionals who are permitted to practice in the Hospital only under the direct supervision of a practitioner appointed to the Medical Staff and who function pursuant to a defined scope of practice. The supervising practitioner is responsible for the actions of the Dependent Practitioner in the Hospital.

(9) **"MEDICAL EXECUTIVE COMMITTEE"** means the Medical Executive Committee of the Medical Staff of the Medical Center;

(10) **"*EX OFFICIO*"** means service by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights;

(11) **“MEDICAL CENTER”** and **“MCCG”** both mean the Medical Center of Central Georgia, Inc., and include all facilities owned or operated by the Medical Center, including but not limited to the Children’s Hospital;

(12) **“MEDICAL STAFF”** means all physicians, dentists, podiatrists and psychologists who are given privileges to attend patients in any facilities owned or operated by the Medical Center;

(13) **“ORAL AND MAXILLOFACIAL SURGEONS”**, as it applies to dentists, shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education;

(14) **“PHYSICIAN”** shall be interpreted to include both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”);

(15) **“PODIATRIST”** shall be interpreted to mean a doctor of podiatric medicine;

(16) **“PSYCHOLOGIST”** shall be defined as a practitioner who holds a Ph.D. in a recognized field of psychology;

(17) **“SPECIAL NOTICE”** means written notification sent by hand delivery, or by certified or registered mail, return receipt requested.

(18) **"SUPERVISING PRACTITIONER"** means the practitioner who employs and/or supervises an Advanced Dependent Practitioner or Dependent Practitioner and who is fully responsible for the actions of that individual while he or she is practicing in the Hospital.

(19) **“UNRESTRICTED”** means, when it is used in regard to licensure or DEA certification, that there are no active or stayed conditions, limitations, qualifications, or proctoring or other supervision requirements that have been imposed.

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

(c) Except as otherwise provided, when a function is to be carried out by the Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, the Chairperson of the Credentials Committee or a Chairperson of any clinical department, the person in such office may delegate performance of the designated function to someone else. Any other individual who proposes to delegate a function set forth in these bylaws to someone else must receive prior approval from the Chief of Staff.