MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

PIEDMONT HEALTHCARE

MEDICAL STAFF BYLAWS

OF

PIEDMONT HENRY HOSPITAL

Adopted by the Medical Staff: June 4, 2013

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MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

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

1.C. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff and the Secretary-Treasurer, with the co-signature of the CFO for administrative purposes only (i.e., the sole discretion with regard to the use of the funds resides in the Medical Staff Officers).

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix A to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in at least 24 patient contacts per two-year appointment term; and

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting, Coverage, or Ambulatory Care).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department, service, and committee meetings;

(c) hold office, serve as department chairs and service chiefs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department (Active Staff members over the age of 55 who were exempt from providing call coverage at the time of adoption of these Bylaws shall be grandfathered and shall remain exempt unless the MEC determines that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities);

(c) participating in the evaluation of new members of the Medical Staff;

(d) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols pertinent to their medical specialties);

(e) accepting inpatient consultations during those times when the member is also on call for the Emergency Department, when requested;

(f) paying application fees, dues, and assessments; and

(g) performing assigned duties.

2.B. AMBULATORY CARE STAFF

2.B.1. Qualifications:

The Ambulatory Care Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital. Except as noted in (b), it is a membership-only category, with no clinical privileges being granted. The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care;

(b) may wish to request only limited outpatient-related therapies (e.g., infusion therapy; injections) for the care and treatment of their patients at the Hospital (for individuals who request such privileges, applications shall be processed in the same manner as any other request for clinical privileges and any granted privileges will be subject to the focused and ongoing professional practice evaluation process); and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.B.2.

2.B.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

(a) May attend general and special meetings of the Medical Staff **without a vote**, and applicable department, service, and committee meeting **with vote**

(b) hold office, serve as department chairs and service chiefs, serve on Medical Staff committees, and serve as chairs of committees;

(c) may attend educational activities sponsored by the Medical Staff and the Hospital;

(d) may refer patients to members of the Medical Staff for admission and/or care;

(e) may be granted limited privileges to order certain outpatient therapies, but should these privileges be requested, (i) they must request specific therapies and demonstrate competence in their ability to carry out the specific therapies in the discretion of the Credentials Committee, and (ii) they must also establish and provide the Hospital with evidence of a formal arrangement with a member of the Active Staff to provide inpatient care for their patients, should that be necessary;

(f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient or outpatient orders (with the exception of (l) below), perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) may actively participate in the professional practice evaluation and performance improvement processes;

(l) may refer patients to the Hospital's diagnostic facilities and order such tests;

(m) must accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

(n) must pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff members would not be eligible to request continued Consulting Staff status at the time of their next reappointments);

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairs, service chiefs, or committee chairs (unless waived by the MEC);

(c) may attend meetings of the Medical Staff and applicable department and service meetings (without vote) and applicable committee meetings (with vote);

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall provide inpatient call coverage for consultations in accordance with Hospital policy, providing requested inpatient consultations on a frequency to be determined by the MEC;

(f) shall cooperate in the professional practice evaluation and performance improvement processes; and

(g) shall pay application fees, dues, and assessments.

2.D. COVERAGE STAFF

2.D.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(c) are not required to satisfy the response time requirements set forth in Section 2.A.1(c) of the Credentials Policy, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.D.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member who is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments, when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff, department, and service meetings (without vote);

(d) may not hold office or serve as department chairs, service chiefs, or committee chairs;

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote); and

(f) shall pay applicable fees, dues, and assessments.

2.E. EMERITUS STAFF

2.E.1. Qualifications:

(a) The Emeritus Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing. (Those individuals who are members of the Honorary Staff at the time of adoption of these Bylaws shall automatically be transitioned into the Emeritus Staff.)

(b) Once an individual is appointed to the Emeritus Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.E.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, department, and service meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs, service chiefs, or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, President-Elect, Immediate Past President, and Secretary-Treasurer.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the Board. They must:

(1) be appointed to the Active Staff in good standing, and have served on the Active Staff for at least two years;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Board members, department chairs, or committee chairs at any other hospital, and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) participate in Medical Staff Leadership training as determined by the MEC or Medical Staff Leaders, and attend continuing education relating to Medical Staff Leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office;

(8) have demonstrated an ability to work well with others; and

(9) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. Members with such financial interests are required to recuse themselves from meetings of the MEC in the event that the MEC discusses a matter that may impact upon that financial interest.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with the CMO, the Hospital President, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities of the Medical Staff to the Hospital President, CMO, and the Board;

(c) be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/ case management program functions delegated to the Medical Staff;

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

(e) appoint all committee chairs and committee members, in consultation with the CMO;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;

(g) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees;

(i) be the spokesperson for the Medical Staff in its external professional and public relations; and

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. President-Elect:

The President-Elect shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC;

(c) serve on the Credentials Committee;

(d) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC; and

(e) become President upon completion of the President's term.

3.C.3. Immediate Past President:

The Immediate Past President shall:

(a) serve on the MEC;

(b) serve as an advisor to other Medical Staff Leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MEC.

3.C.4. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC;

(b) be responsible for accurate and complete minutes of all MEC and general Medical Staff meetings;

(c) be responsible for the collection of, accounting for, and disbursements of any funds in the Medical Staff Fund and report to the Medical Staff; and

(d) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The Nominating Committee shall consist of the President of the Medical Staff, the President-Elect, the Immediate Past President and two additional members of the Active Staff who shall be selected by the three Medical Staff officer members of the Nominating Committee. The additional Active Staff members shall be selected to be broadly representative of the specialties on the Medical Staff. The CMO shall also be a member of the Committee, *ex officio*, without vote.

(2) The Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of two or more qualified nominees for President-Elect and for Secretary-Treasurer. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Additional nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) The election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

(2) In the alternative, at the discretion of the MEC, an election may also occur at a called meeting. Candidates receiving a majority of written votes cast at the meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected.

3.G. REMOVAL

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

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

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

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

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into the departments and services as listed in the Medical Staff Organization Manual.

(2) Subject to the approval of the Board, the MEC may create new departments, eliminate departments, create services within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

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

(2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments; (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given

department; and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS

Each department chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Board after considering the recommendation of the MEC.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS

(1) Except as otherwise provided by contract, department chairs shall be elected by the department, subject to Board confirmation. A Nominating Committee, consisting of the three physicians who have been elected to serve in Medical Staff Leadership roles in the past, shall nominate at least two qualified candidate(s).

Nominations may also be submitted in writing by petition signed by at least three Active Staff members in the department at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve.

The election shall be by ballot. Ballots may be returned in person, by mail, or by facsimile. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.

(2) Any department chair may be removed by a two-thirds vote of the department members, subject to Board confirmation; or by a two-thirds vote of the MEC, subject to Board confirmation; or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies and Bylaws;

(b) failure to satisfy any of the criteria in Section 3.B of these Bylaws;

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

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on such removal. No removal shall be effective until approved by the Board.

(4) Department chairs shall serve a term of two years. A department chair may succeed himself or herself for two additional terms.

4.F. DUTIES OF DEPARTMENT CHAIRS

Department chairs are responsible for the following, to the best of their ability, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and

focused professional practice evaluations (OPPE and FPPE), as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating interdepartmental and intradepartmental services;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the department;

(15) making recommendations for space and other resources needed by the department;

(16) performing all functions authorized in the Credentials Policy, including collegial intervention efforts; and

(17) appointing and removing service chiefs and one or more department vice chairs as deemed necessary, subject to approval of the MEC.

4.G. SERVICES

4.G.1. Functions of Services:

(a) Services may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs;

(4) development of recommendations to the department chair or the MEC;

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

(6) discussion of a specific issue related to credentialing, professional practice evaluation, and/or performance improvement, at the request of a department chair or the MEC.

(b) No minutes or reports will be required reflecting the activities of services, except when a service is making a formal recommendation to a department, department chair, Credentials Committee, or MEC.

(c) Services shall not be required to hold any number of regularly scheduled meetings.

4.G.2. Qualifications and Appointment of Service Chiefs:

Service chiefs shall be appointed by the appropriate department chair, subject to approval by the MEC. Service chiefs shall meet the same qualifications as department chairs.

4.G.3. Duties of Service Chiefs:

The service chief shall carry those functions delegated by the department chair or the MEC, which may include the following:

(a) review and report on applications for initial appointment and clinical privileges;

(b) review and report on applications for reappointment and renewal of clinical privileges;

(c) evaluate individuals who are granted privileges in order to confirm competence;

(d) participate in the development of criteria for clinical privileges within the service;

(e) review and report regarding the professional performance of individuals practicing within the service; and

(f) support the department chair in making recommendations regarding the coordination of service activities, as well as the hospital resources necessary for the service to function effectively.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND

PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff, in consultation with the CMO. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Committee chairs shall be appointed for an initial term of two years, and may serve two additional terms. Committee members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CMO. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the President of the Medical Staff, the CMO, and the Hospital President (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the elected officers of the Medical Staff, the department chairs, and three members at-large (one from the Department of Medicine, one from the Department of Surgery, and one from either the Department of Pediatrics or the Department of Obstetrics/Gynecology). The at-large members shall be selected by the MEC and shall serve two-year terms.

(b) The President of the Medical Staff will chair the MEC.

(c) The Chair of the Credentials Committee and the Medical Director of the Hospitalist Service shall be *ex officio* members of the MEC, with vote.

(d) The Hospital President, one representative of the Board selected by the Chairman of the Board, the CMO, and the Chief Nurse Executive shall be *ex officio* members of the MEC, without vote.

(e) Other individuals may be invited to MEC meetings as guests, without vote.

5.D.2. Duties:

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) ensuring that, at least every three years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(h) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of patients' medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

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

5.F. CREATION OF STANDING COMMITTEES

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

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least once a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the Hospital President, the Board, or by a petition signed by at least 25% of the Active Staff.

6.C. DEPARTMENT, SERVICE, AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department, service, and committee shall meet as necessary to accomplish its functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department, service, or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the Hospital President, or by a petition signed by at least 25% of the Active Staff members of the department, service, or committee (but in no event fewer than two members).

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, services, and committees at least 14 days in advance of the meetings. Notice may also be provided by posting in a designated location at least 14 days prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, a service, and/or a committee is called, the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, service, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and the Credentials Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for amendments to these Medical Staff Bylaws, at least 10% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, services, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, a service, or a committee may also be presented with any question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC and the Credentials Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, service, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff, department, service, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, services (as necessary), and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, services, and committees shall be transmitted to the MEC. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments, services, and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees, departments, or services is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Credentials Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicable department, service, and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, service chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy and the Policy on Allied Health Professionals.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the Hospital President of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the Hospital President of the right to request a hearing.

8.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements;

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the Hospital President.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, or any member of the MEC acting in conjunction with the CMO, the System CMO, or the Hospital President is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the MEC or Hospital President.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION

OR SUSPENSION OF APPOINTMENT AND PRIVILEGES

OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.G. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR

SCHEDULING AND CONDUCTING HEARINGS AND THE

COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any

matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 20% of the voting members of the Medical Staff.

(3) All proposed amendments to these Bylaws must be reviewed by the MEC and the Piedmont Healthcare Quality and Safety Committee prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to these Bylaws to the voting staff by written ballot or e-mail, to be returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) an amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the Board.

(7) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Hospital President within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents are the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place. Any member of the voting staff may submit written comments on the amendments to the MEC.

(3) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(4) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 20% of the voting staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the Board for its final action.

(5) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(6) The present Medical Staff Rules and Regulations 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. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 25% of the voting staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Hospital President, who will forward the request for communication to the Chair of the Board. The Hospital President will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____, 2013

Approved by the Board: _____, 2013

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Consulting	Ambulatory	Coverage	Emeritus
Basic Requirements					
Number of hospital contacts/2-year	≥ 24	NA	N	NA	N
Rights					
Admit	Y	N	N	P	N
Exercise clinical privileges	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y
Voting privileges	Y	P	Y	P	P
Hold office	Y	N, unless waiver	Y	N	N
Responsibilities					
Serve on committees	Y	Y	Y	Y	Y
Emergency call coverage	Y	N	FUC	P	N
Meeting requirements	Y	N	N	N	N
Dues	Y	Y	Y	Y	N
Comply w/guidelines	Y	Y	Y	Y	N

Y = Yes

N = No

P = Partial (with respect to voting, only when appointed to a committee)

FUC = Follow-up care

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or any procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;

- social history, including any abuse or neglect;

- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;

- data reviewed;

- assessments, including problem list;

- plan of treatment; and

- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) <u>H&Ps Performed Prior to Admission</u>

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these

circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination shall be based upon an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document, at a minimum, the patient's chief complaint or reason for the procedure, relevant history of the present

illness or injury, current clinical condition, general appearance, vital signs, and an assessment of the heart and lungs.

(e) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

PIEDMONT HEALTHCARE

(PIEDMONT ATLANTA HOSPITAL, PIEDMONT FAYETTE HOSPITAL, PIEDMONT MOUNTAINSIDE HOSPITAL, PIEDMONT NEWNAN HOSPITAL, AND PIEDMONT HENRY HOSPITAL)

MEDICAL STAFF

CREDENTIALS POLICY

Eighth Discussion Draft

March 14, 2013

Horty, Springer & Mattern, P.C.

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APPENDIX A: CONFLICT OF INTEREST GUIDELINES

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital. All AHPs are described as Category I, Category II, or Category III practitioners in the Medical Staff Bylaws documents:

- "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner, a type of Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in the AHP Policy (i.e., moonlighting residents). See Appendix A to the AHP Policy.

- "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner, a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement. See Appendix B to the AHP Policy.

- "CATEGORY III PRACTITIONER" means a Dependent Practitioner, a type of Allied Health Professional who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 6 of the AHP Policy, all aspects of the clinical practice of Category III practitioners at the Hospital shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures, and the provisions of the AHP Policy shall specifically **not** apply. Hereafter, as used in this Policy, the AHP Policy, and the Medical Staff Bylaws, the term "Allied Health Professional" shall mean Category I and Category II practitioners only *(*except for Article 6 of the AHP Policy*)*. See Appendix C to the AHP Policy.

(2) "BOARD" means the Board of Directors of each individual Hospital, which has the overall authority for that Hospital, including the Medical Staff (or its designated committee).

(3) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Hospital President to act as the chief medical officer of the Hospital, in cooperation with the President of the Medical Staff. The CMO may also be referred to as the Vice President Medical Affairs ("VPMA") at an individual Hospital.

(4) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(5) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(6) "DAYS" means calendar days.

(7) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

(8) “HOSPITAL” means Piedmont Atlanta Hospital, Piedmont Fayette Hospital, Piedmont Mountainside Hospital, Piedmont Newnan Hospital, or Piedmont Henry Hospital, as applicable.

(9) “HOSPITAL PRESIDENT” means the individual appointed by the System Chief Executive Officer to act on behalf of the Board in the overall management of the Hospital. The Hospital President may also be referred to as the Chief Executive Officer (“CEO”) or the Chief Administrative Officer (“CAO”) at an individual Hospital.

(10) “MEDICAL EXECUTIVE COMMITTEE” (“MEC”) means the Executive Committee of the Medical Staff.

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

(12) “MEDICAL STAFF LEADER” means any Medical Staff Officer, department chair, service chief, and committee chair.

(13) “MEDICAL STAFF OFFICE” means the Medical Staff Office at the Hospital or the Piedmont Healthcare CVO.

(14) “MEMBER” means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment by the Board.

(15) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, website, Hospital mail, hand delivery, or other electronic method.

(16) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed an accredited residency in oral and maxillofacial surgery and is fully licensed in the State of Georgia to practice oral and maxillofacial surgery in all its phases.

(17) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients.

(18) "PATIENT CONTACTS" includes any admission, consultation, procedure (inpatient or outpatient), in-person response to emergency call, evaluation, treatment, or service performed in any facility or venture operated by the Hospital or in which the Hospital has an ownership interest, including outpatient facilities.

(19) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals to exercise clinical privileges or a scope of practice.

(20) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(21) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(22) "QUALITY AND SAFETY COMMITTEE" means the subcommittee of the System Board comprised of community members of the Board, CMOs, and elected physician leaders of the Medical Staffs.

(23) "SCOPE OF PRACTICE" means the authorization granted to a Category III practitioner to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.

(24) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(25) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(26) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital.

(27) "SUPERVISION" means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)

(28) "SYSTEM BOARD" means the Board of Piedmont Healthcare.

(29) "SYSTEM CHIEF EXECUTIVE OFFICER" ("System CEO") means the individual appointed by the System Board to act as the chief executive officer of Piedmont Healthcare, in cooperation with the Hospital Presidents.

(30) "SYSTEM CHIEF MEDICAL OFFICER" ("System CMO") means the individual appointed by the System CEO to act as the chief medical officer of Piedmont Healthcare, in cooperation with the Hospital CMOs.

(31) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(32) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

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

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

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

(a) have a current, unrestricted license to practice in Georgia and have never had a license to practice revoked, suspended, or limited by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be located (office and residence) close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any of their patients who have been admitted to the Hospital; (ii) provide inpatient consultations during those times when they are on Emergency Department call; and (iii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:

(1) respond within 15 minutes, via phone, to an initial STAT page from the Hospital and respond within 30 minutes, via phone, to all other initial pages; and

(2) appear in person to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

(e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

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

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

(h) have not had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(i) have not resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(j) have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(k) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage by another member of the Medical Staff;

(l) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;

(m) demonstrate recent clinical activity in their primary area of practice during the last two years;

(n) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

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

(p) document compliance with all applicable training and/or educational protocols that may be adopted by the MEC and/or required by the System Board, including, but not limited to, those involving electronic medical records or patient safety;

(q) have successfully completed:

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

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

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

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

(s) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.*

* These requirements are applicable to those individuals who apply for initial staff appointment at the relevant Piedmont Hospital after the following dates: May _____, 2008 at Piedmont Atlanta Hospital; July 11, 2007 at Piedmont Fayette Hospital; September 26, 2008 at Piedmont Mountainside Hospital; _____ at Piedmont Newnan Hospital; and _____ at Piedmont Henry Hospital. These requirements are not applicable to Medical Staff members who were appointed prior to the above-listed dates at the relevant hospital. Those Medical Staff members shall be grandfathered and shall be governed by the board certification requirement in effect at the time of their initial appointments.

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

(1) the individual has been on the Hospital's Medical Staff for at least three consecutive years;

(2) there have been no documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;

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

(4) the appropriate department chair/service chief at the Hospital provides a favorable report concerning the individual's qualifications; and

(5) the individual provides at least two letters of support from other members of the Medical Staff who are in good standing, who are not in the same specialty as the individual, and who have had direct experience in observing and working with the individual.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's

recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

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

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Georgia or the National Practitioner Data Bank.

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

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

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

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

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

(c) good reputation and character;

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

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

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

2.A.4. No Entitlement to Appointment:

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

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

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

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

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

(e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

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

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

2.A.5. Nondiscrimination:

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

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility, which shall include rounding daily on all inpatients for whom an individual Medical Staff member is the designated attending physician, which may be accomplished in conjunction with an Allied Health Professional, as appropriate;

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

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

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

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

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

(g) to notify the CMO or the President of the Medical Staff, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,

- changes in professional liability insurance coverage,

- the filing of a professional liability lawsuit against the practitioner,

- changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,

- knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

- any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy), and

- any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Practitioner Health Policy or this Credentials Policy.);

(h) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two members of the MEC (or one member of the MEC and the CMO) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

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

(j) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the member;

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

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

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

(n) to seek consultation whenever required or necessary;

(o) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;

(p) to cooperate with all utilization oversight activities;

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

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

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

(t) to comply with all applicable training and/or educational protocols that may be adopted by the MEC and/or required by the System Board, including, but not limited to, those involving electronic medical records or patient safety;

(u) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, or other vendors in accordance with the Piedmont Healthcare Policy on Conflicts of Interest and any additional policies that may be adopted by the MEC and/or required by the System Board, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital purchase;

(v) to satisfy continuing medical education requirements; and

(w) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration.

2.B.2. Burden of Providing Information:

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

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

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

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

2.C. APPLICATION

2.C.1. Information:

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

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions,

reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

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

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

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

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

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information Within Piedmont Healthcare:

The individual specifically authorizes all of the Hospitals within Piedmont Healthcare to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment, reappointment, and/or any other time during the individual's appointment.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

(g) Scope of Section:

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

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

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

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

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

(b) An individual seeking initial appointment will be sent a letter that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the clinical privileges being sought, and (iii) encloses the application form.

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

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all

threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy.

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

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

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references (from the same discipline where practicable) and from other available sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the service chief, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, the CMO, the System CMO, and/or the Hospital President.

3.A.4. Department Chair/Service Chief Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges (and, where applicable, to the service chief). The department chair and/or service chief shall prepare a written report regarding whether the applicant has satisfied all of the

qualifications for appointment and the clinical privileges requested on a form provided by the Medical Staff Office.

(b) The department chair and/or service chief shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chair or service chief and shall make a recommendation.

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

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than

two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

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

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

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

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

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

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

3.A.7. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

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

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

(3) reject or modify the recommendation.

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

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

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. FPPE TO CONFIRM COMPETENCE

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the Policy Regarding FPPE to Confirm Practitioner Competence.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

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

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

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

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills,

clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

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

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

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

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

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

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

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

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

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

(f) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the relevant section chief and/or department chair and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

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

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

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges or the scope of those privileges.

(b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing to the Medical Staff Office.

(c) Increased Privileges.

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

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

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

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

(4) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant department chair. The Credentials Committee's recommendation will be forwarded to the MEC, which shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) Relinquishment and Resignation of Privileges.

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

(2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:

(i) has completed all medical records;

(ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) has completed scheduled emergency service call or has arranged for appropriate coverage to satisfy this responsibility.

After consulting with the President of the Medical Staff and the CMO, the Hospital President will act on the resignation request and report the matter to the MEC.

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

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

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

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

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

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

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

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

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

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

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

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

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chair and the Credentials Committee addressing the following:

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

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

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

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

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

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

The department chair and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

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

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

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

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

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

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

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

(b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

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

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

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

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

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

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

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

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

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

Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges After Age 70:

(a) Beginning at age 70, and then every year thereafter, individuals exercising clinical privileges shall be required to have a health assessment performed by a physician who is acceptable to the Credentials Committee. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

(b) If the Committee determines that there are issues or concerns, the Committee shall determine what next steps are to be taken to address the concerns raised. The Committee may meet with the individual to discuss these concerns and to try to determine what collegial and voluntary steps, such as a voluntary restructuring of privileges, further monitoring, or focused review (as examples only), can be taken.

4.A.6. Clinical Privileges for Dentists:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to

respond and become involved with that individual's care should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The dentist shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.7. Clinical Privileges for Podiatrists:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery shall be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate

elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Physicians in Training:

Physicians in training (residents and fellows) shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.9. Telemedicine Privileges:

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Hospital President or CMO in consultation with the President of the Medical Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed

using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Georgia;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

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

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

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

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

(d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the Hospital President, upon recommendation of the President of the Medical Staff, under the following conditions:

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

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

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary

limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Credentials Committee, after considering the evaluation of the department chair; and

(5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The Hospital President, upon recommendation of the President of the Medical Staff, may grant temporary privileges (both admitting and treatment) to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

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

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

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

(4) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the department chair;

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

(6) the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify the Medical Staff Office at least 15 days prior to each time that s/he will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

(c) Visiting. Temporary privileges may also be granted in other limited situations by the Hospital President, upon recommendation of the President of the Medical Staff and the applicable department chair, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or

(3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the Hospital President and the President of the Medical Staff.

(d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(e) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

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

(a) The Hospital President may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, the service chief, the CMO, or the System CMO, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Hospital President, the department chair,

the President of the Medical Staff, the CMO, or the System CMO may immediately terminate all temporary privileges. The department chair or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

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

4.D. DISASTER PRIVILEGES

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

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

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

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

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

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

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

4.E. CONTRACTS FOR SERVICES

(1) In the event that the Board enters into a deliberative process and determines that it is necessary for quality and/or effectiveness of patient care, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. These types of arrangements are common in the health care setting and traditional examples include the specialties of anesthesia, emergency medicine, radiology, pathology, and hospitalist medicine. This Section is intended to clarify the responsibilities of those involved in this process and to set forth the rights afforded affected practitioners. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

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

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

(4) After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:

(a) The affected member shall be given at least 180 days' advance notice of the anticipated effective date of the exclusive contract or Board resolution and shall have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected member and held within 30 days of the notice, unless this time frame is extended by mutual agreement.

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

(c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution (which shall not be sooner than 180 days from the notice set forth in (4)(a)) and continues for as long as the contract or Board resolution is in effect. In addition, the Board will honor and abide by any and all

existing contractual arrangements that it may have with any such excluded Medical Staff member.

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

(e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Georgia licensure board or to the National Practitioner Data Bank.

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

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

(a) completed all medical records and be current at time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

(e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must

submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fee.

5.A.2. Factors for Evaluation:

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

(a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

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

(d) any focused professional practice evaluations;

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

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least six months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.

(b) Failure to return a completed application within 30 days shall result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term shall result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application.

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

(d) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

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

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Office shall forward the application to the relevant department chair (or service chief) and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

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

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

5.A.5. Conditional Reappointments:

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

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years

does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

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

5.A.6. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff Leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention efforts are a part of the Hospital's ongoing and focused professional practice evaluation activities.

(3) "Collegial Intervention" means a face-to-face discussion between a Medical Staff member and one or more Medical Staff Leaders, the CMO, and/or the Hospital President, along with a follow-up letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's future practice and/or conduct in the Hospital. No legal counsel for the Medical Staff member, the Medical Staff Leaders, or the Hospital shall be present during any collegial intervention efforts, and no recording (audio, video, or transcript) shall be permitted or made.

(4) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and

(b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical practice or evidence-based protocols, in order to assist individuals to conform their practices to appropriate norms.

(5) The relevant Medical Staff Leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review any formal documentation prepared by the Medical Staff Leader(s) and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(6) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital management.

(7) The relevant Medical Staff Leader(s), in conjunction with the Hospital President or CMO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy), or to direct it to the MEC for further review.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the Professional Practice Evaluation Policy. Matters that are not satisfactorily resolved through collegial intervention or through the Professional Practice Evaluation Policy shall be referred to the MEC for its review in accordance with Section 6.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts or actions under the Professional Practice Evaluation Policy have not resolved an issue, regarding:

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

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

(3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, rules and regulations, and policies of the Hospital or the Medical Staff; and/or

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

the matter may be referred to the President of the Medical Staff, the chair of the department, the chief of the service, the chair of a standing committee, the CMO, the System CMO, or the Hospital President.

(b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the President of the Medical Staff, the chair of the department, the chief of the service, the chair of a standing committee, the CMO, the System CMO, or the Hospital President for review and appropriate action in accordance with this Policy.

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

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

6.C.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy), or to proceed in another manner. The MEC may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. Prior to making its determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

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

6.C.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff; however, at least 50% of any appointed ad hoc committee must be comprised of members of the Active Staff of any Piedmont Healthcare Hospital. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).

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

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

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

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

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

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

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording

(audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be prepared by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

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

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

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

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

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

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

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

6.C.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

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

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

(6) recommend reduction of clinical privileges;

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

(8) recommend revocation of appointment and/or clinical privileges; or

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

(b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the Hospital President, who shall promptly inform the individual

by special notice. The Hospital President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

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

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

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

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.D.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any member of the MEC acting in conjunction with the CMO, or the System CMO, or the Hospital President shall have the authority to (1) afford an individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges as a precaution.

(b) A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following

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

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

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

(e) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.D.2. MEC Procedure:

(a) The MEC shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be represented by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made.

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

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

6.D.3. Care of Patients:

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

(b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chair, the MEC, the CMO, the System CMO, and the Hospital President in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

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

Failure to complete medical records, after notification by the medical records department of delinquency, shall result in automatic relinquishment of all clinical privileges (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

6.E.2. Action by Government Agency or Insurer and

Failure to Satisfy Threshold Eligibility Criteria:

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

(b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to a hearing and appeal, if any of the following occur:

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

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

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

(4) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DUIs will be addressed in the manner outlined in Section 2.B.1(g).)

(c) An individual's appointment and clinical privileges shall also be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this Policy, including those set forth in Section 2.A.1.

(d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated, if applicable.

(e) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

(f) Request for Reinstatement.

(1) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (f)(2) below.

(2) All other requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the Hospital President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E.3. Action at Another Piedmont Healthcare Hospital:

Any disciplinary action, involuntary change in appointment and/or clinical privileges status, or the development of a Performance Improvement Plan (collectively "action") that occurs at another Hospital within Piedmont Healthcare (except those relating to medical record completion infractions for paper records only) shall automatically and immediately be effective at this Hospital, without the individual's recourse to any additional review, investigation, hearing, or appeal (as may be applicable). This automatic action may be waived by the MEC and the Board in exceptional circumstances, after a full review of the specific circumstances and any relevant peer review documents (e.g., professional practice evaluation, investigation, and hearing documents) from the Piedmont facility where the action first occurred.

6.E.4. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete and/or comply with training or educational requirements that are adopted by the MEC and/or required by the System Board, including, but not limited to, those pertinent to electronic medical records or patient safety, shall result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 60 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.5. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Credentials Committee, the MEC, a Professional Practice Evaluation Committee, the CMO, the System CMO, the Hospital President, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 60 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.6. Failure to Attend Special Meeting:

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

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

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

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

6.F. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Hospital President. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(2) Except for maternity leaves, members of the Medical Staff must report to the Hospital President any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently.

Under such circumstances, the Hospital President, in consultation with the President of the Medical Staff and the CMO, may trigger an automatic medical leave of absence.

(3) The Hospital President shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Hospital President shall consult with the President of the Medical Staff, the relevant department chair, and the CMO. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

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

(5) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the CMO, and the Hospital President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(6) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Hospital

President. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

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

(9) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.

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

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

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

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

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

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

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

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

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

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

(b) imposition of conditions, monitoring, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

(c) termination of temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) imposition of a requirement for additional training or continuing education;

(f) precautionary suspension;

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

(h) determination that an application is incomplete;

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

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The Hospital President shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

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

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

(c) a copy of this Article.

7.B.2. Request for Hearing:

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

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

(a) The Hospital President shall schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

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

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

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

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

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

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

(a) Hearing Panel:

The Hospital President, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

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

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

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

(5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.

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

(b) Presiding Officer:

(1) The Hospital President, after consulting with the President of the Medical Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing. The Presiding Officer shall be compensated by the Hospital, but the individual requesting the hearing may participate in that compensation should the individual wish to do so.

(2) The Presiding Officer shall:

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

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

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

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

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

(c) Hearing Officer:

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

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

(d) Objections:

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

President may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

7.C.2. Time Frames:

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

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

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

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

7.C.3. Witness List:

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

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

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

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

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

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

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

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

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

The provision of this information is not intended to waive any privilege under the Georgia peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

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

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

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

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

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

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

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

7.D. HEARING PROCEDURES

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

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

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

(2) to introduce exhibits;

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

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel after the conclusion of the hearing session(s).

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

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

7.D.2. Record of Hearing:

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

7.D.3. Failure to Appear:

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

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

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

7.D.5. Persons to be Present:

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

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS,

AND RECOMMENDATIONS

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

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

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

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

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

The Hearing Panel shall deliver its report to the Hospital President. The Hospital President shall send by special notice a copy of the report to the individual who requested the hearing. The Hospital President shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

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

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

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

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

7.F.3. Time, Place and Notice:

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

7.F.4. Nature of Appellate Review:

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

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

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

7.G. BOARD ACTION

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

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

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

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

7.G.2. Further Review:

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

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

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

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES

(A chart summarizing the following guidelines can be found in Appendix A to this Policy.)

8.A.1. General Principles:

(a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

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

8.A.2. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

8.A.3. Employment or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

8.A.4. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

(a) membership in the same group practice;

(b) having a direct or indirect financial relationship;

(c) being a direct competitor;

(d) close friendship;

(e) a history of personal conflict;

(f) personal involvement in the care of a patient which is subject to review;

(g) raising the concern that triggered the review; or

(h) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

8.A.5. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

(a) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

(1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and MEC's subsequent review of credentialing matters; and

(2) participation as case reviewers in professional practice evaluation activities because of a Professional Practice Evaluation Committee's (Peer Review Committee's) subsequent review of peer review matters.

(b) Credentials Committee or Professional Practice Evaluation Committee (Peer Review Committee) Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full

and fair discussion of the issue or would skew the recommendation or determination of the committee.

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) MEC. An Interested Member will be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Board. An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

8.A.6. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or action of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an

Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

(c) not participate in the discussions or action of the MEC when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

8.A.7. Rules for Recusal:

(a) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

(b) Any recusal will be documented in the committee's or Board's minutes.

(c) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

8.A.8. Other Considerations:

(a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff (or to the Vice President if the President of the Medical Staff is the person with the potential conflict), or the applicable committee/Board chair. The member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

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

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

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

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

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

(3) when the disclosures are authorized, in writing, by the Hospital President or by legal counsel to the Hospital.

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

9.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by "Peer Review Committees," "Review Organizations," and "Medical Review Committees" (referred to collectively as "peer review committees") in accordance with Georgia law. These committees include, but are not limited to:

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

(b) all departments and services;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to department chairs, service chiefs, committee chairs and members, officers of the Medical Staff, the CMO, the System CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of O.C.G.A. §31-7-15, O.C.G.A. §31-7-131, *et seq.*, and O.C.G.A. §31-4-140, *et seq.*, and any subsequent state or federal law providing protection for credentialing and peer review activities.

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

ARTICLE 10

AMENDMENTS

Proposed amendments to this Policy shall be presented to the MECs of all the Hospitals within Piedmont Healthcare. This Policy may then be amended by a majority vote of the members of each MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments shall be provided to each voting staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any voting staff member may submit written comments to the MEC. If there is any disagreement between the MECs for the several Hospitals with respect to an amendment(s), a joint meeting shall be scheduled to discuss and resolve the disagreement. No amendment shall be effective unless and until it has been approved by the Board of each Hospital.

ARTICLE 11

ADOPTION

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

Piedmont Hospital, Inc.

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Fayette Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Mountainside Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Newnan Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Henry Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

PIEDMONT HEALTHCARE

MEDICAL STAFF CREDENTIALS POLICY

APPENDIX A: CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
	Provide Information	Individual Reviewer Application/ Case	Committee Member				Hearing Panel	Board
			Credentials	PPEC	MEC	Ad Hoc Investigating		
Family member	Y	N	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y
Partner	Y	Y	Y	Y	R	N	N	R
Direct or indirect financial impact	Y	Y	Y	Y	R	N	N	R
Competitor	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	R	N	N	R
Personally involved in care of patient	Y	Y	Y	Y	R	N	N	R

Reviewed at prior level	Y	Y	Y	Y	R	N	N	R
Raised the concern	Y	Y	Y	Y	R	N	N	R

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

Y – (yellow "Y") means that the Interested Member may generally serve in the indicated role. It is legally-permissible for such Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review, and the fact that neither the PPEC nor the Credentials Committee have disciplinary authority. In addition, the Credentials/PPEC Chair always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would be unfair to the practitioner under review, inhibit the full and fair discussion of the issue before the committee, or skew the recommendation or determination of the committee.

Allowing Interested Members to participate in the credentialing or professional practice evaluation process underscores the importance of establishing (i) objective threshold criteria for appointment and clinical privileges, (ii) objective criteria to review cases against in PPE activities (adopted protocols, etc.), and (iii) objective review and evaluation forms to be used by reviewers.

N – (red "N") means the individual may not serve in the indicated role.

R – (red "R") means the individual must be recused in accordance with the rules for recusal on the following page.

APPENDIX A

CONFLICT OF INTEREST GUIDELINES (cont'd)

Rules for Recusal

- Interested Member must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer question and provide input before leaving.

- Recusal shall be specifically documented in the minutes.

- Whenever possible, the actual or potential conflict should be raised and resolved prior to meeting by the committee or Board chair and the Interested Member informed of the recusal determination in advance.

- No Medical Staff member has the RIGHT to demand recusal – that determination is within discretion of the Medical Staff Leaders.

- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.

MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

PIEDMONT HEALTHCARE

(PIEDMONT ATLANTA HOSPITAL, INC., PIEDMONT FAYETTE HOSPITAL, PIEDMONT MOUNTAINSIDE HOSPITAL, PIEDMONT NEWNAN HOSPITAL, AND PIEDMONT HENRY HOSPITAL)

POLICY ON

ALLIED HEALTH PROFESSIONALS

Fifth Discussion Draft

March 11, 2013

Horty, Springer & Mattern, P.C.

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy document.

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

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

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

(1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.

(2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

(1) Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital. All Allied Health Professionals who are addressed in this Policy shall be classified as either Category I, Category II, or Category III practitioners.

(2) Current listings of the specific categories of Allied Health Professionals functioning in the Hospital as Category I, Category II, and Category III practitioners are attached to this Policy as Appendices A, B, and C, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each category of Allied Health Professional that it approves to practice in the Hospital. These separate protocols shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.A. DETERMINATION OF NEED

(1) Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the MEC and the Board.

(2) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.

(3) The ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of Allied Health Professionals:

(a) the nature of the services that would be offered;

(b) any state license or regulation which outlines the scope of practice that the Allied Health Professional is authorized by law to perform;

(c) any state “non-discrimination” or “any willing provider” laws that would apply to the Allied Health Professional;

(d) the business and patient care objectives of the Hospital, including patient convenience;

(e) the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;

(f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for, and availability of, trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF POLICY

(1) If the ad hoc committee determines that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for these practitioners that addresses:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(b) a detailed description of their authorized scope of practice or clinical privileges;

(c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(d) any supervision requirements, if applicable.

(2) In developing such policies, the ad hoc committee shall consult the appropriate department chair(s) or service chiefs and consider relevant state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice at the Hospital, Allied Health Professionals must:

(a) have a current, unrestricted license, certification, or registration to practice in Georgia (if applicable) and have never had a license, certification, or registration to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be located (office and residence) close enough to fulfill their responsibilities as an Allied Health Professional and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Board;

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

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

(g) have not had clinical privileges or scope of practice denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have not relinquished or resigned affiliation, clinical privileges, or a scope of practice during an investigation or in exchange for not conducting such an investigation;

(i) have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(j) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;

(k) document compliance with all applicable training and/or educational protocols that may be adopted by the MEC and/or required by the System Board, including, but not limited to, those involving electronic medical records or patient safety; and

(l) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff (the "Supervising Physician").

4.A.2. Waiver of Eligibility Criteria:

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

(b) A request for a waiver will be submitted to the Credentials Committee for consideration. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

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

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

(e) No individual is entitled to a waiver or to a hearing if the MEC recommends and/or the Board determines not to grant a waiver.

(f) A determination that an individual is not entitled to a waiver is not a "denial" of permission to practice, clinical privileges, or scope of practice.

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

(h) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

4.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as applicable, as part of a request for permission to practice, as reflected in the following factors:

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

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

(c) ability to safely and competently perform the clinical privileges or scope of practice requested;

(d) good reputation and character;

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

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

4.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.A.5. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

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

(b) to abide by all bylaws, rules and regulations, and policies of the Medical Staff and Hospital;

(c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(d) to maintain a current e-mail address with the Medical Staff Office, which will be the official mechanism used to communicate all information to the individual other than peer review information pertaining to the individual and/or protected health information of patients (this e-mail address will not be shared by Piedmont Healthcare; also, this provision (d) shall not be interpreted to limit the ability of Medical Staff

Leaders to utilize confidential e-mail to communicate about ongoing peer review matters among and between themselves);

(e) to inform the Medical Staff Office, in writing, of any change in the practitioner's status or any change in the information provided on the practitioner's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:

- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;

- the filing of a professional liability lawsuit against the practitioner;

- changes in the practitioner's status at any other hospital or health care entity as a result of peer review activities;

- knowledge of a criminal investigation involving the practitioner, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

- any changes in the practitioner's ability to safely and competently exercise clinical privileges, or scope of practice, or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy); and

- any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so

that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Practitioner Health Policy or this AHP Policy.);

(f) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two members of the MEC (or one member of the MEC and the CMO) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leaders, and the Allied Health Professional will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(g) to appear for personal or phone interviews in regard to an application for permission to practice as may be requested;

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

(i) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

(j) to refrain from deceiving patients as to the individual's status as an Allied Health Professional and to always wear proper Hospital identification of their name and status;

(k) to seek consultation when appropriate;

(l) to participate in the performance improvement and quality monitoring activities of the Hospital;

(m) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital;

(n) to cooperate with all utilization oversight activities;

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

(p) to satisfy applicable continuing education requirements;

(q) to pay any applicable application fees, assessments, and/or fines;

(r) to strictly comply with the standards of practice applicable to the functioning of Category II practitioners in the inpatient hospital setting, as set forth in Section 6.A of this Policy;

(s) to constructively participate in the development, review, and revision of clinical practice and evidence-based protocols pertinent to his or her specialty (including those related to national patient safety initiatives and core measures), and to comply with all such protocols and pathways;

(t) to comply with all applicable training and/or educational protocols that may be adopted by the MEC and/or required by the System Board, including, but not limited to, those involving electronic medical records or patient safety;

(u) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, or other vendors in accordance with the Piedmont Healthcare Policy on Conflicts of Interest and any additional policies that may be adopted by the MEC and/or required by the System Board, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that an Allied Health Professional may request the Hospital purchase; and

(v) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration.

4.B.2. Burden of Providing Information:

(a) Allied Health Professionals seeking permission to practice or renewal of permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

(b) Allied Health Professionals seeking permission or renewal of permission to practice have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) It is the responsibility of the individual seeking permission to practice or renewal of permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.C. APPLICATION

4.C.1. Information:

(a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional application forms existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital, health care facility, or other organization, or is currently being investigated or challenged;

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

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, MEC or Board may deem appropriate;

(4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges or scope of practice requested and the duties of Allied Health Professionals; and

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

(c) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges or scope of practice requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties for any matter relating to permission to practice, clinical privileges, scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical

competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued permission to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges, scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information Within Piedmont Healthcare:

The individual specifically authorizes all of the Hospitals within Piedmont Healthcare to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at the time of initial credentialing, recredentialing, and/or any other time during the individual's affiliation with the Hospital.

(e) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting the permission to practice and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

(g) Scope of Section:

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

(1) whether or not permission to practice, clinical privileges, or scope of practice is granted;

(2) throughout the term of any affiliation with the Hospital and thereafter;

(3) should permission to practice, clinical privileges, or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure as a member of the Allied Health Professional Staff.

ARTICLE 5

CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application:

(a) Any individual requesting an application for permission to practice at the Hospital shall be sent (i) a letter that outlines the eligibility criteria for permission to practice as outlined in this Policy, (ii) any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and (iii) the application form.

(b) An Allied Health Professional who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.A.2. Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.A.1 of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not

be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chair or service chief.

5.A.3. Department Chair/Service Chief Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chair or service chief or the individual to whom the chair or chief has assigned this responsibility. Each chair or chief shall prepare a written report (on a form provided by the Medical Staff Office) regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested.

(b) As part of the process of making this report, the department chair or the service chief has the right to meet with the applicant and the Supervising Physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chair or service chief may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers).

(c) In the event that the department chair or service chief is unavailable or unwilling to prepare a written report, the Chair of the Credentials Committee or the President of the Medical Staff shall appoint an individual to prepare the report.

(d) The department chair or service chief shall be available to answer any questions that may be raised with respect to that individual's report and findings.

5.A.4. Credentials Committee Procedure:

(a) The Credentials Committee shall review the report from the appropriate department chair or service chief and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.

(b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the Supervising Physician. The appropriate department chair or service chief may participate in this interview.

(c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges requested, the Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

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

(e) The Credentials Committee's recommendation will be forwarded to the MEC.

5.A.5. MEC Procedure:

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

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

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC; 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 MEC's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the Hospital President, including the findings and recommendation of the service chief and the Credentials Committee. The MEC's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) If the MEC's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the MEC shall forward its recommendation to the Hospital President, who shall notify the applicant of the recommendation and his or her procedural rights. The Hospital President shall then hold the MEC's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.A.6. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the MEC (or their designees) and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license, certification, or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges, or scope of practice at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board committee to appoint and grant the clinical privileges requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges requested, the Board may:

(1) grant the applicant permission to practice and clinical privileges as recommended; or

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

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the Hospital President shall promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

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

5.B. CLINICAL PRIVILEGES

5.B.1. General:

The clinical privileges recommended to the Board for Category I and Category II practitioners will be based upon consideration of the following factors:

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

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

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

(d) adequate professional liability insurance coverage for the clinical privileges requested;

(e) the Hospital's available resources and personnel;

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

(g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

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

(i) morbidity and mortality data, when available; and

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

5.B.2. Focused Professional Practice Evaluation:

All new clinical privileges for Category I and Category II practitioners, regardless of when they are granted (initial permission to practice, renewal of permission to practice, or at any time in between), will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the Policy on FPPE to Confirm Practitioner Competence.

5.C. TEMPORARY CLINICAL PRIVILEGES

5.C.1. Request for Temporary Clinical Privileges:

(a) Applicants: Temporary privileges for an applicant for initial permission to practice may be granted by the Hospital President, upon recommendation of the President of the Medical Staff and the department chair or service chief, when a Category I or Category II practitioner has submitted a completed application and the application is pending review by the MEC and the Board. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

(b) Locum Tenens: The Hospital President, upon recommendation of the President of the Medical Staff and the applicable department chair or service chief, may grant temporary privileges to a Category I or Category II practitioner serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time. Prior to temporary privileges being granted in this situation, the verification process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, and policies, procedures, and protocols.

(d) Temporary privileges will be granted for a specific period of time, not to exceed 120 days, and will expire at the end of the time period for which they are granted.

5.C.2. Termination of Temporary Clinical Privileges:

(a) The Hospital President may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, the service chief, the CMO, or the System CMO, terminate temporary privileges for any reason.

(b) The granting of temporary privileges is a courtesy. Neither the denial nor termination of temporary privileges will entitle the individual to the procedural rights set forth in Article 8.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application:

(a) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges will be considered only upon submission of a completed renewal application.

(b) At least six months prior to the date of expiration of an Allied Health Professional's clinical privileges, the Medical Staff Office will notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application must be returned to the Medical Staff Office within 30 days.

(c) Failure to return a completed application within 30 days shall result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the individual's current term will result in automatic expiration of clinical privileges at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders.

(d) Once an application for renewal of clinical privileges has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process:

(a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.

(b) As part of the process for renewal of clinical privileges, the following factors will be considered:

(1) an assessment prepared by the applicable department chair or service chief;

(2) an assessment prepared by a peer, if possible;

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

(4) resolution of any verified complaints received from patients or staff; and

(5) any focused professional practice evaluations.

(c) For Category II practitioners, the following information may also be considered:

(1) an assessment prepared by the Supervising Physician(s); and

(2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO

CATEGORY II AND CATEGORY III PRACTITIONERS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF CATEGORY II AND CATEGORY III PRACTITIONERS IN THE INPATIENT HOSPITAL SETTING

(1) Category II and Category III practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II and Category III practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II and Category III practitioners in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice apply to the functioning of Category II and Category III practitioners in the inpatient Hospital setting:

(a) Admitting Privileges. Category II and Category III practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician. However, a Category II or Category III practitioner is permitted to write inpatient admission orders on behalf of a Supervising Physician who has inpatient admitting privileges.

(b) Consultations. Category II and Category III practitioners may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. A Category II or Category III practitioner may gather data, order tests, and generate documentation; however, the Supervising Physician must personally review and concur with the consultation findings within 24 hours (or more timely in the case of any emergency consultation request).

(c) Emergency On-Call Coverage. Category II and Category III practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physicians (or their covering physician) must personally respond to all calls in a timely manner, in accordance with requirements set forth in the Medical Staff Credentials Policy. Following discussion with the Emergency Department, the Supervising Physician may direct a Category II or Category III practitioner to see the patient, gather data, order tests, and generate documentation for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(d) Calls Regarding Supervising Physician's Hospitalized Inpatients. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact a Category II or Category III practitioner prior to the Supervising Physician. Category II and Category III practitioners may not independently respond to calls from the floor or special care units regarding hospitalized inpatients (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

(e) Daily Inpatient Rounds for Attending Physicians. A Category II or Category III practitioner may assist his/her Supervising Physician in fulfilling his/her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

(f) Invasive Procedures. Category II and Category III practitioners may not perform invasive procedures independently. When performing invasive procedures, Category II and Category III practitioners must function under the supervision of their Supervising Physicians and in accordance with their written collaboration and/or supervision agreements. Supervision may not always require the personal presence of the Supervising Physician. The requisite level of supervision will be delineated as "general," "direct," or "personal." ("General" supervision means that the physician is immediately available by phone, "direct"

supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)

6.B. OVERSIGHT BY SUPERVISING PHYSICIAN

(1) Any activities permitted to be performed at the Hospital by a Category II or Category III practitioner shall be performed only under the supervision or direction of a Supervising Physician.

(2) Category II or Category III practitioners may function in the Hospital only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with the Supervising Physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Physician be revoked or terminated, the Category II or Category III practitioner's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another approved physician on the Medical Staff).

(3) As a condition of clinical privileges or a scope of practice, a Category II or Category III practitioner and the Supervising Physician must provide the Hospital with a copy of their written supervision agreement as well as notice of any revisions or modifications that are made to such agreements between them. This notice must be provided to the Medical Staff Office within three days of any such change.

6.C. QUESTIONS REGARDING AUTHORITY OF A CATEGORY II

OR CATEGORY III PRACTITIONER

(1) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner, either to act or to issue instructions outside the physical presence of the Supervising Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Category II or Category III practitioner's Supervising Physician validate, either at the time or later, the instructions

of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Category II or Category III practitioner's activities as permitted by the Board.

(2) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall be immediately reported to the President of the Medical Staff, the Chair of the Credentials Committee, the relevant department chair, the CMO, or the Hospital President, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

6.D. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(1) Physicians who wish to utilize the services of a Category II or Category III practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with Human Resources policies and procedures before the Category II or Category III practitioner participates in any clinical or direct patient care of any kind in the Hospital.

(2) The Supervising Physician will remain responsible for all care provided by the Category II or Category III practitioner in the Hospital.

(3) Supervising Physicians who wish to utilize the services of a Category II practitioner in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 6.A above.

(4) The number of Category II or Category III practitioners acting under the supervision of one Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II or Category III

practitioner, to the extent that such filings are required and shall provide a copy of the same to the Medical Staff Office.

(5) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Board. The insurance must cover any and all activities of the Category II or Category III practitioner in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner will act in the Hospital only while such coverage is in effect.

ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

7.A. COLLEGIAL INTERVENTION

(1) As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial efforts and progressive steps with Allied Health Professionals (and their Supervising Physicians, as applicable) by Medical Staff Leaders and Hospital management in order to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff Leaders.

(2) Collegial intervention efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.

(3) Collegial intervention efforts are a part of the Hospital's ongoing and focused professional practice evaluation activities.

(4) The President of the Medical Staff, in conjunction with the Hospital President or the CMO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy) or to direct the matter to the MEC for further review and/or investigation.

7.B. INVESTIGATIONS

7.B.1. Initiation of Investigation:

When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

7.B.2. Investigative Procedure:

(a) The MEC will either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the Allied Health Professional or, where applicable, the Allied Health Professional's Supervising Physician. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., an Allied Health Professional in a similar discipline).

(b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.

(c) The investigating committee will also have the authority to use outside consultants, if needed.

(d) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual will execute all appropriate releases to permit the sharing of information with the investigating committee. The cost of any such examination will be borne by the individual.

(e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general

questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

(f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

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

7.B.3. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued permission to practice;

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

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

(6) recommend reduction of clinical privileges or scope of practice;

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

(8) recommend revocation of clinical privileges or scope of practice; or

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

(b) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the Hospital President, who will promptly inform the individual by special notice. The Hospital President will hold the recommendation until after the individual has completed or waived a hearing and appeal.

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

7.C. ADMINISTRATIVE SUSPENSION

(1) The President of the Medical Staff, the relevant service chief, the Chair of the Credentials Committee, the CMO, the System CMO, and the MEC will each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.

(2) An administrative suspension will become effective immediately upon imposition, will immediately be reported in writing to the Hospital President and the President of the Medical Staff, and will remain in effect unless or until modified by the Hospital President

or the MEC. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 8 of this Policy.

(3) Upon receipt of notice of the imposition of an administrative suspension, the Hospital President and President of the Medical Staff will forward the matter to the MEC, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.D. AUTOMATIC RELINQUISHMENT/ACTIONS

(1) An Allied Health Professional's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

(b) the Allied Health Professional is indicted, convicted, or enters a plea of guilty or no contest to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another (DUIs will be addressed in the manner outlined in Section 4.B.1(e) of this Policy);

(c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for clinical privileges in response to a written request from the Credentials Committee, the MEC, the CMO, the Hospital President, or any other committee authorized to request such information;

(d) the Allied Health Professional fails to complete and/or comply with training or educational requirements that are adopted by the MEC and/or required by the

System Board, including, but not limited to, those pertinent to electronic medical records or patient safety;

(e) the Allied Health Professional fails to attend a special meeting at the request of a Medical Staff Leader to discuss a concern with clinical practice or professional conduct;

(f) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional;

(g) a Category II or Category III practitioner fails, for any reason, to maintain an appropriate relationship with a Supervising Physician as defined in this Policy; or

(h) any Allied Health Professional employed by the Hospital has his or her employment terminated.

(2) Requests for reinstatement.

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

(b) All other requests for reinstatement will be reviewed by the President of the Medical Staff, the CMO, and the Hospital President. If each of these individuals makes a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of these individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

7.E. ACTION AT ANOTHER PIEDMONT HEALTHCARE HOSPITAL

Any disciplinary action, involuntary change in affiliation status and/or clinical privileges or scope of practice status, or the development of a Performance Improvement Plan (collectively "action") that occurs at another Hospital within Piedmont Healthcare shall automatically and immediately be effective at this Hospital, without the individual's recourse to any additional review, investigation, hearing, or appeal (as may be applicable). This automatic action may be waived by the MEC and the Board in exceptional circumstances, after a full review of the specific circumstances and any relevant peer review documents (e.g., professional practice evaluation, investigation, and hearing documents) from the Piedmont facility where the action first occurred.

7.F. LEAVE OF ABSENCE

(1) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the Hospital President. The Hospital President will determine whether a request for a leave of absence shall be granted. Requests for reinstatement must be made at least 30 days prior to the conclusion of the leave of absence.

(2) Allied Health Professionals must report to the Hospital President anytime they are away from patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Hospital President, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.

(3) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the President of the Medical Staff, the department chair or the service chief, the CMO, and the Hospital President. If each of these individuals makes a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume practice. This

determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. In the event the MEC determines to take action that would entitle the individual to the procedural rights set forth in Article 8, the individual will be given special notice.

(4) If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.A. NOTICE OF RECOMMENDATION AND HEARING RIGHTS

(1) In the event a recommendation is made by the MEC that a Category I or Category II practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(2) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(3) If the Category I or Category II practitioner wants to request a hearing, the request must be in writing, directed to the Hospital President, within 30 days after receipt of written notice of the adverse recommendation.

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

8.B. HEARING COMMITTEE

(1) If a request for a hearing is made in a timely manner, the Hospital President, in conjunction with the President of the Medical Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(2) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the Hospital President, in conjunction with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

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

8.C. HEARING PROCESS

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

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

(3) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Category I or Category II practitioner will be invited to present information to refute the reasons for the recommendation.

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

(5) The Category I or Category II practitioner and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(6) The Category I or Category II practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(7) The Category I or Category II practitioner and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.D. HEARING COMMITTEE REPORT

(1) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the Hospital President. The Hospital President will send a copy of the written report and recommendation by special notice to the Category I or Category II practitioner and to the MEC.

(2) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(4) The request for an appeal will be delivered to the Hospital President by special notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the Hospital President will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.E. APPELLATE REVIEW

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

(2) The Category I or Category II practitioner and the MEC will each have the right to present a written statement on appeal.

(3) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the MEC may also appear personally to discuss their position.

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

(5) The Category I or Category II practitioner will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 9

HOSPITAL EMPLOYEES

A. Except as provided below, the employment of an Allied Health Professional by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract shall apply.

B. A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital shall be processed in accordance with the terms of this Policy and the Medical Staff leadership shall determine whether the individual is qualified for the privileges requested. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

C. If a concern about an employed Allied Health Professional's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital management or Human Resources (as appropriate). This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 10

AMENDMENTS

Proposed amendments to this Policy shall be presented to the MECs of all the Hospitals within Piedmont Healthcare. This Policy may then be amended by a majority vote of the members of each MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments shall be provided to each Active Staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any Active Staff member may submit written comments to the MEC. If there is any disagreement between the MECs for the several Hospitals with respect to an amendment(s), a joint meeting shall be scheduled to discuss and resolve the disagreement. No amendment shall be effective unless and until it has been approved by the Board of each Hospital.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws or rules and regulations or Hospital policies pertaining to the subject matter thereof.

Piedmont Hospital, Inc.

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Fayette Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Mountainside Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Newnan Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

Piedmont Henry Hospital

Adopted by the Medical Staff: _____

Approved by the Board: _____

APPENDIX A

Those individuals currently practicing as Category I practitioners at the Hospital are as follows:

Piedmont Hospital, Inc.

Licensed Clinical Psychologists

Piedmont Fayette Hospital

None at this time.

Piedmont Mountainside Hospital

None at this time.

Piedmont Newnan Hospital

Licensed Clinical Psychologists

Piedmont Henry Hospital

N at this time.

APPENDIX B

Those individuals currently practicing as Category II practitioners at the Hospital are as follows:

Piedmont Hospital, Inc.

Audiologists

Certified Nurse Midwives

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Physician Assistants

Piedmont Fayette Hospital

Certified Nurse Midwives

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Physician Assistants

Piedmont Mountainside Hospital

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Clinical Nurse Specialists

Physician Assistants

Piedmont Newnan Hospital

Certified Nurse Midwives

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Physician Assistants

Piedmont Henry Hospital

Certified Nurse Midwives

Certified Nurse Practitioners

Certified Registered Nurse Anesthetists

Physician Assistants

APPENDIX C

Those individuals currently practicing as Category III practitioners at the Hospital are as follows:

Piedmont Hospital, Inc.

Certified Surgical Assistants

Certified Surgical First Assistants

Pathology Practitioner Assistants

Radiology Practitioner Assistants

Registered Nurse First Assistants

Registered Nurses

Piedmont Newnan Hospital

Certified First Assistants

Certified Surgical Assistants

Certified Surgical Technologists

Dental Assistants

Hospitalist Coordinator

Registered Nurse First Assistants

Registered Nurses

Piedmont Fayette Hospital

Certified Surgical Assistants

Certified Surgical Technologists

Dental Assistants

Physician First Assistants

Registered Nurse First Assistants

Registered Nurses

Surgical Assistants

Piedmont Henry Hospital

Dental Assistants

Registered Nurse First Assistants

Registered Nurses

Surgical Assistants

Piedmont Mountainside Hospital

Certified Surgical Assistants

Certified Surgical First Assistants

First Nurse Assistants

Neurophysiologists

Registered Nurses