

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
PIEDMONT NEWNAN HOSPITAL**

**MEDICAL STAFF
CREDENTIALS POLICY**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions 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.
- (2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital.
- (3) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (5) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment, and Clinical Privileges.
- (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 Newnan Hospital.
- (9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
- (10) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (11) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, and committee chair.
- (12) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

- (13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (14) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or D.M.D. 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.
- (15) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule to describe a clinically integrated care setting in which patients typically receive health care from more than one provider (such as a Hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (16) "PATIENT CONTACTS" includes any admission, consultation, procedure, 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.
- (17) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (18) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (19) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (20) "VICE PRESIDENT FOR MEDICAL AFFAIRS" (or "VPMA") means the individual appointed by the Board to act as the chief medical officer of the Hospital, in cooperation with the President of the Medical Staff.

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

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

1.D. MEDICAL STAFF BYLAWS AND POLICIES
AND RULES AND REGULATIONS

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, subject to the amendment and adoption provisions contained in each document.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. 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 or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) have a primary office within Coweta County or reside close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital (applies to active staff only);
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (g) have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct and have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (i) agree to personally fulfill all responsibilities regarding emergency call or to obtain appropriate coverage by another member of the Medical Staff for their specialty;

- (j) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;
 - (k) demonstrate recent active clinical practice during at least two of the last four years;
 - (l) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association ("AOA") in a specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Council on Dental Education and Licensure of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;*
 - (m) be certified in the area in which they practice by the appropriate specialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. Practitioners in the Emergency Department shall be board certified in Emergency Medicine. 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 within five years from the date of completion of their residency or fellowship training;*
 - (n) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment.*
- * These requirements shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. These requirements are not applicable to existing Medical Staff members. Existing Medical Staff members shall be grandfathered and shall be governed by the requirements in effect at the time of their initial appointment.
- (o) hold and maintain certification in Advanced Cardiac Life Support by an American Heart Association-approved course. This requirement applies to all providers who attend patients greater than fifteen (15) years of age. Emergency medicine and pathologists are exempt from this requirement.

2.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy one or more of the criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department 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 Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such.
- (c) The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.
- (d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. 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 individual or group of individuals.
- (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:

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

- (a) relevant training, experience 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 and their profession;

- (c) good reputation and character;
- (d) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams;
- (e) ability to perform, safely and competently, the clinical privileges requested; and
- (f) recognition of the importance of, and willingness to support, the Hospital'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 licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment 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 consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

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

- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;
- (c) to accept committee assignments, consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned;
- (d) to meet emergency service call obligations and care of unassigned patients with the exception of active staff members who attain age 60 or have at least 20 years of cumulative service in this community who may request to be relieved from providing emergency room call as long as, in the discretion of the Medical Executive Committee, Medical Staff resources allow. Active Staff members who meet these criteria must submit their requests to the Medical Executive Committee for consideration;
- (d) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;
- (e) to also comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;
- (f) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;
- (g) to inform the Credentials Chair of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a malpractice lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital or other health care facility, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");
- (h) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two members of the Medical Executive Committee (or one member of the Medical Executive Committee and the CEO or

designee) 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 Executive Committee member(s);

- (i) to appear for personal interviews in regard to an application for initial appointment or reappointment;
- (j) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (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 participate in monitoring and evaluation activities;
- (p) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;
- (q) to participate in an Organized Health Care Arrangement with the Hospital, to abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;
- (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 and assessments;
- (t) to the Hospital obtaining a criminal background check at appointment and reappointment;
- (u) to satisfy continuing medical education requirements; and
- (v) that any misstatement in, or omission from, the application is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may

be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

2.B.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.
- (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, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. 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 will 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 or health care facility or are currently being investigated or challenged;

- (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Executive Committee, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (5) a copy of government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

- (i) whether or not appointment or clinical privileges are granted;
- (ii) throughout the term of any appointment or reappointment period and thereafter;
- (iii) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (iv) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or

disclosures involving the individual that are made, taken, or received by the 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 and 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:

The individual specifically authorizes Piedmont Newnan Hospital, Piedmont Hospital, Inc., Piedmont Fayette Hospital, and Piedmont Mountainside Hospital to share credentialing and peer review information pertaining to an 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 shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

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

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 Medical Executive Committee and Credentials Committee.
- (b) An individual seeking initial appointment shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable 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 will 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 will not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

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

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be

contained in the application, and obtained from references and other available sources, including the applicant's past or current department 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 with the applicant will 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 will be conducted by any of the following: the department chair, a Credentials Committee representative, the Credentials Committee, the Medical Executive Committee, the President of the Medical Staff, and/or the VPMA.

3.A.4. Department Chair 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. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The department chair shall be available to the Credentials Committee, Medical Executive Committee, and the Board to answer any questions that may be raised with respect to his or her report and findings.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and 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 and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and the CEO, explaining the reasons for the delay.

3.A.6. Medical Executive Committee Procedure:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
 - (1) adopt the findings and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the CEO.
- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO 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 Medical Executive Committee 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 Medical Executive Committee 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 Chairs of the Credentials Committee and Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application and all appropriate verification is deemed complete, it will be presented to the Credentials Committee, Medical Executive Committee, and Board (or its subcommittee) at their next scheduled meetings. The review process by the Committees and the Board (or its subcommittee) will be completed within 90 days (unless the application becomes incomplete during this review process and there is a need for additional information or clarification from the applicant).

3.B. PROVISIONAL STATUS

3.B.1. Nature of Provisional Period:

Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

3.B.2. Focused Professional Practice Evaluation:

During the provisional period, the individual's exercise of the relevant clinical privileges will be evaluated by the chair of the department in which the individual has clinical privileges and/or by a physician(s) designated by the Medical Executive Committee. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other physicians and Hospital employees. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

3.B.3. Duration of Provisional Period:

- (a) The duration of the provisional period for initial appointment and privileges will be from 12 to 24 months, as recommended by the Credentials Committee.
- (b) The duration of the provisional period for all other initial grants of privileges will be as recommended by the Credentials Committee.

3.B.4. Duties During Provisional Period:

- (a) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the department chair or by other designated physicians.
- (b) A new member of the Medical Staff shall automatically relinquish his or her appointment and privileges at the end of the provisional period if that new member fails, during the provisional period, to:
 - (1) participate in the required number of cases;
 - (2) cooperate with the monitoring and review conditions; or
 - (3) fulfill all requirements of appointment, including, but not limited to, those relating to completion of medical records and/or emergency service call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

- (c) If a member of the Medical Staff who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The individual may not reapply for the privileges in question for two years.
- (d) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to a hearing and appeal.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital.
- (b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (c) The grant of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
- (d) In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (e) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.
- (f) The clinical privileges recommended to the Board shall be based upon consideration of the following:
 - (1) education, relevant training, experience, 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) ability to perform the privileges requested competently and safely;
 - (3) appropriateness of utilization patterns;
 - (4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
 - (5) availability of qualified staff members 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, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
 - (h) The report of the chair of the clinical department 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.
 - (i) During the term of appointment, a member may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure ("new procedure")) will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and until (2) criteria to be eligible to request those clinical privileges have been established.
- (b) The Credentials Committee shall make a preliminary recommendation as to whether the new procedure is one that should be offered to patients. Factors to be considered by the Credentials Committee include, but are not limited to, whether

there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

- (c) If the preliminary recommendation is favorable, the Credentials Committee shall 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 shall conduct research and consult with experts – both those on the Hospital's Medical Staff and those outside the Hospital – and develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the procedure or service;
 - (2) the extent of monitoring and supervision that should occur if the privileges are granted;
 - (3) the criteria and/or indications for when the procedure or service is appropriate; and
 - (4) the manner of addressing the most common complications that may arise.
- (d) The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board (or its designated committee) for final action.
- (e) After receiving the recommendations from the Credentials Committee and the Medical Executive Committee, the Board shall make a determination as to whether the new procedure or service will be offered to patients. If the Board determines to offer the procedure or service, it shall 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 appointees who wish to perform the procedure or service may be processed.

4.A.3. Clinical Privileges That Cross Specialty Lines:

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

- (b) The Credentials Committee may conduct research and consult with experts, 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).
- (c) 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 shall 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 of monitoring and supervision that should occur if privileges were to be granted;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (d) The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.
- (e) Once the foregoing steps are completed, specific requests from eligible Medical Staff appointees who wish to perform the procedure or service may be processed.

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

- (a) Individuals who desire to exercise clinical privileges after the age of 70 must apply for reappointment on a yearly basis.
- (b) As part of the annual reappointment process, these members will be required to have a physical and mental health assessment performed by a physician who is acceptable to the Credentials Committee at the applicant's expense. The examining physician shall provide a written report, addressing whether the individual has the appropriate cognitive and physical skills 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.

- (c) If the Committee determines that there are issues in any of these areas and/or other concern areas, 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.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chair of Surgery. 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 shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.6. Clinical Privileges for Podiatrists:

- (a) Requests for clinical privileges from podiatrists shall be processed in the same manner as applications from other practitioners. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be delineated and recommended in accordance with the provisions of the policies governing such practitioners as may be adopted by the Board from time to time.

- (b) It shall be the responsibility of the podiatrist to arrange for a history and physical by a physician member of the Medical Staff except as provided in this paragraph. A podiatrist who has clinical privileges to perform the history and physical for a "Class 1" outpatient (a normal, healthy patient) or a "Class 2" outpatient (a patient with mild systemic disease) may perform the history and physical for such outpatients. For all other outpatients, and for all inpatients, the physician member of the Medical Staff performing the history and physical shall be responsible for any medical problems that may be present at admission or that may arise during hospitalization. The responsible physician shall advise on the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When a significant medical abnormality is present, the decision on whether to proceed with surgery shall require the consensus of the podiatrist and the responsible physician.
- (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 licenses and consistent with the Medical Staff and Department of Surgery rules and regulations, and in compliance with the Medical Staff Bylaws and this Policy.

4.A.7. 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 Medical Executive Committee or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.8. Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate department chairs, the Credentials Committee, and the Medical Executive Committee.
- (b) Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements

relating to geographic residency, coverage arrangements, and emergency call responsibilities.

- (c) Qualified applicants may be granted telemedicine privileges but shall not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to, and coterminous with, the agreement.
- (d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except that the Hospital may utilize the credentialing information provided by the applicant's primary hospital/group, provided that hospital/group is accredited by the Joint Commission.
- (e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above.
- (f) Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations, and peer review activities.

4.B. CORE PRIVILEGES

4.B.1. Application Process Requirements:

Individuals requesting clinical privileges at the Hospital are required to apply for core privileges in their specialties as may be defined by each clinical department. The scope of core privileges for each clinical department shall be recommended by the department chair and must be approved by the Credentials Committee, Medical Executive Committee, and Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the department chair and approved by the Credentials Committee, Medical Executive Committee, and Board.

4.B.2. Rules Governing Exercise of Core Privileges:

Individuals who have been granted core privileges shall be required to do the following:

- (a) provide emergency call coverage for patients requiring emergency care within the scope of their core privileges; and
- (b) provide consultations for patients requiring consults within the scope of their core privileges.

4.B.3. Exemption from Core Privileges:

- (a) Any individual who wishes to be exempt from a particular privilege(s) within the core for a specialty must apply for an exemption in writing, documenting the good cause basis for the request.
- (b) After considering the recommendations from the relevant department chair and the Credentials Committee, the Medical Executive Committee shall make a recommendation in support of or against such exemption. The following factors may be considered by the Medical Staff leadership in their review of the request:
 - (1) the Hospital's mission and its obligation to serve the health care needs of the community by providing timely, quality health care on a local basis;
 - (2) fairness to the individual requesting the exemption, including past service and the other demands placed upon the individual;
 - (3) fairness to the other Medical Staff members who serve on the call roster in that specialty, including the effect that the removal would have upon them;
 - (4) any gaps in call coverage that might/would result from a Medical Staff member's removal from the call roster for the specific privilege and the feasibility and safety of transferring patients to other facilities in that situation;
 - (5) the expectations of other members of the Medical Staff who are in different specialties but who routinely rely on the specialty in question in the care of the patients who present to the emergency department;
 - (6) the perceived inequities in exemptions being available to some; and
 - (7) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
- (c) If the Medical Executive Committee recommends against granting an exemption, the individual shall be entitled to appear before the Medical Executive Committee before the Committee makes a final recommendation to the Board.

- (d) If the Medical Executive Committee recommends in favor of granting the exemption, the recommendation shall be forwarded to the Board for its review and action.
- (e) The Board shall make a final decision on the exemption request based upon consideration of the factors set forth in (a) above. The Board's decision shall be reported in writing by the President of the Medical Staff to the member, the Medical Executive Committee, and the applicable department chair, and shall specify the effective date of the exemption.
- (f) Individuals who have been granted an exemption from certain privileges within the core for their specialty are nevertheless required to participate in the emergency call schedule and to provide consultations for the privileges that remain within their core.
- (g) No individual is entitled to an exemption or to a hearing if the Board determines not to grant an exemption. A denial of a request for exemption does not entitle an individual to the procedural rights contained in Article 7 of this Policy.

4.B.4. Special Privileges Beyond the Core:

Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis, as may be requested.

4.C. TEMPORARY CLINICAL PRIVILEGES

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

- (a) Non-Applicants. Temporary privileges may be granted to non-applicants by the CEO, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following: (i) the care of a specific patient; or (ii) when necessary to prevent a lack or lapse of services in a needed specialty area. The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure, current competence, current professional liability coverage acceptable to the Hospital, results of a query to the National Practitioner Data Bank, and results of any criminal background check. The grant of clinical privileges in these situations shall not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the President of the Medical Staff.
- (b) Locum Tenens. The CEO may grant temporary admitting and clinical privileges to an individual serving as a locum tenens for a member of the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in paragraph (a), except with respect to time periods. The individual serving as a

locum tenens may exercise privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the date they are granted.

- (c) Applicants. Temporary privileges may also be granted by the CEO, upon recommendation of the President of the Medical Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Executive Committee and Board, following a favorable recommendation of the Credentials Committee. Prior to temporary privileges being granted in this situation, the credentialing process must be 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 Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate 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. Temporary privileges in this situation shall be granted for a maximum period of 120 consecutive days.
- (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.

4.C.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chair. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the CEO upon notice of any failure by the individual to comply with any such special conditions.

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

- (a) The CEO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the department chair, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the department chair, or the President of the Medical Staff 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. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

- (c) The granting of temporary privileges is a courtesy and may be terminated for any reason.
- (d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.D. 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.E. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO or 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;
 - (v) identification by a current Hospital 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.

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 the 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;
- (e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and
- (f) paid the reappointment processing fee.

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 and emergency call;

- (c) the results of the Hospital's performance improvement processes, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that other practitioners shall not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to 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 this time frame will result in the assessment of a reappointment processing fee. 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 automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed.
- (c) Reappointment shall be for a period of not more than two years.
- (d) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the CEO shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO shall consult with the chair of the applicable department, the Chair of the Credentials Committee, or the President of the Medical Staff. The temporary clinical privileges shall be only for a period not to exceed 120 days.
- (e) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

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

5.A.4. Processing Applications for Reappointment:

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

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this 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) In addition, in the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.
- (c) Reappointments may also be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

5.A.6. Time Periods for Processing:

Once an application and all appropriate verification is deemed complete, it will be presented to the Credentials Committee, Medical Executive Committee, and Board (or its subcommittee) at their next scheduled meetings. The review process by the Committees and the Board (or its subcommittee) will be completed within 90 days (unless the application becomes incomplete during this review process and there is a need for additional information or clarification from the applicant).

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 administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.
- (3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff 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, emergency call obligations, and the timely and adequate completion of medical records;
 - (b) proctoring, monitoring, consultation, and letters of guidance; and
 - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.
- (6) The relevant Medical Staff leader, in conjunction with the VPMA or CEO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., physician health policy, code of conduct policy, peer review policy).

Medical Staff leaders may also direct these matters to the Medical Executive Committee for further action.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
 - (3) 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 chair of a standing committee, or the CEO.

- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff member, the matter shall be referred to the President of the Medical Staff, the chair of the department, the chair of a standing committee, or the CEO for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Medical Executive Committee.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., physician health policy, code of conduct policy, peer review policy), or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall

begin only after a formal determination by the Medical Executive Committee to do so.

- (b) The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The President of the Medical Staff shall keep the CEO fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, or podiatrist).
- (b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that
 - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
 - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
- (c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the 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.

6.B.4. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
 - (1) determine that no action is justified;

- (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) recommend additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by special notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
 - (c) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
 - (d) In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the CEO 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.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the President of the Medical Staff, the chair of a clinical department, the Chair of the Credentials Committee, the CEO, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the

individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.

- (b) A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee 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 CEO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO or Medical Executive Committee.
- (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.C.2. Medical Executive Committee Procedure:

- (a) The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Care of Patients:

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

6.D. AUTOMATIC RELINQUISHMENT

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

Failure to complete medical records shall result in automatic and temporary relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff.

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

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below or failure to satisfy any of the threshold eligibility criteria set forth in this Policy must be promptly reported by the Medical Staff member to the Credentials Chair.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:
 - (1) Licensure: Revocation, expiration, suspension or the placement of 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: 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 any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.
- (c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this Policy.
 - (d) Automatic relinquishment or restriction shall take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment shall be deemed permanent.
 - (e) Failure to resolve the underlying matter leading to an individual's clinical privileges being automatically relinquished in accordance with paragraphs (b)(1), (b)(2) or (b)(3) above, within 90 days of the date of relinquishment, shall result in automatic resignation from the Medical Staff.
 - (f) Requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, and the CEO. 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, Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

6.D.3. Action at Another Piedmont-Affiliated Hospital:

Any disciplinary action or involuntary change in status concerning an individual's appointment and/or clinical privileges that occurs at Piedmont Newnan Hospital, Piedmont Hospital, Inc., Piedmont Fayette Hospital, or Piedmont Mountainside Hospital (except those relating to medical record completion infractions) shall automatically and immediately be effective at this Hospital, without the individual's recourse to any

additional investigation, hearing, or appeal (as may be applicable). This automatic action/change in status may be waived by the Medical Executive Committee and the Board in exceptional circumstances, after a full review of the specific circumstances and any relevant peer review documents (e.g., investigation and hearing documents) from the Piedmont facility where the action/change first occurred.

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

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the CEO, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party. However, the individual in question shall be entitled to meet with the applicable committee or individual prior to the relinquishment to determine whether any other alternative is appropriate.

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

- (a) Whenever there is a concern regarding clinical practice or professional conduct involving any individual, the department chair or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
- (c) Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.E. LEAVES OF ABSENCE

- (1) Any absence from the Medical Staff and/or patient care responsibilities for longer than 60 consecutive days shall require an individual to request a leave of absence.
- (2) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.
- (3) Members of the Medical Staff must report to the CEO any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the

reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

- (4) The CEO will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CEO shall consult with the President of the Medical Staff and the relevant department chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditional upon the individual's completion of all medical records.
- (5) 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.
- (6) 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, and the CEO. 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 Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (7) If the leave of absence was for health reasons (with the exception of a 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.
- (8) 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 CEO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (9) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall lapse at the end of the

appointment period, and the individual shall be required to apply for reappointment.

- (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 Medical Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges 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 professional competence or conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these recommendations without an adverse recommendation by the Medical Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the Medical Executive Committee" shall be interpreted as a reference to "the Board."

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

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

- (a) issuance of a letter of guidance, counsel, warning, or reprimand;
- (b) imposition of conditions, monitoring, 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 professional competence or conduct;
- (h) determination that an application is incomplete;
- (i) determination that an application will not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

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

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.A.4. Request for Hearing:

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

7.A.5. Notice of Hearing and Statement of Reasons:

- (a) The CEO shall schedule the hearing and provide, by special notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

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

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

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

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

- (2) The Hearing Panel may include any combination of the following:
 - (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).
 - (3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
 - (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
 - (5) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
 - (6) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.
 - (7) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- (b) Presiding Officer:
- (1) In lieu of a Hearing Panel Chair, the CEO may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
 - (2) If no Presiding Officer has been appointed, the Chair of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.
 - (3) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

- (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence;
 - (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (4) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
 - (5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- (c) Hearing Officer:
- (1) As an alternative to a Hearing Panel, the CEO, 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, 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, the Hearing Officer, or the Presiding Officer shall be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objections must be provided to the President of the Medical Staff and must provide the basis for the objections. The President of the Medical Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

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

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Medical Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff.
- (d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

- (f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the Medical Executive Committee'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 employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

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

7.B.5. Provision of Information to the Panel:

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

7.C. THE HEARING

7.C.1. Failure to Appear:

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

7.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the 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.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

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

7.C.4. Admissibility of Evidence:

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

7.C.5. Post-Hearing Statement:

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

7.C.6. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the President of the Medical Staff.

7.C.7. Postponements and Extensions:

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

7.C.8. Presence of Hearing Panel Members:

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

7.D. HEARING CONCLUSION, DELIBERATIONS,
AND RECOMMENDATIONS

7.D.1. Order of Presentation:

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

7.D.2. Basis of Hearing Panel Recommendation:

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

7.D.3. Deliberations and Recommendation of the Hearing Panel:

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

7.D.4. Disposition of Hearing Panel Report:

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

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

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

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

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

7.E.4. Nature of Appellate Review:

- (a) The Board may consider the appeal as a whole body, 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 Board (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

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

7.F. BOARD ACTION

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

- (a) Within 30 days after the Board (i) considers the appeal, (ii) receives the Review Panel's recommendation (if applicable), 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 will review all information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, 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 for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility for the conduct of the Hospital and the quality of care being provided.
- (c) The Board shall render its final decision in writing, including specific reasons, and shall send special notice thereof to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

7.F.2. Further Review:

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

7.F.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

CONFLICTS OF INTEREST

- (a) When performing a function outlined in this Policy, the Bylaws, the Organization Manual, the Allied Health Professionals Policy, or the Rules and Regulations, if any Medical Staff member has a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.
- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may 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 department or committee chair. The President of the Medical Staff or the applicable department or committee chair will make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a department chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel disqualification of another staff member based on an allegation of conflict of interest.
- (d) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

ARTICLE 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 peer review activities shall make no disclosures of any such information (discussions or documentation) outside of appropriate peer review committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review 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 CEO or by legal counsel to the Hospital.

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

9.B. PEER REVIEW PROTECTION

- (1) All credentialing and peer review 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. Peer review committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Hospital committees;
 - (b) all departments;
 - (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, committee chairs and members, officers of the Medical Staff, the VPMA, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of O.C.G.A. '31-7-15, O.C.G.A. '31-7-131 *et seq.*, O.C.G.A. '31-4-140 *et seq.*, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related 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

This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Executive Committee meeting and any member of the Medical Staff may submit written comments to the Medical Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

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.

Adopted by the Medical Staff: 6-23-08

Approved by the Board: 6-23-08