WakeMed Raleigh
Medical Staff Bylaws

Part I: Governance

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Part III: Credentials Process

Approved by WakeMed Board of Directors September 1, 2015
# WakeMed Raleigh Medical Staff Bylaws

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the Board of Directors of WakeMed (the “Board of Directors”).

1.2 Authority

Subject to the authority and approval of the Board of Directors, the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules, regulations and policies and under the corporate bylaws of WakeMed. Henceforth, whenever the term “the hospital” is used, it shall mean WakeMed Raleigh Campus, WakeMed North Family Health & Women’s Hospital, and other locations operating under the same CMS Certification Number (CCN); and whenever the term “the Board” is used, it shall mean Board of Directors. Whenever the term “CEO” is used, it shall mean the chief executive officer appointed by the Board to act on its behalf in the overall management of the hospital. The term CEO includes a duly appointed acting administrator serving when the CEO is away from the hospital.
Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the medical staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, clinical psychologists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, regulations, policies and procedures of the medical staff and the hospital.

2.2 Qualifications for Membership

The qualifications for medical staff membership are delineated in Part III of these bylaws (Credentials Process).

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, sexual orientation, physical or mental impairment that does not pose a direct threat to the health or safety of patients, the physician himself or herself or others, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the medical staff. The Board shall act on appointment and reappointment only after the medical staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for medical staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Process) of these bylaws.

2.6 Medical Staff Members Responsibilities

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.6.2 Each staff member or practitioner with privileges must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions (including service on appropriate medical staff committees) as may be required.
2.6.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each staff member or practitioner with privileges must submit to any pertinent type of health evaluation as requested by the President of the Medical Staff, Chief Executive Officer (CEO), Chief Quality Officer (CQO), appropriate Executive Medical Director (EMD) and/or medical staff committee/Department chair when it appears necessary, to the requestor, to protect the well-being of patients and/or staff, or when requested by the MEC or Shared Credentials Committee as part of an evaluation of the member’s ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.

2.6.5 Each staff member or practitioner with privileges must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.

2.6.6 Each staff member or practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member shall notify the medical staff services office promptly of any and all malpractice claims filed in any court of law against the medical staff member.

2.6.7 Each applicant, staff member, or practitioner with privileges agrees to absolutely release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the medical staff member and his/her credentials.

2.6.8 Each staff member shall prepare and complete in timely fashion, according to medical staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

A. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
B. An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

C. The content of complete and focused history and physical examinations is delineated in the Medical Staff Rules and Regulations.

2.6.9 Each staff member or practitioner with privileges will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA and State of North Carolina laws and regulations, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital’s business information designated as confidential by the hospital or its representatives prior to disclosure.

2.6.10 Each staff member or practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member’s clinical privileges.

2.6.11 Each staff member must properly supervise healthcare professionals (such as PSPs and residents) under his or her supervision, including allied health professionals and students.

2.6.12 Each staff member must refuse to engage in improper inducements for patient referral.

2.6.13 Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate medical staff leader(s), that practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.
2.7.2 Each staff member in the Active category has the right to initiate a recall election of a medical staff officer by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff by presenting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the Active category may challenge any rule, regulation or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by ten percent (10%) of the Active members of the Department. Upon presentation of such a petition, the Department Chair will schedule a Department meeting.

2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any practitioner eligible for medical staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the medical staff’s hearing and appeal plan (Part II of these bylaws).

2.8 Staff Dues
Members of the medical staff shall pay all Staff fees, dues, and assessments within the time frame required.

2.9 Indemnification
To the extent permitted by the bylaws of WakeMed, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.
Section 3. Categories of the Medical Staff

3.1 Membership Categories of the Medical Staff

Medical Staff membership does not in itself convey the privilege of practicing medicine. One can be a member of the medical staff (such as an Active staff member) with or without having been granted the privilege to diagnose or treat patients. Likewise, privileges may be granted to qualified practitioners who are not members of the medical staff (such as physician assistants, nurse practitioners, telemedicine physicians, and others). Medical staff members who are Senior Active category as of November 1, 2011 will be moved to Active and remain exempt from call responsibilities.

3.2 Active Category

3.2.1 Qualifications

Members of this category must have served on the medical staff for at least one (1) year and satisfied the board certification requirements stipulated in Part III, Section 2 of this document plus one of the following:

A. twenty-five (25) patient contacts per two-year reappointment cycle (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure) at the hospital,

B. be a member of a hospital-based service such as anesthesiology, emergency medicine, pathology, or radiology,

C. attendance at least six (6) meetings (general medical staff, Department, or hospital/medical staff committee) per two-year reappointment cycle which must include at least one (1) general medical staff meeting per year.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

3.2.2 Prerogatives

Members of this category may:

A. Attend medical staff and Department meetings of which s/he is a member and any medical staff or hospital education programs;

B. Vote on all matters presented by the medical staff, Department, and committee(s) to which the member is assigned; and

C. Hold office and be a member of or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.
3.2.3 Responsibilities

Members of this category shall:

A. Contribute to the organizational and administrative affairs of the medical staff;

B. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

C. Fulfill or comply with any applicable medical staff or hospital policies or procedures.

3.3 Associate Category

3.3.1 Qualifications

The associate category is reserved for medical staff members who do not meet the qualification requirements for the Active category.

3.3.2 Prerogatives

Members of this category may:

A. Attend medical staff and Department meetings of which s/he is a member and any medical staff or hospital education programs;

B. Not vote on matters presented by the entire medical staff or Department or be an officer of the medical staff or be department chair or vice chair; and

C. Serve on medical staff committees, other than the MEC, and may vote on matters that come before such committees.

3.3.3 Responsibilities

Members of this category shall have the same responsibilities as Active category members.

3.4 Affiliate Category

3.4.1 Qualifications for Affiliate Category

The affiliate category is reserved for medical staff members with no privileges. The affiliate staff member must meet the qualifications for medical staff membership pursuant to Section 4.2 with the exception of maintaining DEA registration.

3.4.2 Prerogatives

Members of this category may:

A. Serve on committees, with or without vote, at the discretion of the Medical Executive Committee.
B. Attend staff and department meetings, including open committee meetings and educational programs.

The affiliate staff member may not:
A. Admit patients to the hospital or be granted any clinical privileges.
B. Hold office in the medical staff organization.

3.4.3 Responsibilities
A. The affiliate staff member must pay all dues, fees and assessments within the required time frame.
B. Affiliate staff members do not participate in mandatory Emergency Department on-call coverage.

3.5 Honorary Category
The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time without necessitating a hearing. Members of the Honorary Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote. Honorary Members are not required to maintain current medical license, DEA, or professional liability coverage.
Section 4. Officers of the Medical Staff and MEC at-large Members

4.1 Officers of the Medical Staff and MEC at-large Members

4.1.1 President of the Medical Staff

4.1.2 President-Elect of the Medical Staff

4.1.3 Immediate Past President

4.2 Qualifications of Officers and MEC at-large Members

4.2.1 Officers must be members in good standing of the Active category and meet the requirements of clinical activity for the Active category. MEC at-large members must be members in good standing of the Active category. Officers and MEC at-large members must indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges within the WakeMed System, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have appropriate administrative and communication skills. In addition, Officers must have previously served in a significant leadership position on a medical staff (e.g. Department or section chair, committee chair). Qualifications for the positions of President of the Medical Staff and President-Elect of the Medical Staff also include the degree of MD, DO, DDS, DMD, or DPM. The medical staff nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria. The immediate past President of the Medical Staff attains his/her position by automatic succession from the office of President of the Medical Staff.

4.2.2 It is the policy of the medical staff that all practitioners serving in an elected or appointed position in the organized medical staff (such as an officer, department chair, or a member of the medical executive, peer review, or credentials committees), or otherwise carrying out a function of the organized medical staff (such as peer review), shall act in good faith to fulfill their responsibilities under the medical staff’s bylaws, rules and regulations, and policies. In order to achieve this goal, practitioners shall fully and openly disclose any actual or potential conflicts of interest at the time they arise in the course of serving in such a position or fulfilling such a medical staff function. At the time of disclosure, it is the responsibility of the medical staff, through its self-governing structure, to determine whether and to what extent such conflict of interest should limit the practitioner’s participation in their position, medical staff function, or the particular issue under consideration.
4.3 **Election of Officers and MEC at-large Members**

4.3.1 The nominating committee (as defined in the Organization and Functions Manual) shall offer at least one nominee for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the Active medical staff at least 30 days prior to the election.

4.3.2 A petition signed by at least ten percent (10%) of the members of the Active staff may add nominations to the ballot. The medical staff must submit such a petition to the President of the Medical Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The candidate must meet the qualifications in section 4.2 above before he/she can be placed on the ballot.

4.3.3 Officers and MEC at-large members shall be elected prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member’s voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes will be elected. In the event of a tie vote, the MEC will make arrangements for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a greater number of votes.

4.4 **Term of Office**

All officers and MEC at-large members serve a term of two (2) years. Officers shall take office in the month of January in odd years. At-large members shall take office in the month of January in staggered years. An individual may serve no more than two consecutive terms. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 **Vacancies of Office**

The MEC shall fill vacancies of office during the medical staff year, except the office of the President and Immediate Past President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the President-Elect shall serve the remainder of the term. If there is a vacancy in the office of the Immediate Past President of the Medical Staff, the office will remain vacant for the remainder of the term.

4.6 **Duties of Officers and MEC at-large Members**

4.6.1 **President**: The President shall represent the interests of the medical staff to the MEC and the Board. The President will fulfill the duties specified in Part I, Section 4.8 of these bylaws.
4.6.2 **President-Elect:** In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. S/he shall perform the duties as delineated in Part I, Section 4.9 of these bylaws and any such further duties to assist the President as the President may request from time to time.

4.6.3 **Immediate Past President:** This officer will serve as a consultant to the President and President-Elect and provide feedback to the officers regarding their performance of assigned duties. S/he shall perform such further duties to assist the President as the President may request from time to time.

4.6.4 **MEC at-large Members:** These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.

4.7 **Removal and Resignation from Office**

4.7.1 The medical staff may initiate the vote for removal of any officer or MEC at-large members if at least ten percent (10%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two thirds (2/3) of those Active staff members casting ballot votes when a quorum is present (as defined in Part I, Section 7.4.1).

4.7.2 Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in his/her duties after consulting with the Joint Committee on Quality Care.

4.7.3 Any elected officer or MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, or any later time which is specified therein, but in no event shall the resignation take effect later than the date on which a successor is elected.

4.8 **Responsibilities of the President of the Medical Staff**

The President of the Medical Staff is the primary elected officer of the medical staff and is the medical staff’s advocate and representative in its relationships to the Board and the administration of the hospital. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations and policies. Specific responsibilities and authority are to:

A. Call and preside at all general and special meetings of the medical staff;
B. Serve as chair of the MEC and as ex-officio member of all other medical staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

C. Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;

D. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

E. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

F. Report to the Board the MEC’s recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

G. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

H. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

I. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

J. Attend Board meetings and Board committee meetings as invited by the Board including being a voting member of the Joint Committee on Quality Care;

K. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

L. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.
4.9 Responsibilities of the President-Elect of the Medical Staff

As the second ranking elected Medical Staff officer, the President-Elect has these responsibilities and authority:

A. Assume all of the duties and responsibilities and exercise all of the authority of the President of the Staff when the latter is temporarily unable to accomplish the same. If the President becomes permanently unable to fulfill the duties of his office by reason of illness, resignation, removal or other absence, the President-Elect will succeed to the office of President.

B. Serve as a member of the Medical Executive Committee, Quality Improvement Committee, and Joint Committee on Quality Care.

C. Perform such additional duties and exercise such authority as may be assigned or granted by the Medical Staff President, by the Medical Executive Committee, by the Board or in the Medical Staff Bylaws and related manuals or in other Staff or hospital policies.

D. Serve as ex-officio member of all committees without vote, except the Medical Executive Committee, Joint Committee on Quality Care and Medical Staff Quality Improvement Committee where s/he is a voting member.

E. Be responsible for the enforcement of the Medical Staff Bylaws, manuals, rules, policies and procedures; for implementation of sanctions where they are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

F. Serve on the Medical Staff Quality Improvement Committee.
5.1 Organization of the Medical Staff

5.1.1 The medical staff shall be organized into Departments including the Departments of Anesthesiology, Emergency Services, Medicine, Obstetrics/Gynecology, Orthopedic Surgery, Pathology, Pediatrics, Radiology, and Surgery. A Department Chair shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

5.1.2 The medical staff may create clinical sections, when applicable, within a Department in order to facilitate medical staff activities. The following criteria shall apply in making section designations:

A. The area of practice is an established, professionally-recognized specialty/subspecialty field within the general field of the department and is a significant area of practice at the hospital. (‘Significant’ means that specialists in that area devote most of their time to that specialty rather than having a broader-based practice and the numbers and/or activity level in that area are such to require a chief specifically responsible for the coordination of services, quality control and day-to-day problem resolution); and

B. The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to sections; and

5.1.3 A Section Chief shall head each Section and will be appointed by the Department Chair. Each Section Chief will have duties as delegated by the Department Chair.

5.1.4 The MEC, with approval of the Board, may designate or dissolve new medical staff Departments as it determines will best promote the medical staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.1.5 The MEC will work collaboratively with the Operations Leadership Team in development of service lines if needed.
5.2 Qualifications, Selection, Term, and Removal of Department Chair

5.2.1 Each Department Chair shall serve a term of two (2) years commencing on January 1 of even years for the Departments of Anesthesiology, Emergency Services, Pediatrics and Surgery and on January 1 of odd years for the Departments of Medicine, Obstetrics/Gynecology, Orthopaedic Surgery, Pathology and Radiology. For Departments not governed by an exclusive contract, Department Chairs may be re-elected to one additional term. Limitations apply to contracted services unless the contract specified otherwise. Term limits may be waived by the Medical Executive Committee upon petition of the department. All Department Chairs must be members of the Active medical staff with an active clinical practice in the hospital, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

5.2.2 Department Chairs and Department Vice Chairs shall be elected by majority vote of the Active members of the Department. Each Department shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC.

5.2.3 The MEC may recommend, to the Department, removal of a Department Chair or Vice Chair. If the Department does not remove the Department Chair or Vice Chair upon recommendation of the MEC, the MEC may remove the Department Chair or Vice Chair upon a 2/3 majority decision if any of the following occurs:

A. The Department Chair or Vice Chair suffers an involuntary loss or significant limitation of practice privileges; or

B. The MEC determines that the Department Chair or Vice Chair has failed to demonstrate to the satisfaction of the MEC and the Board that he or she is effectively carrying out the responsibilities of the position.

5.2.4 Department Chairs or Vice Chairs will be removed from office automatically if the Department Chair or Vice Chair ceases to be a member in good standing of the medical staff.

5.2.5 If a Department Chair or Vice Chair is removed through the above process, a new election will be held according to established Department procedures.

5.2.6 Department Chairs or Vice Chairs shall carry out the responsibilities assigned in Part I, Section 5.4 of these bylaws (the Organization and Functions Manual).

5.2.7 Department Vice Chairs are to fulfill the responsibilities of the Department Chair in their absence, including attendance at the MEC.
5.3 **Assignment to Department**

The MEC will, after consideration of the recommendations of the Department Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department assignment.

5.4 **Responsibilities of Department Chairs**

In assuring the accomplishment of the functions of medical staff departments and in meeting his responsibility for the professional and administrative activities within the department, a Department Chair has these specific responsibilities and authority:

A. To oversee all clinically-related activities of the Department;

B. To oversee all administratively-related activities of the Department, unless otherwise provided by the hospital;

C. To provide ongoing surveillance of the performance of all individuals in the medical staff Department who have been granted clinical privileges;

D. To recommend to the Shared Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Department;

E. To recommend clinical privileges for each member of the Department and other licensed independent practitioners practicing with privileges within the scope of the Department;

F. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff Department or the hospital;

G. To integrate the Department into the primary functions of the hospital;

H. To coordinate and integrate interdepartmental and intradepartmental services and communication;

I. To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

J. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service;

K. To provide input to the CEO regarding the qualifications and competence of Department or service personnel who are not LIPs but provide patient care, treatment, and services;

L. To continually assess and improve of the quality of care, treatment, and services;

M. To maintain quality control programs as appropriate;
N. To orient and continuously educate all persons in the Department or service; and

O. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff Department to provide patient care services.

P. Establish the process and identify the medical staff members responsible for taking Emergency Department call in coordination with Medical Staff Services and in compliance with the directives of the MEC.
Section 6. Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and ad hoc committees as established by the MEC. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

The following shall be the standing committees of the medical staff: (medical executive, credentials, medical staff quality improvement (MSQI), nominating, bylaws,). A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff and the CEO, or their designees, are ex-officio members of all standing and ad hoc committees.

6.2 MEC

6.2.1 Committee Membership:

A. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the medical staff, the Department Chairs (or their designated Vice Chairs in their absence), the chair or vice chair of the Shared Credentials Committee, Chair of the Medical Staff Quality Improvement Committee (or Vice Chair in the Chair’s absence), and three (3) members of Active medical staff members elected at-large. The chair will be the President of the Medical Staff. The non-voting members of the MEC shall be the: Chief Executive Officer (CEO) or designee, Chief Operating Officer (COO), Chief Nursing Officer (CNO), Chief Physician Executive (CPE), Senior VP and Raleigh Administrator, VP and North Administrator, vice chair of the Medical Staff Quality Improvement Committee (MSQI), Chief Quality Officer, and Executive Medical Directors for Raleigh and North. Regular invitees shall be hospitalist director, VP of Medical Education, and Senior VP of Physician Practices who are invited on a periodic basis. Other individuals may be invited as determined by the President of the Medical Staff. The MEC shall go into executive session with members only to discuss confidential items, such as but not limited to credentialing, peer review, and corrective action. Generally, this executive session will be limited to voting members, CEO or designee, Chief Quality Officer, and Executive Medical Directors only and all
other regular or episodic invitees will be dismissed, except with the express approval of the Chair.

B. Removal from MEC: An officer, MEC At-Large Member, or Department Chair who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC. When the chair of either the shared credentials or quality improvement committees or Department Chair resigns or is removed from these positions, his/her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. When a member of the MEC who was elected at-large resigns or is removed, the MEC will arrange for an at-large election for a replacement to serve out the remainder of the vacated term. Such an election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

6.2.2 Duties: The duties of the MEC, as delegated by the medical staff, shall be to:

A. Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;

B. Coordinate the implementation of policies adopted by the Board;

C. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action;

D. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;

E. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;

F. Make recommendations to the Board on medical administrative and hospital management matters;

G. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;

H. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

I. Review and act on reports from medical staff committees, Departments, and other assigned activity groups;

J. Formulate and recommend to the Board medical staff rules, policies, and procedures;
K. Request evaluations of practitioners privileged through the medical staff process when there is question about an applicant or member’s ability to perform privileges requested or currently granted;

L. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

M. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital;

N. Address that portion of corporate compliance that pertains to the medical staff;

O. Hold medical staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;

P. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws;

Q. Delineate emergency department on-call responsibilities; and

R. The MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.

6.2.3 **Meetings**: The MEC shall meet at least 10 times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.
Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 A full medical staff meeting will be held at least annually and more frequently at the discretion of the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.

7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or secure electronic ballot, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Full Meetings of the Medical Staff

A. The President of the Medical Staff may call a special full meeting of the medical staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

B. A special full meeting of the medical staff shall also be called by the President of the Medical Staff upon presentation of a petition signed by ten percent (10%) of the Active members of the full medical staff.

C. Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) business days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee or Department may be called by the chair or Department Chair thereof or by the President of the Medical Staff. A special department meeting shall also be called by the chair upon presentation of a petition signed by ten percent (10%) of the Active members of the department.
7.4  Quorum

7.4.1  Full Medical Staff Meetings: Those eligible medical staff members present and voting on an issue. The quorum for voting on amendments to the bylaws or for the removal of officers or MEC at-large members will be twenty percent (20%) of the eligible voting members. (For example, a bylaws amendment would require 20% of the members of the Active category voting to constitute a quorum). This quorum requirement applies to amendments to rules and regulations challenged pursuant to Part I, Section 2.7.4

7.4.2  MEC, Shared Credentials Committee, and the Medical Staff Quality Improvement Committee(s): A quorum will exist when fifty percent (50%) of the members are present.

7.4.3  Department meetings or medical staff committees other than those listed in 7.4.2 above: Those present and eligible medical staff members voting on an issue. The quorum for voting for the removal of department chair or vice chairs will be twenty percent (20%) of the eligible voting members.

7.5  Attendance Requirements

7.5.1  Members of the medical staff are encouraged to attend meetings of the medical staff.

MEC, Shared Credentials Committee, and Medical Staff Quality Improvement Committee meetings: Members of these committees, or their designees, are expected to attend at least seventy-five percent (75%) of the meetings held.

7.5.2  Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable Department Chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) business days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner’s appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner’s membership and privileges. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).
7.6 **Participation by the CEO**

The CEO or his/her designee may attend any general, committee or Department meetings of the medical staff as an ex-officio member without vote.

7.7 **Robert’s Rules of Order**

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert’s Rules of Order shall determine procedure.

7.8 **Notice of Meetings**

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than three (3) business days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 **Action of Committee or Department**

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.

7.10 **Rights of Ex-Officio Members**

Except as otherwise provided in these bylaws, persons serving as ex-officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 **Minutes**

Minutes of each regular and special meeting of a committee and Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The meeting minutes will be approved at the next committee or department meeting. A permanent file of the minutes of each meeting shall be maintained.
Section 8.  Conflict Resolution

8.1  Conflict Resolution

8.1.1  In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to the Joint Committee on Quality Care for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2  To promote timely and effective communication and to foster collaboration between the Board, management and medical staff, the chair of the Board, CEO or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3  Any conflict between the medical staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these bylaws.
Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by ten percent (10%) of the members of the Active category.

Each Active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff if the medical staff receives an affirmative vote by two-thirds (2/3) of those members voting in a forum in which a quorum of twenty percent (20%) of the Active medical staff have cast ballots.

Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations and Policies

9.3.1 The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
9.3.2 If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the MEC immediately informs the medical staff. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action. The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.3 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2 above will be followed.

9.3.5 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party prior to vote.

9.3.6 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee’s judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.
WakeMed Raleigh

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan
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Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual’s clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital’s performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

A. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

B. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

C. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears that the practitioner’s performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm’s way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner’s membership and/or privileges. Before issuing such a recommendation, the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.
Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a medical staff officer, committee chair, Department Chair, CEO, CQO, appropriate EMD, or hospital Board Chair to the MEC. The request must be supported by references to the activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons.

A. Whenever the activities or professional conduct of any practitioner no longer meet the standards or aims of the Medical Staff, are detrimental to the delivery of quality patient care, disrupt the operations of the hospital, or violate the bylaws and related manuals, rules, policies or standards of the hospital or Medical Staff, an investigation may be requested.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the Chief Quality Officer.

If the investigating body decides, in its sole discretion, that it is necessary or appropriate for a pending investigation to obtain additional documents, records, or materials (e.g. medical records, imaging, lab results, etc.), it may make a written request of any practitioner on the Medical Staff (not just the practitioner under review). Unless prohibited by law, a practitioner on the Medical Staff is required to provide the investigating body with all documents, records, and other materials requested to evaluate competency and credentialing/privileging qualifications of a practitioner under investigation, and, if requested, to execute a general or specific release to allow the investigating body to obtain such documentation. Failure to provide such documentation and/or execute a general or specific release of information when requested by the investigating body or the MEC may be considered a voluntary relinquishment of privileges under Section 3.1.11 or may result in corrective action, up to and including termination of a practitioner’s privileges and membership.
The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams.

The investigating body shall notify the practitioner in question, by special notice, of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. If the practitioner in question is a PSP, then special notice will also be given to the supervising physician. The meeting between the practitioner in question, and supervising physician in the case of PSPs, and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including recommending suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

A. The hospital is faced with ambiguous or conflicting information, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;

B. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the physician under review; or

C. The MEC or the investigating body feels that this action is appropriate.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

A. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner’s file;

B. Deferring action for a reasonable time when circumstances warrant;
C. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee or Department chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner’s file;

D. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

E. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

F. Recommending reductions of membership status or limitation of any prerogatives directly related to the member’s delivery of patient care;

G. Recommending suspension, revocation, or probation of medical staff membership; or

H. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

2.4.1 If the MEC recommends any termination or restriction of the practitioner’s membership or privileges for a period longer than fourteen (14) days and is due to a reason of competence or conduct, the affected practitioner will be offered the fair hearing and appeal rights in these bylaws.

If the practitioner waives the right to a fair hearing and subsequent appeal, the MEC recommendation will be forwarded to the Board for action.

If the practitioner exercises his/her right to the fair hearing and appeal process, the process delineated in these bylaws will be followed.

2.4.2 In addition to the actions listed above in Section 2.4.1, if the affected practitioner exercises privileges at WakeMed Raleigh and WakeMed Cary, the routine corrective action matter, other than a summary or automatic suspension, will be invoked at the second institution through Corporate Leadership. If the second institution is WakeMed Raleigh, “Corporate Leadership” is the CEO or his designated representative. If the second institution is WakeMed Cary, “Corporate Leadership” is the WakeMed Cary Senior VP/Administrator or his designated representative. Medical Staff Services shall promptly notify Corporate Leadership of the second institution of any corrective action. If the termination or restriction of the practitioner’s membership or privileges for a period longer than fourteen (14) days and is due to a reason of competence or conduct, the affected practitioner will be offered the fair hearing and appeal rights in these bylaws.
Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the practitioner’s privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing; provided, however, the practitioner’s privileges may be reinstated by the MEC in specific instances in which the triggering circumstances have been rectified or are no longer present or are reinstated automatically when specified below.

Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible and may reinstate the practitioner’s privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the MEC has not agreed to reinstate the practitioner within sixty (60) days of the triggering event, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 Licensure

A. Revocation and suspension: Whenever a practitioner’s license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

B. Restriction: Whenever a practitioner’s license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

C. Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
3.1.2 **Medicare, Medicaid, Tricare** (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or any other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General’s List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 **Controlled substances**

Whenever a practitioner’s United States Drug Enforcement Agency (DEA) registration is revoked, limited, suspended or not renewed, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the registration, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical record completion requirements:** A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **Professional liability insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies shall result in immediate automatic relinquishment of a practitioner’s clinical privileges. If this is corrected and evidence is provided to the Hospital within 60 days of adequate insurance coverage (including coverage for any period during which insurance was not maintained), the practitioner’s privileges are automatically reinstated. If within 60 calendar days of the relinquishment, the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.
3.1.6 **Medical Staff dues/special assessments**: Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner’s appointment and clinical privileges. If this is corrected within 60 days, the practitioner’s privileges are automatically reinstated. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

3.1.7 **Felony conviction**: A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony involving a charge related to violence, physical or sexual abuse, insurance or healthcare fraud or abuse, or drug offenses in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.8 **Failure to satisfy the special appearance requirement**: A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement, provided it is within 30 days. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

3.1.9 **Failure to participate in an evaluation**: A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation, provided it is within 30 days. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

3.1.10 **Failure to become board certified**: A practitioner who fails to become board certified or maintain board certification as required by these bylaws or applicable medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges, unless an exception is granted, for good cause, by the Board upon recommendation from the MEC.
3.1.11 **Failure to execute release and/or provide documents**: A practitioner who fails to execute a general or specific release of information and/or provide documents, medical records, and/or materials when requested by the MEC, President of the Medical Staff or designee, or an investigative committee to evaluate the competency and credentialing/privileging qualifications of the practitioner or another practitioner on the Medical Staff who is under investigation pursuant to Section 2.2 of this Part II may be treated as having automatically relinquished all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the practitioner may be automatically reinstated. Otherwise, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.12 **Failure to obtain TB testing**: For failure to comply with WakeMed’s requirements for annual tuberculosis testing, a practitioner’s Medical Staff membership and/or clinical privileges are immediately suspended. They may be reinstated upon compliance with testing requirements, as long as requirements are met prior to the next scheduled reappointment.

3.1.13 **Failure to obtain Influenza Vaccination**: For failure to comply with WakeMed’s requirements for annual influenza vaccination, a practitioner’s clinical privileges are immediately suspended unless granted an exemption. They may be reinstated automatically upon compliance with vaccination requirements and submission of appropriate documentation, provided it is within 60 days. Failure to comply within 60 calendar days will be considered a voluntary resignation from the medical staff.

3.1.14 **Failure to comply with mandatory training or other administrative requirements**: For failure to comply with WakeMed’s mandatory training requirements or other mandatory administrative requirements, a practitioner’s Medical Staff membership and/or clinical privileges are immediately suspended. They may be reinstated upon compliance with all applicable mandatory requirements, provided that these requirements are met and any required documentation is received within 60 days. Failure to comply within 60 calendar days will be considered a voluntary resignation from the medical staff.

3.1.15 **MEC Deliberation**: As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

3.2 **Precautionary (Summary) Restriction or Suspension**

3.2.1 **Criteria for initiation**: A precautionary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to:
A. protect the life or well-being of patient(s);

B. reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders (medical staff leader defined as an MEC member), the CQO and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution; or

C. prevent or mitigate the actual or substantial likelihood of intentional, wrongful disclosure of any confidential identifying patient health information.

Under such circumstances two of the following (CEO or designee, President of the Medical Staff or designee, CQO, Department Chair or the MEC) may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written special notice to the practitioner, the MEC, the CEO. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner’s patients shall be promptly assigned to another medical staff member by the President of the Medical Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

If the affected practitioner exercises privileges at both WakeMed Cary and WakeMed Raleigh, the summary suspension will be invoked at the second institution through the Corporate Leadership as described in Section 2.4.2 of these bylaws.
3.2.2 **MEC action**: As soon as feasible and within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a “hearing” as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 **Procedural rights**: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.
Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for medical staff appointment or privileges shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following “adverse actions” when the basis for such action is related to clinical competence or professional conduct:

A. Denial of medical staff appointment or reappointment;
B. Revocation of medical staff appointment;
C. Denial or restriction of requested clinical privileges;
D. Involuntary reduction or revocation of clinical privileges;
E. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or
F. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

A. Issuance of a letter of guidance, warning, or reprimand;
B. Imposition of a requirement for proctoring (i.e., observation of the practitioner’s performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges (i.e., can still perform the privilege without the presence of the proctor);
C. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
D. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
E. Requirement to appear for a special meeting under the provisions of these bylaws;
F. Automatic relinquishment or voluntary resignation of appointment or privileges;
G. Imposition of a precautionary suspension or administrative time out that does not exceed 14 calendar days;
H. Denial of a request for leave of absence, or for an extension of a leave;
I. Determination that an application is incomplete or untimely;
J. Determination that an application will not be processed due to misstatement or omission;
K. Decision not to expedite an application;
L. Denial, termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
M. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;
N. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;
O. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
P. Termination of any contract with or employment by hospital;
Q. Proctoring (prospective, concurrent, or retrospective), monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;
R. Any recommendation voluntarily accepted by the practitioner;
S. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
T. Change in assigned staff category;
U. Refusal of the Shared Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;
V. Removal or limitations of emergency department call obligations;
W. Any requirement to complete an educational assessment;
X. Retrospective chart review;
Y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;
Z. Grant of conditional appointment or appointment for a limited duration;
AA. Appointment or reappointment for duration of less than 24 months; or
BB. Any other action or recommendation not listed above which does not result in reducing, restricting, suspending, revoking or denying clinical privileges or staff membership.
4.3 Notice of Recommendation of Adverse Action

The President of the Medical Staff (which in the case of a practitioner or PSP applying for or exercising the affected privileges at both institutions, “President of the Medical Staff” for purposes of this Section 4 shall mean the President of the Medical Staff at the institution first imposing suspension or otherwise making an adverse recommendation) shall, within 15 days of an adverse action, proposed action, or recommendation by the Medical Staff (or the President of WakeMed in the case of a Board adverse action or recommendation) under Section 4.1, give the practitioner or PSP special notice thereof. (In the event of two adverse MEC recommendations, a Joint MEC recommendation, or two adverse Board recommendations, the practitioner or PSP shall be entitled to only one hearing and one Appellate Review, notwithstanding any other provisions of this Fair Hearing Plan, Bylaws or Related Manuals or Corporate Bylaws to the contrary, to respond to the adverse recommendation(s) arising from the practitioner’s or PSP’s application for (re)application or the practitioner’s or PSP’s conduct giving rise to corrective action under Part II of the Bylaws for practitioners for PSPs. In the event both MEC recommendations are adverse but are not identical, a Joint MEC will be convened within 10 days of the latter MEC’s recommendation to make a single adverse recommendation to the Board.) The notice to the practitioner or PSP shall:

A. Advise the practitioner or PSP of the adverse action or proposed adverse recommendation or action, the reasons for the proposed action, recommendation or action and of his right to request a hearing upon timely and proper request pursuant to Section 4.4 below;

B. Specify that the practitioner or PSP has 30 days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 4.4; and that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice;

C. Specify that the hearing will be held as determined by the President of the Medical Staff, or the Chair of the Board, as appropriate, by one of the following methods:

(1) before an arbitrator mutually acceptable to the practitioner or PSP and President of the Medical Staff (or Board Chair, as appropriate); or,

(2) before a hearing officer, who is a lawyer, who is appointed by the President of the Medical Staff (or Board Chair, as appropriate); or,

(3) before a panel of practitioners and/or individuals (Ad Hoc Hearing Committee) who are appointed by the President of the Medical Staff (or Board Chair, as appropriate) and are not in direct economic competition with the practitioner or PSP involved. At the discretion of the Medical Staff President (or Board Chair, as appropriate) a hearing officer may also be
appointed under this provision to preside over the hearing but not to render a recommendation.

(4) If the affected practitioner or PSP invokes fair hearing and appeal rights for privileges exercised at both hospitals in the WakeMed System, only the following method for hearing shall be used: Before a panel of practitioners and/or individuals (Ad-hoc hearing committee) who are appointed in equal numbers by the Presidents of the Medical Staffs and are not in direct economic competition with the practitioner or PSP involved. A hearing officer shall be appointed by the WakeMed CEO and shall preside over the hearing and shall only participate in the recommendation in the event of a deadlock.

D. Specify that the right to the hearing may be forfeited if the practitioner or PSP fails, without good cause, to appear;

E. Specify that in the hearing the practitioner or PSP has the following rights:

   (1) to representation by an attorney or other person of the practitioner’s or PSP’s choice;

   (2) to have a record made of the proceedings, copies of which may be obtained by the practitioner or PSP upon payment of the reasonable charge associated with the preparation thereof;

   (3) to call, examine, and cross-examine witnesses;

   (4) to present evidence determined to be relevant by the presiding practitioner or PSP regardless of its admissibility in a court of law; and,

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

F. Specify that upon completion of the hearing, the practitioner or PSP involved has the following rights:

   (1) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and,

   (2) to receive a written decision of the hospital including a statement of the basis for the decision.

G. State that any higher authority required or permitted under this plan to act on the matter following a waiver is not bound by the adverse recommendation or action that the practitioner or PSP has accepted by virtue of the waiver but may take any action it deems warranted by the circumstances; and

H. State that upon receipt of the hearing request, the practitioner or PSP will be notified of the date, time, and place of the hearing.

If the action of the MEC/Joint MEC or Board is based upon any one, or combination thereof, of the adverse actions listed in Section 4.1 of the Medical Staff Bylaws, the President of the Medical Staff shall, within 15 days of an adverse action, proposed action, or recommendation by the Medical Staff (or the
President of WakeMed in the case of a Board adverse action or recommendation) under Section 4.3, give the practitioner or PSP special notice thereof. The notice shall advise the practitioner or PSP of the adverse action or proposed adverse recommendation or action, the reasons for the proposed action, recommendation or action and of the fact that this action does not entitle the practitioner or PSP to a hearing pursuant to Part II of the Medical Staff Bylaws.

4.4 Request for Hearing

The practitioner or PSP shall have 30 days after receiving a notice under Section 4.3 to file a written request for a hearing. The request must be delivered to the person who sent the notice under 4.3 above. A practitioner or PSP who fails to request a hearing within the time and in the manner specified in this section waives his right to any hearing or appellate review to which he might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse recommendation or action triggering the notice. As soon as reasonably practicable, the practitioner or PSP will be sent special notice of the action taken; either the details of the hearing (as more particularly described in Section 4.5) or the effective date of the adverse action.

4.5 Notice of Hearing and Statement of Reasons

Upon receiving a timely and proper request for hearing, the President of the Medical Staff of the institution first imposing suspension or adverse recommendation shall then schedule a hearing. (If the request for hearing is in response to a notice sent by the WakeMed President as described in 4.3, the Chair of the Board, through the Office of the WakeMed President, shall schedule the hearing). The Medical Staff President of the institution first imposing suspension or adverse recommendation (or WakeMed President, as appropriate), shall send the practitioner or PSP special notice of the time, place, and date of the hearing. The hearing date shall be set for not less than 30 days after the date of the notice, and shall only be postponed or continued for good cause shown. Unless postponed by the MEC, the hearing shall commence no more than 120 days after the request for hearing is received by the person who sent the notice under 4.3 above. The practitioner or PSP shall be personally present at all hearings. The failure of the practitioner or PSP to appear personally shall be a waiver of the right to a hearing. The notice shall include a list of witnesses, if any, expected to testify at the hearing on behalf of the reviewing body.

4.6 Method of Hearing

4.6.1 By Medical Staff

A hearing occasioned by an adverse Medical Executive Committee recommendation on Medical Staff actions shall be conducted in the manner as selected by the President of the Medical Staff in accordance
with 4.3(C). If a hearing is occasioned by an adverse action invoked at multiple hospitals in the WakeMed System, the panel shall be composed of equal numbers of members appointed by the respective Medical Staff Presidents totaling no fewer than 6 members one of whom the Medical Staff President at the institution first imposing the suspension or making an adverse recommendation shall designate the chair of the committee.

4.6.2 **By the Board**

A hearing occasioned by an adverse recommendation or action of the Board shall be conducted in the manner as selected by the Board Chair in accordance with 4.3(C). If the Chair selects the Ad Hoc Hearing Committee specified in 4.3(C)(3), the panel shall be composed of no fewer than 5 members, one of whom the Chair shall designate as Chair of the committee.

4.6.3 **Service on Hearing Committee**

The hearing committee may be composed either of members of the Medical Staff (and/or Board where the hearing committee is appointed by the Board) or other practitioners or individuals not connected with the hospital or a combination of such persons. A Medical Staff member, Board member, or other person is not disqualified from serving on a hearing committee merely because he has heard of the case or has knowledge of the facts involved or what he supposes the facts to be.

4.7 **Witness List**

At least 10 days prior to the scheduled date for commencement of the hearing, the practitioner or PSP subject of the hearing shall give to the Medical Staff President of the institution first imposing suspension or adverse recommendation (or WakeMed President, as appropriate) by special notice a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of that party at the hearing. Such list and the list of witnesses previously provided under Section 4.5 shall be amended as soon as possible when additional witnesses are identified. The hearing body under 4.3(C) may permit a witness for the practitioner or PSP who has not been listed in accordance with this section 4.7 to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the hearing body in making its report and recommendation under Section 6.9 below. For good cause shown, under this circumstance and upon request by the President of the Medical Staff (or WakeMed President, as appropriate) the hearing body may grant a postponement under 6.6. Upon consent by the practitioner or PSP who is subject of the hearing, the hearing body under 4.3(C) may permit a witness to testify for the party giving notice of the hearing who has not been identified under 4.5 or this 4.7. If consent is not granted, then for good cause shown under 6.9, upon request by the party wishing to call the previously unidentified witness, a postponement of the hearing may be granted.
Section 5. Hearing Panel and Presiding Officer

5.1 The Parties
The personal presence of the practitioner or PSP is required throughout the hearing, unless such personal presence is excused for any specified time by the hearing body. The presence of the practitioner's or PSP's counsel or other representative does not constitute the personal presence of the practitioner or PSP. A practitioner or PSP who fails without good cause to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with this Fair Hearing Plan shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 4.4 if applicable.

5.2 Presiding Officer
The arbitrator or hearing officer identified in 4.3(C)(1), 4.3(C)(2), or 4.3(C)(3) [if one is so appointed], or 4.3(C)(4) shall be the presiding officer. If no hearing officer is appointed under 4.3(C)(3), the hearing committee Chair shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He shall determine the order of procedure during the hearing and make all rulings on matters of law, procedure, and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed under 4.3(C)(3), he shall not be entitled to vote. If the Chair of the hearing panel serves as the presiding officer, he shall be entitled to vote.

5.3 Representation
The practitioner or PSP may be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his local professional society. The Medical Executive Committee; or Joint Medical Executive Committee as stipulated in Section 5.3 of Part II of these bylaws or Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual or practitioner to represent it. Representation of either party by an attorney-at-law is governed by Section 7.16 of these bylaws.

5.4 Rights of Parties
During a hearing, consistent with the provisions in 4.3(E), each party shall have the following rights, subject to the rulings of the presiding officer on matters of law, procedure and the admissibility of evidence and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

A. call and examine witnesses;
B. introduce exhibits;
C. cross-examine any witness on any matter relevant to the issues;
D. impeach any witness;
E. rebut any evidence;
F. to have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may/may not argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
G. submit a written statement at the close of the hearing.

If the practitioner or PSP does not testify on his own behalf, he may be called and examined as if under cross-examination.
Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information
The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. The hearing body may require such memoranda to be filed at a time specified by the hearing body. The hearing body may ask questions of witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents in the state where the hearing is held. As provided in 4.3(E)(5), the practitioner or PSP has the right to submit a written statement at the close of the hearing.

6.2 Pre-Hearing Conference
The presiding officer may require the individual requesting the hearing, and/or his/her representative, and a representative of the MEC (or the Board, if applicable) 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, and determine the time to be allotted to each witness’s testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear
Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing
A record of the hearing shall be kept. The hearing body shall determine the method to be used for making the record, such as court reporter, or electronic recording unit with detailed transcription.

6.5 Burden of Proof
When a hearing relates to Section 4.1(A) through 4.1(F), the practitioner or PSP
has the burden of coming forward with evidence and proving that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious. In all other circumstances, the body whose adverse action or recommendation occasioned the hearing shall have the burden of coming forward with evidence in support thereof, but thereafter the practitioner shall have the burden of presenting evidence and proving that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

6.6 Postponements and Extensions

Requests for postponement or continuance of a hearing may be granted by the presiding officer only upon a timely showing of good cause.

6.7 Presence of Hearing Committee Members and Vote

Where a hearing committee is appointed under 4.3(C)(3) or 4.3(C)(4) a majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing or deliberations, the presiding officer, in his discretion, whether or not upon motion by either party, may rule that such member not participate further in the hearing or deliberations or in the decision of the committee. Such ruling may be based upon concerns including, but not limited to, delaying the hearing or compromising the committee’s deliberations or decision.

6.8 Recesses and Adjournment

The hearing body may recess and reconvene the hearing without special notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. Where used under 4.3(C)(3) or 4.3(C)(4) the hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

6.9 Hearing Body Report

Within 30 days after final adjournment of the hearing, the hearing body shall make a written recommendation including a statement of the basis for the recommendations and with such reference to the hearing record and other documentation and items considered as it deems appropriate. The hearing body shall forward the recommendation along with the record and other documentation to the body whose adverse action or recommendation occasioned the hearing. The hearing body shall also forward to the practitioner or PSP by special notice a copy of the written recommendation, including the statement of the basis for the recommendations.
6.10 **Action on Hearing Body Report**

If the hearing body was appointed by the Medical Executive Committee, or Joint Medical Executive Committee, as appropriate, such committee shall consider the hearing body recommendation. If the hearing was occasioned by two identical adverse MEC recommendations, the Joint MEC shall consider the hearing body recommendation. The Medical Executive Committee or Joint Medical Executive Committee, as appropriate, shall then make its own written recommendation to the Board. Said recommendation may be to affirm, modify, or reverse the Medical Executive Committee’s (s’) or Joint Medical Executive Committee as appropriate, original adverse recommendation or action. For good cause, the Medical Executive Committee or Joint Medical Executive Committee as appropriate may remand to the hearing body for further review or clarification any matter it deems necessary to the proper disposition of the issue prior to rendering its recommendation in the matter. Any referral back shall state the reason for referral, set a time limit within which either a subsequent recommendation or clarification is requested, and may include a directive for any additional hearing. The Medical Executive Committee, or Joint Medical Executive Committee as appropriate, shall transmit its written recommendation, including a statement of the basis of the recommendations, together with the hearing record, hearing body recommendations, and all other documentation considered to the Board.

The Medical Executive Committee or Joint Medical Executive Committee as appropriate, shall also forward by special notice to the practitioner or PSP a copy of its written recommendation, including the statement of the basis of the recommendations, and any other materials considered by the Medical Executive Committee or Joint Medical Executive Committee as appropriate, not heretofore sent to the practitioner or PSP by the hearing body. If the Medical Executive Committee's or Joint Medical Executive Committee's recommendation is adverse, the special notice shall inform the practitioner or PSP of his right to request an appellate review by the Board.

6.11 **Board Review**

6.11.1 **Favorable recommendation and favorable decision**

Following receipt by the Board of a favorable recommendation as described in 6.10, the Board shall review the recommendation. If the Board’s decision is in accord with the favorable decision, special notice to the practitioner or PSP with a copy to the applicable President(s) of the Medical Staff(s) shall be sent by the President of WakeMed.

6.11.2 **Favorable recommendation and proposed unfavorable decision**

Following receipt by the Board of a favorable recommendation as described in 6.10, the Board shall review the recommendation. If the Board’s proposed decision is adverse to the practitioner or PSP, special notice shall be sent to the practitioner or PSP with a copy to the applicable President(s) of the Medical Staff(s) by the President of WakeMed. The
notice shall state the proposed decision and the basis for the decision and inform the practitioner or PSP of his right to request an appellate review by the Board in accordance with Part II of the bylaws.

6.11.3 Unfavorable recommendation

Following receipt by the Board of an unfavorable recommendation as described in 4.1, the Board shall review the recommendation. If the Board’s proposed decision is adverse to the practitioner or PSP, special notice shall be sent to the practitioner or PSP with a copy to the applicable President(s) of the Medical Staff(s) by the President of WakeMed. The notice shall state the proposed decision and the basis for the decision and inform the practitioner or PSP of his right to request an Appellate Review. If the practitioner or PSP requests an appellate review from the adverse recommendation as set forth in 4.1 and in accordance with Section 7 of Part II of these bylaws, the appellate review and subsequent action shall be as set forth in Section 7 of Part II of these bylaws. If the practitioner or PSP waives his right to an appellate review, the matter proceeds to the Board for a final decision.

If the hearing body was appointed by the Board, a comparable process to that described in the preceding two paragraphs shall be followed.
Section 7. Appeal to the Hospital Board

7.1 Request for Appellate Review

A practitioner or PSP shall have 10 days after receiving special notice of an adverse recommendation or decision under Section 6 of Part II of these bylaws to file a written request by special notice for an appellate review. The request must be delivered by special notice to the President of WakeMed and may include a request for a copy of the hearing committee report and record and all other material, favorable or unfavorable, if not previously forwarded that was considered in taking the adverse recommendation or action. Representation by either party by an attorney-at-law is governed by Section 7.16 of Part II of these bylaws.

7.2 Failure to Request Appellate Review

A practitioner or PSP who fails to request an appellate review within the time and in the manner specified shall have waived any right to a review. The waiver has the same force and effect as provided in Section 4.4.

7.3 Time, Place and Notice

The WakeMed President shall deliver a timely and proper request for appellate review to the Chair of the Board. As soon as practicable, the Chair of the Board shall schedule an appellate review to commence not less than 21 days and not more than 45 days after the WakeMed President received the request; provided, however, that an appellate review for a practitioner or PSP who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than 15 days after the WakeMed President receives the request. The WakeMed President shall send the practitioner or PSP special notice of the time, place and date of the review. The time may be extended by the Chair of the Board prior to appointment of the appellate review body or thereafter by the Chair of the appellate review body for good cause.

7.4 Appellate Review Body

The appellate review shall be conducted by an Appellate Review Committee. The Chair of the Board shall appoint an Appellate Review Committee of at least three members to conduct an appellate review and shall designate one of the members of the committee as Chair.

7.5 Nature of Appellate Review

The proceedings by the review body are a review based upon the hearing record, the hearing body’s recommendation, all subsequent results and actions, the written statements, if any, previously provided or provided below and any other material that may be presented and accepted under Section 7.9. Appellate review shall be limited to determining whether the practitioner has established by
clear and convincing evidence that: (A) there has been a substantial failure to comply with the bylaws during the course of the corrective action which has materially prejudiced the practitioner; (B) the recommendation is arbitrary, unreasonable, or capricious; or (C) the recommendation is not supported by any reliable evidence.

7.6 Written Statements

The practitioner or PSP may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees and his reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body and to the group whose adverse recommendation or action occasioned the appellate review through the WakeMed President at least 10 days prior to the scheduled date of the review, except if the time limit is waived by the presiding officer. A similar statement may be submitted by the group whose adverse recommendation or action occasioned the appellate review, and if submitted, the WakeMed President shall provide a copy to the practitioner or PSP and to the review body at least 3 days prior to the scheduled date of the appellate review.

7.7 Presiding Officer

The Chair of the appellate review body is the presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum. If oral statements are permitted under 7.8, unless otherwise directed by the Chair of the Appellate Review Committee, the order of presentation shall be as follows:

A. the party making the adverse recommendation or counsel thereto shall introduce the record;

B. the affected practitioner/PSP or his representative or counsel shall be permitted to speak against the adverse recommendation or decision;

C. the speaker in (A) shall be permitted to speak in favor of the adverse recommendation or decision;

D. the affected practitioner/APP or his representative or counsel shall be permitted rebuttal; and

E. the speaker in (A) shall be permitted rebuttal.

7.8 Oral Statements

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the review body.
7.9  **Consideration of New or Additional Matters**

New or additional matters or evidence not raised or presented during the original hearing or in the hearing recommendation and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the appellate review body and only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the WakeMed President, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced at the review. Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment and rebuttal provided at the hearing.

7.10  **Powers**

The appellate review body shall have all the powers granted to the hearing committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

7.11  **Presence of Members and Vote**

A majority of the review body members must be present throughout the review and deliberations. If a member is absent from any part of the proceedings, the Chair of the review body whether or not upon motion by either party, may rule that the member shall not be permitted to participate further in the deliberations or in the decision of the review body. Such ruling may be based upon concerns including but not limited to delaying the hearing or compromising the body’s deliberations or decision.

7.12  **Recesses and Adjournments**

The review body may recess and reconvene the proceedings without special notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, the appellate review shall be adjourned. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

7.13  **Recommendation**

Within 10 days after final adjournment pursuant to Section 7.12 above, the appellate review body shall prepare its report recommending that the Board affirm, modify, or reverse the prior recommendation or decision. The Appellate Review Committee shall act as an appellate body and in making its recommendation shall determine whether the preceding adverse recommendation was justified and was not arbitrary and capricious.

7.14  **Final Decision of the Hospital Board**

Within 30 days after the conclusion of the appellate review, the Board shall make
its final decision in the matter and shall send notice thereof including a statement of the basis for the decision through the President to the affected practitioner or PSP by special notice and to the Medical Executive Committee or Joint Medical Executive Committee as appropriate.

7.15 Hearing Officer Appointment and Duties
The use of a hearing officer or arbitrator to preside at the evidentiary hearing is determined as provided in 4.3(C). A hearing officer need not be an attorney-at-law but must be experienced in and recognized for conducting hearings in an orderly, efficient and non-partisan manner (e.g., arbitration proceedings, employee labor disputes and/or grievance procedures, administrative proceedings, military court-martials or like proceedings, and so on).

7.16 Attorneys
7.16.1 At hearing
The practitioner or PSP may be represented by an attorney at the hearing. He shall indicate his intent to be so represented at the time he requests the hearing or as soon thereafter as he determines he intends to be so represented.

7.16.2 At appellate review
The practitioner or PSP may be represented by an attorney at the appellate review. He shall indicate his intent to be so represented at the time he requests the hearing or as soon thereafter as he determines he intends to be so represented.

7.16.3 Representation and preparation assistance
The Medical Executive Committee(s), Joint Medical Executive Committee, or the Board may be represented by an attorney at any hearing or appellate review permitted under this Fair Hearing Plan, whether or not the practitioner or PSP is so represented. If the Medical Executive Committee, Joint Medical Executive Committee or Board is not to be represented by counsel it may select such other representatives as it deems appropriate. Whether or not counsel are used by either or both parties at the hearing or appellate review, nothing shall be deemed to deprive the practitioner or PSP, the Medical Executive Committee, Joint Medical Executive Committee, or the Board of the right to legal counsel in connection with preparation for a hearing or an appellate review.

For purposes of 7.15, the word “representation” or “represent” means “present” as a spokesperson for one of the parties.

7.17 Number of Hearings and Reviews
Notwithstanding any other provision of the Medical Staff Bylaws or the WakeMed Bylaws, of the Systemwide Credentialing Plan, or of this Plan, no practitioner or
PSP is entitled as a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse recommendation(s) or action(s) triggering the right.

7.18 Confidentiality and Privilege

All information created, produced, or considered during the investigation and/or fair hearing process (including any appeal), including but not limited to notes, records, minutes, documents, exhibits, transcripts, or materials of any kind, relating to Medical Staff credentialing, membership, or clinical privileges, shall be confidential and privileged, shall not be admissible or discoverable in any legal proceedings, and shall be subject to all other protection afforded to such documents or proceedings by law including N.C. Gen. Stat. § 131E-95 and the United States Health Care Quality Improvement Act.

Release

All individuals participating in or providing information to any department, section, committee, hearing or appellate review body, or officer of the Medical Staff, to the fullest extent permitted by law, shall not be liable for any actions taken or information provided in connection with the review, granting, or denial of Medical Staff membership or clinical privileges, or any other action taken pursuant to these bylaws or this Investigations, Corrective Action, Hearing and Appeal Plan.
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Section 1.  Shared Credentials Committee

1.1  Composition
Members of the Shared Credentials Committee shall consist of a Chair and a Vice Chair, one representing each medical staff. When the Vice Chair moves to the position of Chair, the Medical Staff President at the campus of the former Chair will appoint a new Vice Chair to the Committee. The committee will consist of at least nine (9) other members, appointed by the respective MECs, insofar as feasible, representing the major clinical specialties, and shall include, at least one PSP. There shall be no more than one committee member from any one hospital-based clinical department on the committee. Members shall serve for two years and may continue to serve if recommended by the Credentials Committee Chair and appointed by both MECs. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite members such as representatives from hospital administration and the Board.

1.2  Meetings
Meetings are defined in the credentials procedure manual.

1.3  Responsibilities
Responsibilities are defined in the credentials procedure manual.

1.4  Confidentiality
Confidentiality is defined in the credentials procedure manual.
Section 2. Qualifications for Membership and/or Privileges

2.1 No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met and continuously maintained by all applicants for medical staff appointment, reappointment or clinical privileges:

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, or clinical psychology or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current unrestricted state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of North Carolina;

2.2.3 Have a record that is free from current Medicare/Medicaid exclusions and not be on the OIG List of Excluded Individuals/Entities;

2.2.4 Have a record that is free of felony convictions related to physical or sexual abuse, violence, drug offenses or healthcare fraud and abuse within the last seven (7) years;

2.2.5 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association OR those who completed residency/fellowship training more than six years ago must become board certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association after serving no more than one reappointment period. Those who completed residency/fellowship training less than six years ago must become board certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association after serving no more than two reappointment periods. A request for an extension of these time frames will only be considered to accommodate scheduling of board examinations and certification requirements. Consideration for foreign trained physicians will be made on a case by case basis;

2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation. Consideration for foreign trained dentists will be made on a case by case basis;
2.2.7 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified by the American Board of Oral and Maxillofacial Surgery OR those who completed residency/fellowship training more than six years ago must become board certified by the American Board of Oral and Maxillofacial Surgery after serving no more than one reappointment period. Those who completed residency/fellowship training less than six years ago must become board certified by the American Board of Oral and Maxillofacial Surgery after serving no more than two reappointment periods. A request for an extension of these time frames will only be considered to accommodate scheduling of board examinations and certification requirements. Consideration for foreign trained oral and maxillofacial surgeons will be made on a case by case basis;

2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified by a board recognized by the American Podiatric Medical Association OR those who completed residency/fellowship training more than six years ago must become board certified by a board recognized by the American Podiatric Medical Association after serving no more than one reappointment period. Those who completed residency/fellowship training less than six years ago must become board certified by a board recognized by the American Podiatric Medical Association after serving no more than two reappointment periods. A request for an extension of these time frames will only be considered to accommodate scheduling of board examinations and certification requirements. Consideration for foreign trained podiatrists will be made on a case by case basis;

2.2.9 Possess a current, valid, unrestricted drug enforcement administration (DEA) number which is valid in the State of North Carolina, if applicable;

2.2.10 Have the ability to read, understand, and communicate the English language in an intelligible manner, and to prepare medical record entries and other require documentation in a legible manner;

2.2.11 Have appropriate personal qualifications, including applicant’s consistent observance of ethical and professional standards. These standards include, at a minimum:

A. Abstinence from any participation in fee splitting, “ghost” surgery, delegating the responsibility for diagnosis or care of patients to a practitioner not qualified to undertake that responsibility, or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities;
B. Obtaining informed consent for treatments;
C. Adhering to stipulations in the Code of Conduct Administrative-
Corporate Policy; and
D. A history of consistently acting in a professional, appropriate and
collegial manner with others in previous clinical and professional
settings.

2.3 In addition to privilege-specific criteria, the following qualifications must also be
met and continuously maintained by all applicants requesting clinical privileges:

2.3.1 Demonstrate his/her background, experience, training, current
competence, knowledge, judgment, and ability to perform all privileges
requested;

2.3.2 To be free of, or have under adequate control, with or without reasonable
accommodation, any physical, mental, or behavioral impairment that
affects cognitive, motor, or communication ability in a manner that
significantly interferes with, or presents a reasonable probability of
interfering with, the qualifications required to perform the privileges
requested;

2.3.3 Any practitioner granted privileges who may have occasion to admit an
inpatient must demonstrate the capability to provide continuous and timely
care to the satisfaction of the MEC and Board;

2.3.4 Demonstrate recent clinical performance within the last twenty-four (24)
months with an active clinical practice in the area in which clinical
privileges are sought adequate to meet current clinical competence
criteria;

2.3.5 The applicant is requesting privileges for a service the Board has
determined appropriate for performance at the hospital. There must also
be a need for this service under any Board approved medical staff
development plan; and

2.3.6 Provide evidence of professional liability insurance appropriate to all
privileges requested and of a type and in an amount established by the
Board.

2.4 Exceptions

2.4.1 All practitioners who have clinical privileges November 1, 2015 and who
have met prior qualifications for privileges, but who are not board certified
as of November 1, 2015 shall be exempt from board certification
requirements.
2.4.2 All practitioners who are current medical staff members and/or hold privileges and who are board certified as of November 1, 2015 shall be required to maintain board certification. If any such practitioner does not have sufficient time to take the necessary steps to maintain board certification due to the adoption of this bylaw revision in November 2015, he or she shall be required to recertify within the time frames provided in Part III, Section 2.2 of these bylaws.

2.4.3 Honorary medical staff members are not required to maintain current medical license, DEA, professional liability insurance coverage, or board certification.

2.4.4 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.
Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All applicants for membership and/or privileges must complete an application as defined in the credentials procedure manual.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant’s responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information as defined in the credentials procedure manual.

3.2 Applicant’s Attestation, Authorization and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant attests to the accuracy and completeness of all information, consents to appear for any requested interviews, authorizes the hospital and medical staff representatives to consult with prior and current association and others who may have information bearing on his/her application, consents to hospital and medical staff representatives’ inspection of all records and documents that may be material to the application, releases from liability and promises not to sue all individuals and organizations who provide information to the hospital or the medical staff, authorizes release of credentialing and peer review information to other organizations, acknowledges that they have had access to the medical staff bylaws and associated documents and agree to abide by their provisions and to provide answers to the questions pertinent to the application. All items are further defined in the credentials procedure manual.
3.3 Application Evaluation

3.3.1 Applicant interview

A. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chair, Shared Credentials Committee, MEC or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant’s ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.

B. The applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.3.2 Chief Nursing Officer action

A. All completed applications for advanced practice registered nurses are presented to the Chief Nursing Officer (or designee) for review and recommendation. The Chief Nursing Officer reviews the application and all supporting documentation to ensure that 1) the applicant meets requirements as set forth by the North Carolina Board of Nursing and 2) fulfills the established standards for clinical privileges. The Chief Nursing Officer may obtain input if necessary from an appropriate subject matter expert.

B. The Chief Nursing Officer forwards to the Shared Credentials Committee the following:

(1) A recommendation to approve the applicant’s request for privileges; or

(2) A recommendation to approve a modification of the requested privileges; or

(3) A recommendation to deny privileges; and

(4) Comments to support the recommendation.
3.3.3 Department Chair action

A. All completed applications are presented to the Department Chair for review, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair may obtain input if necessary from an appropriate subject matter expert. If a Department Chair believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation, the Vice Chair will address the matter. If the Vice Chair believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation, s/he will notify the Shared Credentials Committee Chair and forward the application without comment.

B. The Department Chair forwards to the Shared Credentials Committee the following:

   (1) A recommendation to approve the applicant’s request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

   (2) A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

   (3) Comments to support these recommendations.

3.3.4 Shared Credentials Committee action

The Shared Credentials Committee reviews the application and forwards the following to the MEC:

A. A recommendation to approve the applicant’s request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

B. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

C. Comments to support these recommendations.

3.3.5 MEC action

The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

A. A recommendation to approve the applicant’s request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;
B. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

C. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 Resolution of disparate recommendations:

The Board of Directors has directed the Medical Executive Committees of both WCH and WRC to collaborate on the evaluation of applicants that are applying within the WakeMed System for initial and reappointment. The principal vehicle for collaboration is the Shared Credentials Committee. For an applicant applying to both hospitals, it is expected that after collaboration via the Shared Credentials Committee, the Medical Executive Committees of both hospitals will deliver the same recommendation with regard to the qualifications and competency of the applicant.

When the applicant is applying to both WCH and WRC and the Shared Credentials Committee receives disparate (defined as not identical) recommendations from the two department chairs regarding their evaluation of the applicant, the Shared Credentials Committee may require the two department chairs to appear at the next meeting of the Shared Credentials Committee for further discussion of the matter. If the Shared Credentials Committee is unable to align the recommendations of the two department chairs, it will forward a report on the applicant and the associated issues under discussion to the Medical Executive Committees of both WCH and WRC at which time a Joint Medical Executive Committee meeting shall be convened within 10 days of the last WRC or WCH Medical Executive Committee meeting to resolve the matter. The Joint Medical Executive Committee will consist of the department chair from each of the Medical Staff departments to which the applicant has applied; the two Medical Executive Committee Chairs; the Shared Credentials Committee Chair or Vice Chair; the CQO; and the CEO or designee (Ex-Officio). If the Joint Medical Executive Committee cannot arrive at a single recommendation within 12 days of the last Medical Executive Committee meeting by a simple majority, a report on the applicant and the associated issues under discussion will be forwarded to the Board of Directors.

3.3.7 Board action without benefit of MEC/Joint MEC recommendation:

The following procedure shall be followed if the Board, in its determination, does not receive a recommendation from the Medical Executive
Committee(s) within the time frame specified in Part III, Section 3.3.9 of these bylaws or the Joint Medical Executive Committee within the time frame provided in Part III, Section 3.3.9 of these bylaws manual or within any reasonable extension of that time frame resulting from a deferral of a recommendation in order to obtain additional data/explanation or a specific release/authorization, or from implementation of the Part II of these Bylaws, or from any other good cause. The Board may, after notifying the Medical Executive Committee(s) of its intent, including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Staff authorities. Favorable action by the Board is effective as the Board’s final decision. If the Board's final action is adverse to a practitioner in any respect, they shall promptly inform the applicant by special notice of their tentative action. The practitioner applicant shall then be entitled to the procedural rights as provided in the Medical Staff Bylaws and the Part II of these Bylaws. If an appellate review is required, it will be conducted pursuant to the Part II of these Bylaws. If the Board’s tentative action is adverse to the PSP in any respect, it shall promptly inform the PSP by special notice of its tentative action. The PSP shall then be entitled to the procedural rights pursuant to Part II of these bylaws.

3.3.8 Board action:

A. The application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months.

B. The application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The Board reviews the application and votes for one of the following actions:

(1) The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant’s request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

(2) If the Board’s action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or
(3) The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.9 **Notice of final decision**: Notice of the Board’s final decision shall be given, through the CEO to the MEC and to the chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.10 **Time periods for processing**: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.
Section 4. Professional Practice Evaluation

4.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE as further defined in the Focused Professional Practice Evaluation (FPPE) For New Members of the Medical Staff Granted Privileges & Newly Requested Privileges Policy and the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Low Volume/No Volume Practitioners.

4.2 Ongoing Professional Practice Evaluation (OPPE)

The medical staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety as further defined in the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Current Practitioners and the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Low Volume/No Volume Practitioners.

4.3 Physician Re-Entry

A re-entry process is available for practitioners who have not provided relevant clinical care within the past twenty-four (24) months as further defined in the credentials procedure manual.
Section 5. Reappointment

5.1 Criteria for Reappointment

It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the medical staff standards regarding ongoing quality and the hospital performance improvement program. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation.

5.2 Information Collection and Verification

5.2.1 Information will be gathered from the appointee, from internal and/or external sources as further defined in the credentials procedure manual.

5.2.2 Information will also be verified as further defined in the credentials procedure manual.

5.2.3 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

5.3 Evaluation of Application for Reappointment of Membership and/or Privileges

The reappointment application will be reviewed and acted upon as described in Section 3.3 above, excluding board re-certification. For the purpose of reappointment an “adverse recommendation” by the Board as used in Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms “applicant” and “appointment” as used in these sections shall be read respectively, as “staff appointee” and “reappointment”.

Section 6. Clinical Privileges

6.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), Anesthesiology Assistants (AAs), physicians serving short locum tenens positions, telemedicine physicians, or others deemed appropriate by the MEC and Board.

6.2 Requests

When applicable, each application for appointment or reappointment to the medical staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

6.3 Basis for Privileges Determination

6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

6.3.2 A procedure for determination of privilege criteria is further defined in the credentials procedure manual.

6.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital’s capability to support the type of privileges being requested and the availability of qualified coverage in the applicant’s absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner’s performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

6.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.
6.4 **Special Conditions for Dental Privileges**

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists will require that all dental patients receive a basic medical evaluation (history and physical) by a physician licensed by the NC Medical Board which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence. Dentists may be granted the privilege of performing a history and physical on their own patients upon satisfactory completion of a two-year general practice or pediatric dentistry residency accredited by the American Dental Association and a letter from the residency director attesting to training/competency in evaluating medical histories and physical examinations.

6.5 **Special Conditions for Licensed Independent Practitioners Eligible for Privileges without Membership**

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Providers with Supervised Privileges (PSPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of these PSPs shall terminate immediately, without right to due process, in the event that the employment of the PSP with the hospital is terminated for any reason or if the employment contract or sponsorship of the PSP with a physician member of the medical staff organization is terminated for any reason.

6.6 **Special Conditions for Podiatric Privileges**

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) that will be recorded in the medical record. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric medicine or surgery and demonstrated current competence. Privileges for surgical procedures performed by podiatrists will require that all podiatric patients receive a basic medical evaluation (history and physical) by a physician licensed by the NC Medical Board which will be recorded in the medical record.
6.7 Special Conditions for Residents or Fellows in Training

6.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the graduate education committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident’s progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

6.7.2 The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.8 Telemedicine Privileges

Practitioners providing only telemedicine services to the hospital from a distant site will not be appointed to the medical staff but must be granted privileges at this hospital. Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through one of the following mechanisms:

A. The hospital fully privileges and credentials the practitioner; or

B. The hospital may privilege practitioners using static, historical credentialing information from the distant site if the distant site is a Medicare-participating hospital. This information is supplemented and then the applicant is processed through the normal credentialing mechanism.

6.9 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two circumstances: (1) to fulfill an important patient care, treatment or service need, or (2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.
6.9.1 **Important Patient Care Treatment or Service Need:** Temporary privileges may be granted on a case by case basis when an important patient care treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure and current competence.

6.9.2 **Clean Application Awaiting Approval:** Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital which is similar to that for initial application other than re-verifying static information. Additionally, to be considered for temporary privileges, none of the following conditions can be present:

A. The application is deemed to be incomplete;

B. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

C. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

D. The applicant has a record that is free of felony conviction related to physical or sexual abuse, violence, drug offenses or healthcare fraud and abuse within the last seven (7) years;

E. Applicant has had two (2) or more malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of $75,000;

F. Applicant changed medical schools or residency programs or has gaps in training or practice;

G. Applicant has changed practice affiliations more than three times in the past ten (10) years;

H. Applicant has one or more reference responses that raise concerns or questions;

I. Discrepancy is found between information received from the applicant and references or verified information;

J. Applicant has an adverse National Practitioner Data Bank report based on a behavioral concern;
K. The request for privileges are not reasonable based upon applicant’s experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

L. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

M. Applicant has potentially relevant physical, mental and/or emotional health problems;

N. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

6.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

6.9.4 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner’s privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner’s privileges. When a patient’s life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may affect the termination. In the event of any such termination, the practitioner’s patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.9.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.
6.9.6 Emergency privileges: In the case of a medical emergency when a privileged practitioner is not available, any practitioner is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the practitioner’s license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.9.7 Disaster privileges:

A. If the institution’s Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution’s Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected practitioners. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:

(1) A current picture hospital ID card that clearly identifies professional designation;

(2) A current license to practice;

(3) Primary source verification of the license;

(4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), a State Medical Assistance Team (SMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

(5) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

(6) Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

B. The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.
C. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

D. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: (1) why primary source verification could not be performed in 72 hours; (2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and (3) an attempt to rectify the situation as soon as possible.

E. Once the immediate situation has passed and such determination has been made consistent with the institution’s Disaster Plan, the practitioner’s disaster privileges will terminate immediately.

F. Any individual identified in the institution’s Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.
Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision is not eligible to reapply to the medical staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision. Except as otherwise determined by the MEC or Board, a practitioner who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of two (2) years from the date of the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for Modification of Appointment Status or Privileges

A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the medical staff office. A modification request must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the medical staff services office, to the Shared Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner’s credentials file.
7.3 **Resignation of Staff Appointment or Privileges**

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner’s credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 **Exhaustion of Administrative Remedies**

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 **Reporting Requirements**

The CEO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.
Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities unrelated to planned vacation, educational sabbatical, or medical mission work and whether or not such absence is related to the individual’s physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to Medical Staff Services stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year, except for military service or with express permission of the Board. Requests for leave must be forwarded with a recommendation from the department chair, credentials committee, and MEC and approved by the Board. While on a leave of absence, the practitioner may not exercise clinical privileges or prerogatives at WakeMed and has no obligation to fulfill medical staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for leave or for an extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

Termination of a leave of absence must be requested and approved by the MEC and the Board before exercising privileges.

Unless otherwise approved by the MEC, at least sixty (60) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to Medical Staff Services. The practitioner must submit a written summary of relevant professional activities during the leave along with current practice information and evidence of appropriate professional liability insurance. Clinical activity is primary source verified as well as current medical/professional license. DEA registration, if applicable, is verified as current, NPDB report is obtained, and sanctions checks are completed.

A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the department chair, credentials committee, MEC or Board may have as part of considering the request for reinstatement. If requested, the practitioner must sign a release or authorization allowing a representative selected by the Medical Staff President to discuss the practitioner’s health and ability to practice with his or her physician.
The evaluation process outlined in Part III, Section 3.3, of these bylaws will be followed. If the practitioner’s current grant of membership and/or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment; if granted, reappointment shall be subject to the leave of absence; if a timely application is not received, his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.
Section 9. Practitioners Providing Contracted Services

9.1 Telemedicine
When the hospital contracts for services with licensed independent practitioners who provide readings of images, tracings or specimens through a telemedicine mechanism, all LIPs, who will be providing services under this contract, will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

9.2 Exclusivity Policy
Whenever the hospital has contracted for services to be performed by specified qualified practitioners or their practices, then other practitioners must adhere to the exclusivity contract(s) in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted membership and/or privileges, which then become covered by an exclusive contract, will no longer be a member of the department of the exclusive practice and not be able to exercise those privileges unless they become a party to the contract.

9.3 Qualifications
A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

9.4 Disciplinary Action
The terms of the medical staff bylaws will govern disciplinary action taken by or recommended by the MEC.

9.5 Effect of Contract or Employment Expiration or Termination
Practitioners whose request for membership and/or clinical privileges would conflict with the hospital’s contractual obligation under an exclusive contract arrangement will not be granted the requested membership or privileges. Said requesting Practitioner will not be entitled to the procedural rights as defined in the fair hearing plan, notwithstanding any provision of the bylaws or related manuals to the contrary, for the exclusive contract arrangements for services or privileges which are subject to an exclusive agreement on November 1, 1998.
If WakeMed or WRC/WCH enters into an exclusive contract or other exclusive arrangement for a particular service or services, any practitioner previously privileged to provide such services in arrangement may not do so as of the effective date of the exclusive contract/arrangement whether or not such a date is a full two years from the most recent granting to him of such privileges. Similarly, the practitioner will no longer be a member of the department of the exclusive practice.
Section 10. Medical Administrative Officers

10.1 A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer’s direction. These positions may include, CPE, CQO, EMD, Senior VP of Physician Practices, medical directors, physician advisors, or other contracted individuals.

10.2 Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities, if any, and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

10.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer’s staff appointment and privileges and the effect an adverse change in the officer’s staff appointment or clinical privileges has on his remaining in office.

10.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

10.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.
MEDICAL STAFF BYLAWS DEFINITIONS

“APPOINTEE” means any medical physician or osteopathic physician, dentist, oral and maxillofacial surgery, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

“CPE” means the Chief Physician Executive.

“CQO” means the Chief Quality Officer.

“CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted to a practitioner to render patient care and includes unrestricted access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

“DEPARTMENT” is an organization of practitioners into specific areas of practice.

“DENTIST” means a doctor of dental medicine or dental surgery.

“EMD” means the applicable Executive Medical Director.

“IN GOOD STANDING” means having no adverse actions, limitations, or restriction on privileges or medical staff membership in effect at the time of inquiry.

“INVASIVE PROCEDURE” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

“MEMBER” means a physician, dentist, oral and maxillofacial surgeon, or podiatrist who meets the qualifications of membership and has been approved by the Board of Directors upon recommendation of the Medical Executive Committee.

“MEMBER IN GOOD STANDING” means a member of the Medical Staff or of a particular category of the Staff, as the context requires, who is not under either a full membership suspension or a full or partial suspension of voting, office-holding, or other membership prerogatives imposed by operation of any section of these Bylaws or related manuals or any other policies of the Medical Staff of WakeMed Raleigh Campus.

“MEMBERSHIP” means status within the medical staff organization.

“PHYSICIAN” means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the North Carolina Medical Board and who has a current valid licensed to practice medicine and surgery in the North Carolina.

“PODIATRIST” means an individual who has received a doctor of podiatric medicine degree (DPM).
“PRACTITIONER” means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or provider with supervised privileges who has been granted clinical privileges.

“PROVIDER WITH SUPERVISED PRIVILEGES” or “PSP” means individuals who are either advanced practice registered nurses (i.e., nurse practitioners, nurse midwives, CRNAs, and clinical nurse specialists) physician assistants who practice a medical level of care, or anesthesiology assistants.

“SPECIAL NOTICE” means written notification sent by certified mail, return receipt requested, or by special delivery with signed acknowledgment of receipt.

“WAKEMED RALEIGH” means the WakeMed Raleigh Campus plus WakeMed North Family Health & Women’s Hospital and other locations operating under the same CMS Certification Number (CCN).

“WAKEMED CARY” means the campus at WakeMed Cary Hospital plus WakeMed Apex Healthplex and other locations operating under the same CMS Certification Number (CCN).