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Section 1.  Organization and Functions of the Staff

1.1 Organization of the Medical Staff

1.1.1 The medical staff shall be organized into the following Departments: Anesthesiology, Emergency Services, Medicine, Obstetrics/Gynecology, Orthopedics, 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 as stipulated in Medical Staff Bylaws, Part I, Section 5.4.

1.1.2 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
C. The practitioners to be assigned to the section agree to, and, in fact, carry out the meeting, review and other activities required of sections at this hospital.

1.1.3 A Section Chief shall head each Section with duties delegated by the Department Chair.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Department Chairs, hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, is responsible for or participates in the following activities:

1.3.1 Governance, direction, coordination, and action
A. Receive, coordinate and act upon, as necessary, the reports and recommendations from Departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
B. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;
C. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted;
D. Make recommendations on medical, administrative, and hospital clinical and operational matters;
E. Inform the medical staff of the accreditation and state licensure status of the hospital;
F. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;
G. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;
H. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
I. Provide oversight concerning the quality of care provided by residents, interns, students, and encourage that the same act within approved guidelines established by the medical staff and governing body; and
J. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the Board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities
A. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;
B. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;
C. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include, but are not limited to, the following:
   1. Medical assessment and treatment of patients;
   2. Use of medications;
   3. Use of blood and blood components;
   4. Operative and other procedures;
   5. Education of patients and families;
   6. Accurate, timely, and legible completion of patients’ medical records to include the quality of medical histories and physical examinations;
   7. Appropriateness of clinical practice patterns to include any significant departures from established pattern of clinical performance;
   8. Use of developed criteria for autopsies;
   9. Sentinel event data;
   10. Patient safety data;
11. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient;

12. Findings of the assessment process relevant to individual performance; and

D. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

A. Understand the medical staff’s and administration’s approach to and methods of performance improvement;

B. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

C. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis;

D. Participate as requested in the hospital’s patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials Review (see Part III: Credentials Process)

1.3.5 Information Management

A. Review and evaluate medical records to determine that they:

1. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

2. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

B. Develop, review, enforce, and maintain surveillance at least quarterly of compliance with medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, and recommend methods of enforcement thereof and changes therein; and

C. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Strategic Planning

A. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

B. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and
C. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.7 Bylaws Review
A. Conduct periodic review of the medical staff bylaw, rules, regulations and policies; and
B. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

1.3.8 Nominating
A. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and
B. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.9 Infection Control
A. The medical staff participates in the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;
B. Develop and approve policies describing the type and scope of surveillance activities including:
   1. Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;
   2. Review of prevalence and incidence studies, as appropriate; and
   3. Collection of additional data as needed.
C. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
D. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
E. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;
F. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
G. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and
H. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.10 Pharmacy and Therapeutics Functions
A. Maintain a formulary of drugs approved for use by the hospital;
B. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
C. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);
D. Perform drug usage evaluation studies on selected topics;
E. Perform medication usage evaluation studies as required by the Joint Commission;

F. Perform practitioner analysis related to medication use;

G. Approve policies and procedures related to The Joint Commission Provision of Care, Treatment, and Services Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

H. Develop and measure indicators for the following elements of the patient treatment functions:
   1. Prescribing/ordering of medications;
   2. Preparing and dispensing of medications;
   3. Administrating medications; and
   4. Monitoring of the effects of medication.

I. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

J. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

K. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and

L. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.11 Utilization Management

A. Study recommendations from medical staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

B. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

C. Forward all unjustified cases in any review category to the appropriate clinical department or committee for review and action;

D. Review case-mix financial data and any other internal/external statistical data;

E. Upon review of any data, conduct further studies, perform education or refer the data to the quality improvement committee for their review and action;
Section 2. Medical Staff Committees

2.1 General language governing committees

The following shall be the standing committees of the medical staff: Medical Executive (MEC), Credentials, Medical Staff Quality Improvement (MSQI), Nominating, and 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.

Except as otherwise specified in the Medical Staff Bylaws, committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

2.2 Medical Executive Committee - MEC

Description of the MEC is in Part I: Governance; Section 6.2.

2.3 Shared Credentials Committee

Description of the Shared Credentials Committee is in Part III: Credentials Process; Section 1.

2.4 Medical Staff Quality Improvement Committee –MSQI

2.4.1 Composition: The Medical Staff Quality Improvement Committee is chaired by the elected Chair of MSQI (as defined in Part 1: Medical Staff Bylaws, Section 4.3) and is composed of the elected Vice Chair of MSQI (as defined in Part 1: Medical Staff Bylaws, Section 4.3), elected Vice Chairs of all Departments, President-Elect of the Medical Staff, Chief Quality Officer, Chair of Pharmacy and Therapeutics Committee, Chair of Infection Control Committee, Medical Director of Transfusion Services, Director of Trauma Services, and Chair (or his designee) of Invasive Cardiology.

Also serving on the Committee as non-voting members will be WakeMed’s Chief Executive Officer or designee, Senior Vice President/Raleigh Administrator, Raleigh Executive Medical Director, Vice President/North Administrator, North Executive Medical Director, Chief Nursing Officer, Provider with Supervised Privileges (PSP) appointed by the Medical Staff President, Medical Staff Performance Improvement Management Specialist, and Director of Medical Staff Services.

Regular invitees attend by invitation only when input is needed at the discretion of the MSQI Chair. Regular invitees will be the Utilization Management Committee Chair, Adult Special Care Committee Chair, Hospitalist Director or designee, Chief Medical Information Officer, Chief Information Officer, and Peer Review Advisory Committee Chair.
Closed sessions will be limited to physician members, CEO or designee, CNO, PSP representative, Performance Improvement Management Specialist, and Medical Staff Services Director.

2.4.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.2 A-D above.

2.4.3 **Trauma Peer Review Committee**

2.4.3.1 **Composition:** The Trauma Peer Review Committee shall consist of trauma surgeons and representatives from emergency services, anesthesia, neurosurgery, and orthopedics who are appointed by their respective department chairs. These individuals are voting members of the committee. Representatives from other clinical departments may be asked to attend on a PRN basis. The Director of Trauma Services shall serve as Chair. The Trauma Coordinator will serve as recorder.

2.4.3.2 **Responsibilities:** The committee shall be responsible for the following functions:

A. Determine whether the morbidity/mortality is disease or provider-related.
B. Refer credentialed provider-related issues to the appropriate quality improvement committee for review and follow-up.
C. Submit written reports of committee conclusions and recommendations to the Medical Staff Quality Improvement Committee.

2.4.4 **Systemwide Anesthesia & Sedation Committee**

2.4.4.1 **Composition:** The Anesthesia Sedation Committee shall consist of a Chair and Vice Chair who are anesthesiologists and are appointed by the Medical Executive Committees at the Raleigh and Cary campus alternately, as well as medical staff representatives of the Emergency Department, Pediatric Intensivists, Adult Intensivists, Anesthesiology, other at-large members as deemed appropriate by this committee. These individuals will be voting members of the committee. Non-voting members will be the Chief Medical Officer, Vice President of Patient Safety and Quality, a CRNA representative, and representatives from Nursing, Surgery, Endoscopy, Invasive Cardiology, Radiology, and Pharmacy.

2.4.4.2 **Responsibilities:** The committee shall be responsible for the following functions:

A. Review/recommend improvements to all policies, including Medical Staff Bylaws and Rules and Regulations, regarding anesthesia or sedation practices;
B. Review/recommend development of or revisions to credentialing criteria;
C. Review and report to MSQI patterns of issues concerning administration of anesthesia and sedation and make recommendations regarding identified areas or processes when improvements in the care provided may be made;
D. Serve as consultant to other medical staff peer review bodies for particular problems with anesthesia/sedation involving medical staff members or PSPs. (After non-physician members have been excused from the proceedings, the physician members of the committee may identify physician specific problems and discuss solutions.)
E. Make recommendations to the MSQI where the results of ongoing monitoring have identified areas when improvements in the care provided may be made.

2.4.5 Utilization Management Committee

2.4.5.1 Composition: The Utilization Management Committee composition is described in the Utilization Management Plan. Any physician who holds a financial interest in any WakeMed hospital is not eligible for appointment to the committee.

2.4.5.2 Responsibilities: The committee shall be responsible for those functions described in section 1.3.11 above.

2.4.6 Systemwide Pharmacy & Therapeutics Committee

2.4.6.1 Composition: The P&T Committee will consist of a Chair and Vice Chair who are appointed by the Medical Executive Committee(s) or MSQI Committee(s). A member from the following specialties/services will be appointed by the P&T Committee Chair: anesthesiology, emergency medicine, cardiology, hospitalists, pediatric hospitalist, office pediatrics, intensivists, OB/GYN, pathology, surgery, PSP, imaging, psychiatry, and ad hoc, as needed, infectious diseases, neonatology, and oncology.

Also serving on the committee are the following: Chief Quality Officer, VP Hospital Administration, and Nursing Administration and representatives from the following hospital departments: Infection Control, Clinical Nutrition, Imaging Services, Clinical Analysis, Patient Safety/Risk Management, Accreditation Services, and Pharmacy.

2.4.6.2 Responsibilities: The committee shall be responsible for those functions described in section 1.3.10 above. Submit written reports of committee conclusions and recommendations to the Medical Staff Quality Improvement Committee.

2.5 Bylaws Committee

2.5.1 Composition: The Bylaws Committee shall consist of the current President, President-Elect, and Past President of the WakeMed Raleigh Campus and the WakeMed Cary Hospital. The chair shall be appointed by mutual agreement between the Presidents of the WakeMed Raleigh Campus and the WakeMed Cary Hospital Medical Staffs.

2.5.2 Responsibilities: The committee shall be responsible for those functions described in section 1.3.7 above.

2.6 Nominating Committee

2.6.1 Composition: The nominating committee shall consist of five (5) members of the medical staff who are the immediate Past President, prior immediate past president, President, President-Elect, and Raleigh and North Executive Medical Directors (non-voting). The immediate Past President will serve as Chair.

2.6.2 Responsibilities: The committee shall provide an annual slate of nominees for the elected medical staff positions.
2.7 Hospital Committees with Medical Staff Leadership

The following is a representative list of hospital committees defined by hospital policies which require medical staff leadership.

A. Infection Control
B. Adult Special Care
C. Ethics (Systemwide)
D. Institutional Review Board (Systemwide)
E. Clinical Resource Management (Systemwide)
F. Utilization Management

2.8 Hospital Committees with Medical Staff Participation

The following is a representative list of hospital committees defined by hospital policies which require medical staff participation.

A. Systemwide Quality Oversight Committee
B. Women & Children’s Operational Council
C. Patient Safety Steering Committee
D. Nutrition Support
E. Surgical Services Executive Committee
Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

A. Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
B. Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services;
C. Contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care; and
D. Patient information as defined by federal and/or state laws.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The absolute immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility’s or organization’s activities concerning, but not limited to:

A. Applications for appointment/affiliation, clinical privileges, or specified services;
B. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
C. Corrective or disciplinary actions;
D. Hearings and appellate reviews;
E. Quality assessment and performance improvement/peer review activities;
F. Utilization review and improvement activities;
G. Claims reviews;
H. Risk management and liability prevention activities; and
I. Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.
3.4 **Releases**
When requested by the President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 **Conflict of Interest**

3.5.1 **Medical Staff Leadership:**
Subsequent to nomination and prior to election, execute the Medical Staff Eligibility to Serve Statement and Conflict of Interest Policy Statement and Questionnaire. Such statements shall include confirmation of compliance with the Medical Staff Conflict of Interest Policy and a commitment to fulfill the applicable position’s specifically designated responsibilities, obligations, and duties now or as hereafter amended as set forth in Medical Staff Bylaws, Related Manuals, Rules & Regulations and, where applicable, as set forth in contract with WakeMed. Such Statements shall also include the nominee’s commitment to maintain confidentiality as set forth in Medical Staff Bylaws, Related Manuals, Rules & Regulations, now or a hereafter amended, and where applicable, as set forth in contract with WakeMed. Additional information can be found in Part 1; Medical Staff Bylaws, Section 4.2.2.

3.5.2 **Medical Staff Committee Members:**
A member of the medical staff requested to perform a medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. When a potential conflict is identified in advance, the committee chair will be informed and make the determination if a substantial conflict exists. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.