### WAKEMED CARY HOSPITAL
### GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF ORGANIZATION
### Revised 5-3-2007

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<th>POLICY STATEMENTS OR RULES</th>
<th>RELATED PROCEDURES</th>
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<td>1. Expectations associated with Emergency Department (ER) call and disposition of unassigned patients.</td>
<td><strong>A.</strong> Private patients shall be attended by their own private physicians or physician on-call for the attending physicians group. &lt;br&gt;<strong>B.</strong> Patients who have no attending physician will be assigned to a physician member of the medical staff who is covering the ER on the day the patient is referred. In the event there is no unassigned call schedule for a particular specialty and a practitioner of appropriate specialty cannot respond, the patient will be transferred to another facility. &lt;br&gt;<strong>C.</strong> Such patients who are assigned to the covering physician shall, unless it is not in the best interest of the patient, be treated in and/or admitted to WakeMed and not transferred to another facility without the specific agreement and request of the patient. &lt;br&gt;<strong>D.</strong> All members of the Active and Associate staff must participate in an equitable rotational schedule for ER call coverage as assigned by the department chair or his designee. &lt;br&gt;<strong>E.</strong> A physician may not sign out to the Emergency Department. &lt;br&gt;<strong>F.</strong> All on-call physicians are required to be in contact by two-way communication to the ER within 30 minutes of a page or phone call initiated by WakeMed staff or physicians. If the on-call physician cannot be reached (physician cannot respond due to conditions beyond his or her control or physician is on simultaneous call at another hospital or performing elective surgery and is not available to respond), a practitioner of an appropriate specialty will try to be reached. In the event a practitioner of an appropriate specialty cannot respond, the patient will be transferred.</td>
<td>Failure to respond within required time frames will result in a letter of reprimand being sent to the on-call physician from the department chair. Documentation shall be maintained in the practitioners credentials file. A second occurrence within two reappointment cycles may result in corrective action being initiated as stipulated in Section 12 of the Medical Staff Bylaws. Refusal to respond may result in corrective action being initiated immediately as stipulated in Section 12 of the Medical Staff Bylaws.</td>
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G. When a patient in the Emergency Department is determined, after appropriate evaluation by the Emergency Department physician, to be in need of admission, the Emergency Department physician will notify the patient's attending physician or the physician on call for the attending physician’s group, or, in the case of an unassigned patient, the appropriate on-call physician from the unassigned call schedule. The physician so notified will issue orders for admission or initiate further evaluation of the patient within 90 minutes of notification. The Emergency Department physician will be responsible for the patient until the physician so notified issues orders or initiates evaluation.

H. If the on-call physician is consulted only for purposes of evaluating the patient for an interventional procedure, the on-call physician will assume care of the patient during the evaluation and subsequent treatment, if any, which must be initiated by orders or other evaluation within 90 minutes of notification. If the result of the evaluation is that the patient will not undergo an interventional procedure, then the care of the patient reverts to the ER physician. If the result of the evaluation is that the patient undergoes an interventional procedure, then the care of the patient during the procedure and recovery and follow-up is the responsibility of the on-call physician or his/her successor or designee.

2. Expectations of attending and consultant

A. On admission, the attending physician is designated. The attending physician is a member of the medical staff who directs and coordinates patient care. Responsibilities of the attending physician include, but are not limited to:

1) Coordinating medical information that is provided to the family. This includes coordinating physician consultations, which includes personally contacting the consultant, when appropriate, and providing him/her with pertinent information. The attending shall write an order in the medical record for consultation, including the purpose of the consultation. In the event of a disagreement between the attending and consulting physician, the attending
physician is responsible to direct care and to communicate plans to the patient and family.

2) Working with hospital staff to satisfy family requests for family meetings.

3) Discussing code status with the patient and/or designee and writing the appropriate order in the patient's medical record.

4) Completing all requirements for transfer and/or discharge of a patient.

5) Transfer of Attending Physician responsibilities may be done only by direct communication with another physician (face-to-face or by telephone) who agrees to assume the Attending Physician role. Following direct communication, the Attending Physician shall write an order in the chart for “transfer of Attending Physician responsibilities to” designating the physician who has agreed to the transfer. The original attending shall remain the Attending Physician until there is documentation in the medical record of the acceptance of the transfer of Attending Physician responsibility by the contacted physician. At the time of acceptance of the transfer, the hospital staff shall enter the new Attending Physician into the computer system generating necessary documentation. The new attending physician will inform the family that he/she has assumed responsibility of the care of the patient.

B. The consulting physician is a member of the medical staff who evaluates and treats a patient at the request of the attending physician and in coordination with the attending physician. At the first documentation in the medical record by the consulting physician, the hospital staff shall enter the consultant into the computer system for the consulted patient. Responsibilities of the consulting physician include, but are not limited to:

1) Evaluating the patient in a timely fashion, in agreement with the attending physician.

2) Documenting findings and recommendations immediately in the patient’s medical record. At a minimum, this will include a brief, legible handwritten note and, when clinically appropriate, a
3. Expectations regarding residents.

| A. Medical students and residents at WakeMed must be under the supervision of a medical staff member approved by the University of North Carolina at Chapel Hill (UNC) or the Executive Director of Wake AHEC. |

4. Expectations regarding physician orders.

| A. All orders for treatment shall be in writing, dated, timed and signed by ordering physician, ordering Physician Assistant or ordering Nurse Practitioner, or the covering physician if the ordering physician so elects. |
| B. An order shall be considered to be in writing if dictated to a RN, LPN, respiratory therapist, occupational therapist, physical therapist, speech therapist/pathologist, pharmacist, clinical dietician, cardiovascular specialists, another physician, or nurse midwives and signed by the ordering physician, ordering Physician Assistant, ordering Nurse Practitioner, or the covering physician if the ordering physician so elects. |
| C. Verbal orders dictated in the following disciplines will be within their expertise: respiratory therapists, occupational therapists, physical therapists, speech therapists/pathologists, pharmacists, and clinical dieticians. |
| D. All verbal orders shall be dated, timed and signed by the person to whom dictated with the name of the physician, Physician's Assistant, or Nurse Practitioner per his or her own name. |
| E. All verbal orders shall be authenticated within 48 hours with date, time and signature by prescribing practitioner or other practitioner responsible. |

Medical records shall monitor compliance with this standard via discharge record analysis. Incomplete records shall be processed in accordance with procedures described in section 4.
| 5. Expectations regarding medication administration and management. | A. Drugs used shall be those listed in the United States Pharmacopoeia and National Formulary with the exception of drugs for bona fide clinical investigations. Exceptions to this rule shall be well justified.  

B. When a brand name drug is ordered by a physician, any brand name drug having the same pharmacological composition may be used, unless the ordering physician writes the order on a prescription blank, whereby the brand name drug specified on the prescription blank will be procured immediately for the patient by the Pharmacy.  

C. Orders for narcotics expire automatically after 72 hours and must be renewed every 3 days. Orders for all parenteral antibiotics must be renewed every 5 days and for all other antibiotics every 10 days. This rule does not apply to orders designating a specific number of doses or a termination date. No medications are to be discontinued without the attending physician being notified. There is an automatic cancellation of standing drug orders when a patient undergoes surgery or major procedures requiring local or regional anesthesia.  

E. No investigational drugs and FDA drugs for experimental usage shall be used without prior approval of the Institutional Review Committee.  

F. Upon admission to the hospital, the nurse should make all efforts to identify the medications which the patient has been taking regularly and then get a verbal or written order from the physician to continue those medications which he deems appropriate. Furthermore, if a physician wishes a patient to take medications brought from home, those medications should be turned over to, and in turn, dispensed by the nurse to assure appropriate timing and dosage of medications. At the discretion of the attending physician, specific medications may be kept at the bedside of the patient with a written order from the attending physician. |

| 6. Expectations regarding the | A. An adequate medical record shall be maintained for every person admitted as an inpatient and/or seen as an outpatient or emergency |
| Initiation and maintenance of medical records. | room patient. The medical record shall contain sufficient information to clearly identify the patient, support the diagnosis, justify the treatment, document the course and results and facilitate the continuity of care. The medical records shall contain the specific data and information addressed in the Joint Commission on Accreditation of Healthcare Organizations standards and Medicare Conditions of Participation.  

B. The attending/admitting physician is responsible for the medical record; incidents of transfer to another physician shall require a written order.  

C. An H&P shall be documented as described in Section 6 and 7.  

D. A discharge summary, including the reasons for hospitalization, the significant findings, the procedures performed and treatments rendered, the patient's condition upon discharge and instructions given to the patient or family is required.  

E. A final progress note may be substituted for a discharge summary for uncomplicated stays less than 48 hours. This note shall include the patient’s condition at discharge, discharge instructions and required follow-up care.  

F. Progress notes shall be written daily on acute care patients and shall reflect an actual encounter with the patient. For all other patients, i.e., those awaiting disposition to an alternate level of care, as noted in the medical record, progress notes should be written at least every other day.  

G. Printed forms completed by the patient, his family or others giving supplemental medical data approved by the attending physician are acceptable as part of the medical record as well as recent, still-valid copies (completed within 30 days prior to admission) of office records.  

H. Medical records and individually identifiable patient health information |
in any form shall be confidential in accordance with state and federal law.

I. All clinical entries must be dated, authenticated and include the signature and WakeMed assigned 5 digit identification number by the practitioner, physician assistant, or nurse practitioner who documented the entry. Authentication must include the WakeMed assigned 5 digit identification number and may be by written signature, electronic signature (the electronic signature does not require the 5 digit ID#), initials or rubber signature stamp. Signature stamps may be used when a physician, signs a statement that he/she alone will use the stamp and that the stamp will remain in their possession. This statement is on file in the Medical Records Services Department. Authentication by the practitioner, physician assistant, or nurse practitioner is required to assure the completeness and accuracy of their clinical entries.

J. All Clinical entries in the medical record shall be legible.

K. No Medical Staff member shall complete a record on a patient unfamiliar to him in order to retire a record that was the responsibility of another staff member who is unavailable permanently or protractedly for any reason. Such records shall be referred to the Medical Executive Committee for disposition.

L. Physician orders shall not include abbreviations that are identified as Do Not Use abbreviations. A list of these abbreviations is located on clinical/nursing units and on the intranet.

M. All records are the property of the hospital and shall not be removed from the hospital premises except by court order, subpoena, or statute.

N. In cases of readmission of a patient, all previous records shall be available for the use of the physician.
| O. For the purpose of bona fide study and research, staff physicians in good standing may be permitted access without charge to: (1) all medical records of patients who have given written consent; or (2) to individually identifiable health information that may be disclosed without written consent or authorization for research purposes pursuant to state and federal law. The Institutional Review Board shall determine what constitutes “bona fide” study and research. Subject to the discretion of the Hospital President, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. |

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<th>7. <strong>Expectations regarding admission and discharge of patients.</strong></th>
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<td><strong>A.</strong> The patient must be seen by the admitting physician, resident, Physician Assistant (PA), or Nurse Practitioner (NP) prior to admission or within twelve (12) hours for admissions to all non-ICU floors. Please refer to the Critical Care Admissions Policy regarding admissions to ICUs.</td>
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<td><strong>B.</strong> In all cases, the admitting physician will see the patient within twenty-four (24) hours.</td>
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| **C.** A history and physical (H&P) is to be completed and documented within the first 24 hours of inpatient admission by a qualified member of the Western Wake medical staff, resident, Physician Assistant, or Nurse Practitioner and shall include:  
  a) Chief complaint,  
  b) Details of present illness,  
  c) Relevant past social, and family history,  
  d) Inventory of body systems,  
  e) Physical examination and assessment,  
  f) Preliminary diagnosis or impression or conclusion, and  
  g) Plan of care. |
| **D.** If the H&P is provided by the admitting physician's office, a durable and legible copy is to be provided. H&P is valid when written or |

- If a complete H&P has not been documented or dictated within 24 hours after the admission of the patient, the Manager of Medical Record Services or her designee will then notify the physician of this deficiency.  
- Medical Records Services shall monitor compliance with this standard via concurrent record analysis.
dictated within thirty (30) days prior to the admission of the patient. If written prior to admission, physician will note whether or not there have been changes since the H&P was performed.

E. Patients shall be discharged only with the approval of the attending physician. The standard discharge time is 11:00 am unless the patient is undergoing a test, specified evaluation, procedure, or therapy on the day of discharge.

8. Expectations regarding management of operative procedures.

A. Prior to performance of surgery or procedure that places the patient at significant risk and/or is performed in an operating room, an H&P (including a preoperative assessment and diagnosis) must be completed by a qualified member of the Western Wake medical staff and documented in the medical record. H&P is considered valid when it is written or dictated within thirty (30) days prior to the surgery or procedure. When the H&P is written or dictated prior to the day of surgery, an update of the patient’s condition shall be documented. Acceptable means for meeting this requirement are:
   1) The physician who will perform the procedure, or his/her PA or FNP, documents the update of the patient’s status in the record or
   2) Completes the Patient Status Update form.

NOTE: Patient status update is NOT required for inpatients who have a surgical procedure after the first 24-hours of admission.

When such history and physical examination are not recorded before the time stated for operation or procedure, the operation or procedure shall be canceled unless the attending surgeon documents in the patient’s medical record that such delay would constitute a hazard to the patient.

B. In an unusual emergency situation in which there is inadequate time to record the H&P before surgery, a brief note, including the preoperative diagnosis, is recorded before surgery. In these cases, a complete H&P must be completed and documented following surgery. The scope of an appropriate preoperative assessment shall include,

• Medical Record Services shall monitor compliance with this standard via review of preoperative information submitted in the days prior to the surgery date. OR staff will delay surgery/procedure for those patients who do not have a valid H&P documented and present on the medical record.
but not be limited to, the following:

1) **Chief Complaint**
2) **History:** Patient’s medical, anesthetic, drug and pertinent family history.
3) **Physical Examination:** Current physical status with emphasis on the current diagnosis.
4) Results of any relevant diagnostic studies.
5) Planned choice of anesthesia.
6) **Preoperative diagnosis.**
6) **Blood/Blood Products:** The need for blood/blood products should be identified and appropriate products available prior to the procedure.

C. A surgical operation shall be performed only after a consent has been obtained in accordance with the corporate policy entitled “Informed Consent”, except in emergencies.

D. Surgeons must be in the Operating Room and ready to commence operation at the time scheduled, and in no case shall the Operating Room be held longer than 15 minutes after the time scheduled. Patients will not be induced by the anesthesiologist unless the surgeon is present on the premises of the hospital and the H&P is documented in the medical record.

E. A progress note shall be entered in the patient’s medical record immediately following surgery and contain:
   a) Name of the primary surgeon, assistants,
   b) Findings,
   c) Technical procedure used,
   d) Specimens removed, and
   e) Post-op diagnosis.

F. A complete description of the surgery/procedure, to include patient name, date of surgery and medical record number in addition to other pertinent clinical information, shall be dictated immediately following the procedure.
| 9. Expectations regarding the **timely completion of medical records** |  
|---|---|
| A. All portions of the medical record of a patient are to be completed by the responsible practitioner within thirty (30) days of discharge. A department chair may require a record to be prepared within a shorter time frame, including immediately, if he deems it necessary for the welfare of the patient |  
| B. A Practitioner with an incomplete record(s) will be notified every week by letter that the record is available for completion. |  
| C. Thirty (30 days after discharge), the incomplete medical record is considered a delinquent record. A practitioner with a delinquent medical record is notified via a special notice letter from the President of the Medical Staff or his designee, that automatic suspension has occurred in accordance with Section 12 of the Medical Staff Bylaws. A copy of the notice will be forwarded to the Medical Director, the operating room, and the Medical Staff Services Office. |  
| D. If deficient records are not corrected within the next seven (7) calendar days (37 days from discharge), the practitioner may lose his Medical Staff membership and clinical privileges as defined in Section 12 of the Bylaws. |  
| E. The Medical Staff President and Department Chair, in conjunction with the Medical Director and for good cause shown, may waive imposition of a suspension by extending the period of completion of a medical record for a defined number of days not to exceed thirty (30) days. Generally, a “good cause” that must be shown by the practitioner is an unexpected, unplanned, exceptional circumstance necessitating the practitioner’s absence from his routine practice. |
F. A bona fide emergency, as defined in Section 20 of the Systemwide Credentialing Plan, deactivates the automatic suspension sanctions during the time of the emergency.

10. **Expectations regarding autopsies and reporting requirements to the Medical Examiner.**

   A. Every member of the Medical Staff shall secure legally and medically appropriate autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent of the deceased patient.

   B. All autopsies shall be performed by the Hospital pathologist or by a physician delegated this responsibility.

   C. The death of a patient must be reported to the Medical Examiner if any of the following criteria are met.
   1. Suspicion that death is due to an injury (potential accident, suicide, or homicide), regardless of the time elapsed between the injury and death.
   2. Suspicion that death is due to a toxic agent (potential accident, suicide, or homicide).
   3. Suspicion that death is due to a contagious agent that represents a potential threat to the public health.
   4. Suspicion that therapeutic misadventure or a known complication of care caused or contributed to death.
   5. Suspicion of or history of child abuse.
   6. Suspicion that death was due to some other than a natural cause.

   If any of the criteria for reporting cases to the Medical Examiner are met, the attending physician must discuss the case with the Medical Examiner. The family should not be approached about an autopsy before calling the Medical Examiner. Following a discussion of the case, the Medical Examiner may or may not assume jurisdiction. If the Medical Examiner assumes jurisdiction, a Medical Examiner’s autopsy may or may not be ordered.

   If the Medical Examiner declines jurisdiction and the attending physician would like an autopsy for medical purposes, the attending physician may approach the family for permission. If the Medical Examiner accepts jurisdiction and is able to determine during the initial discussion of the case that an autopsy will be necessary, then the attending physician should notify the family that the death falls under the NC State Medical Examiner statutes and the Medical Examiner will order an autopsy. The attending physician should explain why an autopsy is being performed. If the family has difficulty understanding or accepting that an
## 11. Expectations regarding participation in quality related programs.

The Medical Staff shall actively participate, through its appointed representative in the hospital-wide review functions of infection control, utilization review, risk management program, safety, and internal disaster planning. Within the risk management program, the Medical Staff shall help identify general areas of potential risk in the clinical aspects of care, develop criteria for identifying specific cases with the potential risk identified through the risk management program.

WakeMed does not operate psychiatric/substance abuse units. Patients judged to be in need of acute psychiatric care are evaluated by a medical staff psychiatrist.

If the Medical Examiner accepts jurisdiction but needs to do further investigation before determining if an autopsy is necessary, they should be given the number to leave a message for the Medical Examiner, who will return their call.

| 12. Expectations regarding medical staff participation in the hospital-wide review functions of infection control, utilization review, risk management program, safety, and internal disaster planning. The Medical Staff shall actively participate, through its appointed representative in the hospital-wide review functions of infection control, utilization review, risk management program, safety, and internal disaster planning. Within the risk management program, the Medical Staff shall help identify general areas of potential risk in the clinical aspects of care, develop criteria for identifying specific cases with the potential risk identified through the risk management program. | 13. Expectations regarding medical staff participation in the hospital-wide review functions of infection control, utilization review, risk management program, safety, and internal disaster planning. The Medical Staff shall actively participate, through its appointed representative in the hospital-wide review functions of infection control, utilization review, risk management program, safety, and internal disaster planning. Within the risk management program, the Medical Staff shall help identify general areas of potential risk in the clinical aspects of care, develop criteria for identifying specific cases with the potential risk identified through the risk management program. |
| management of psychiatric patients | staff member with the appropriate qualifications and, if necessary, transferred to an appropriate psychiatric institution for further evaluation and treatment as soon as the medical condition of the patient permits such transfer. |
| 13. Expectations regarding self-treatment or treatment of family members | It is the position of the WakeMed Cary Hospital that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. |
| 14. Expectations regarding behavior | **A.** It is the objective of WakeMed and its affiliates to ensure optimum patient care by promoting a safe, cooperative, and professional health care environment in which to address the concerns of its patients. Physicians who engage in inappropriate or unprofessional behavior disrupt the operation of the Hospital and its employees by creating a hostile work environment that interferes with the effectiveness of the entire health care team.

**B.** Disruptive behavior includes, but is not limited to, the following:

1. impertinent or inappropriate comments to patients or entries in medical record or other official document that impugn the quality of care delivered by Medical Staff appointees, nurses, or other healthcare workers and otherwise go beyond the bounds of fair professional conduct;

2. sexual, ethnic, or other types of harassment, whether verbal or physical in nature;

3. criticism presented in such a way as to intimidate, humiliate, belittle, and impute stupidity of others;

4. unprofessional, pejorative, or abusive behavior toward patients, members of their families, nurses, colleagues, and other employees; |

All reports of disruptive behavior should be submitted in writing as soon as possible after the incident to the Chief Medical Officer or his designee and the department chair.

Once received, a report of disruptive behavior shall then be investigated by the Immediate Past President or his designated representative. The Immediate Past President may request the assistance of others (i.e., the Human Resources Director) in performing the investigation. If an allegation is found to be without merit, it will be dismissed and all records relating to the alleged event shall not become part of the practitioner’s file. The individual filing the complaint and the physician in question shall be notified of this decision. Particularly serious offenses may warrant immediate suspension of privileges by those empowered to do so. Furthermore, it may be appropriate to
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<td>imposing requirements on nursing staff that have nothing to do with better patient care;</td>
<td>proceed to higher or lower levels of interaction, as described below, with the offending physician, or seek recourse as otherwise set forth in the Bylaws and Related Manuals, at the discretion of the Departmental Chair, Medical Executive Committee Chairman, Immediate Past President and/or the Administration, depending on the nature or frequency of the alleged offenses. Otherwise, the process shall proceed as follows:</td>
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<td>any other behavior that represents an egregious disruption of hospital, departmental or medical staff rules.</td>
<td>FIRST ENCOUNTER: If the complaint is found to be credible, the Immediate Past President or his designated representative should speak privately and informally with the alleged offender. The initial approach should be collegial and designed to be helpful and informative to the alleged offender. It should emphasize that such conduct is inappropriate and therefore must cease. All meetings should be documented and written memos should be maintained in the medical staff member's confidential peer review file. The following guidelines should be observed with regard to the communication between the medical staff member and the Immediate Past President or his designee: A. Emphasize that if such behavior persists, formal action will be taken to stop it.</td>
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B. Document the meeting in writing.
C. Inform the staff member that he/she may submit a rebuttal to the charge. Such rebuttal shall be submitted in writing and will be maintained as part of the physician’s permanent record.
D. Send a follow-up letter to the staff member stating the nature of the problem and the need to correct the behavior. This should include a reminder to the staff member that he/she is required to behave in a cooperative, professional manner within the hospital according to the Medical Staff Bylaws.

SECOND ENCOUNTER:
If the disruptive behavior continues and is substantiated the Immediate Past President, Department Chair, and the Chair of the Medical Executive Committee shall meet with the medical staff member to advise that such conduct is intolerable and must stop.

The following guidelines should be observed with regard to the meeting between the medical staff member the Immediate Past President, Departmental Chair, and the Chair of the Medical Executive Committee
A. Emphasize that if such behavior persists, formal action will be
taken to stop it.

B. Document the meeting in writing.

C. Inform the staff member that he/she may submit a rebuttal to the charge. Such rebuttal shall be submitted in writing and will be maintained as part of the physician’s permanent record.

D. Send a follow-up letter to the staff member stating the nature of the problem and the need to correct the behavior. This should include a reminder to the staff member that he/she is required to behave in a cooperative, professional manner within the hospital according to the Medical Staff Bylaws.

THIRD ENCOUNTER:
If the disruptive behavior continues and is substantiated, the Immediate Past President, Department Chair, the Chair of the Medical Executive Committee and the WakeMed President or his designated representative shall meet with the medical staff member to advise that such conduct is intolerable and must stop. This is not meant to be a discussion but simply a final warning. It shall be followed by a letter from the Chair of the Medical Executive Committee reiterating the warning. It should be made clear to the offending physician that the next substantiated
| 15. Expectations regarding practitioner impairment. | A. WakeMed and its medical staff are committed to providing patients with quality care and are aware of their obligation to protect patients from harm. It is recognized that the quality of patient care could potentially be compromised if a member of the medical staff is suffering from an impairment. Impairment may result from a physical, psychiatric, or emotional condition. It is the intent of WakeMed and its medical staff to facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.

B. The purpose of this process is assistance and rehabilitation rather than discipline. The goal is to aid the practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients. Any practitioner shall have the right to refer him/herself to the Immediate Past President or directly to the North Carolina Physician Health Program.

C. Education of the medical staff and other organization staff about illness and impairment recognition issues specific to physicians shall be conducted periodically. | infraction will result in summary suspension of privileges.

FOURTH ENCOUNTER:
Summary suspension of medical staff privileges may result if the pattern of disruptive behavior continues or if a single event is so egregious that it warrants immediate intervention. Corrective action against the practitioner may be initiated as outlined in the Medical Staff Bylaws under “Summary Suspension”. The physician shall be entitled to procedural rights as set forth in the Fair Hearing Plan. |
If the report is found to be without merit, it will be dismissed and all records relating to the alleged event shall not become part of the practitioner’s file. The individual filing the report and the practitioner in question shall be notified of this decision.

If the report is found to have merit, the Immediate Past President will refer the matter to the North Carolina Physician Health Program (NCPHP) for formal evaluation and development of a plan of care. The involved practitioner will be notified of this referral. The involved practitioner will be required to sign a written release allowing NCPHP to provide written confidential monitoring reports to the Manager of WakeMed Medical Staff Services at least quarterly. If the involved practitioner does not voluntarily sign a release, the matter may be referred for corrective action pursuant to the Medical Staff Bylaws.

The Manager of Medical Staff Services will remove any information in the report that identifies the involved practitioner and forward the blinded report to the Medical Executive Committee which will then forward the blinded report to the Board of Directors. Monitoring reports will be required for the duration of the NCPHP Treatment Contract.
If at any time in this process, it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter will be forwarded to the medical staff leadership for appropriate corrective action pursuant to the Medical Staff Bylaws that includes strict adherence to any state or federally mandated reporting requirements.

Approved by the Board of Directors on May 7, 2002

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<td>Sections add new 2 (subsequent sections renumbered), 4, 6</td>
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<td>Section 4</td>
<td>April 1, 2003</td>
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<td>January 7, 2004</td>
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